GLOSSARY OF ACCESS TO HEALTH CARE AND RELATED CONCEPTS FOR LOW- AND MIDDLE-INCOME COUNTRIES (LMICs): A CRITICAL REVIEW OF INTERNATIONAL LITERATURE

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Access to health care is a multidimensional and complex concept. Achieving equitable access to care is an important goal for all countries, but particularly challenging in Low- and Middle-Income Countries (LMICs). Despite wide use of the concept of access, it continues to be defined and measured in very different ways. This glossary is a structured overview of key definitions for concepts related to access to health care, with special focus on the interpretation for LMICs. It aims to help people with interest in health service delivery to draw an overview and provide some pointers for further reading in both conceptual and empirical advances in access to health care in LMICs. This document is structured in five sections. The first introduces a general description of the concept of access to health care and its relevance to LMICs, the second displays the search conducted on access to health care for LMICs and the framework used for presentation of glossary terms, the third describes theoretical models most frequently used in the past when looking at access to health care in LMICs, the fourth is the list of terms, and the final section is a discussion of the most salient aspects of this critical review.

INTRODUCTION

Access to Health Care in Low- and Middle-Income Countries

The concept of access to health care is complex and multidimensional (1). Achieving equitable access to care is an important goal for all countries (2), but

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particularly challenging in Low- and Middle-Income Countries (LMICs), given the high burden of health needs and chronically under-resourced health systems (3, 4). The most vulnerable face the greatest barriers to access: people living in socioeconomic deprivation, ethnic minority groups, women, and other people who are stigmatized and discriminated against (5, 6). Improving access to health care has been set as an explicit target to achieve Millennium Development Goals (7).

Despite wide use of the concept of access, it continues to be defined and measured in very different ways. Research on access to health care has been widely conducted for several decades across countries, methodological approaches, and disciplines. As a result, numerous conceptualizations and theoretical models of the impact of access to health care on health have been proposed. Furthermore, one of the key challenges of research on access to health care is how closely related this topic is to its social context (8). Access is inextricably connected to the type of health care system available, the general level of development of the country, its demography and geography, and wider issues such as population beliefs and values about health and ill health. For this reason, how access to health care is defined can significantly vary across populations, depending on broad social, economic, and cultural components.

Why a Glossary on Access to Health Care and Related Concepts for Low- and Middle-Income Countries?

There is currently no glossary for access to health care in LMICs. Previous reviews have contributed some useful conceptual discussion of the complex and multidimensional concept of access (1, 5, 9). A number of related glossaries have been published (10–13), but none of them have a particular focus on access to health care or LMICs.

There are at least four key differences between LMICs and high-income country contexts, which provide justification for developing a framework and glossary for LMICs. First, there are well-known demographic and epidemiological differences between high-income countries and LMICs. Second, LMIC health care systems experience significant resource restrictions, not only financial but also in terms of infrastructure and human resources (14). Third, there are considerable differences between the health care systems in high-income countries and LMICs (15, 16). Multiple actors with multiple priorities, including governments, donors, international organizations, and private sectors, influence provision of services, with implications for access to health care. Fourth, LMICs often face multiple sociopolitical problems that impose ongoing burdens to their systems. Constant changes in political leaders, oppressive political systems, conflict, poverty, and economic instability are some of the many difficulties that frequently affect access in LMICs (17).

In addition to these differences, there are also important distinctions between LMICs that need further attention. As we will describe later in this article, there are

differences in terms of development trajectories and economic policies. There is also great diversity in terms of geography and sociocultural contexts that should be considered. However, given the existence of systematic and substantial shared challenges in LMICs, such as poor financial and resources, scarce research development, and others, we have decided to keep them together in this article.

Purpose and Structure of this Glossary

The purpose is to provide a structured overview of theories and definitions of concepts related to access to health care, with special focus on LMICs. We pay particular attention to the contextual differences and provide relevant examples from LMICs. The article is structured in five sections. The first one (this introductory section) provides a general description of the complex concept of access to health care, the second section displays the review on access to health care for LMICs and the way in which such evidence was organized for this glossary, the third part briefly informs about different theoretical models most frequently used in the past in LMICs, the fourth section is the list of terms, and the final section is a discussion and conclusion.

METHODS

Literature Search

We conducted a review of the literature in November 2011 in the following databases: PubMed, Cinhal, ISI Web of Knowledge, Embase, Lilacs, Cochrane Library, and ProQuest/Asia ProQuest. The search terms were "access," "health care," and "low and middle income countries" (terms adapted to MeSH words according to each database). We then included the string words of "need," "quality," "trust," and "equity" to expand the potential articles to retrieve that could be relevant to LMICs. We chose these particular words after a brief scoping search in an early stage of this article (July 2011) identified a number of relevant articles with these key words. In order to retrieve the maximum possible articles, we decided to conduct the final search with the MeSH and the string words together. There was no predefined limit of year or language. We included further papers and key "gray literature" based on our previous experience and manual searches of reference lists. A total of 68 papers and 12 pieces of gray literature were finally included in this article (n = 80 included in this review).

Framework Used for Analysis of Key Concepts and Definitions

We developed a framework to provide an overview of the themes and concepts in the glossary, their linkages, and interrelations (Figure 1). This framework was developed after reviewing the literature and through discussions between the

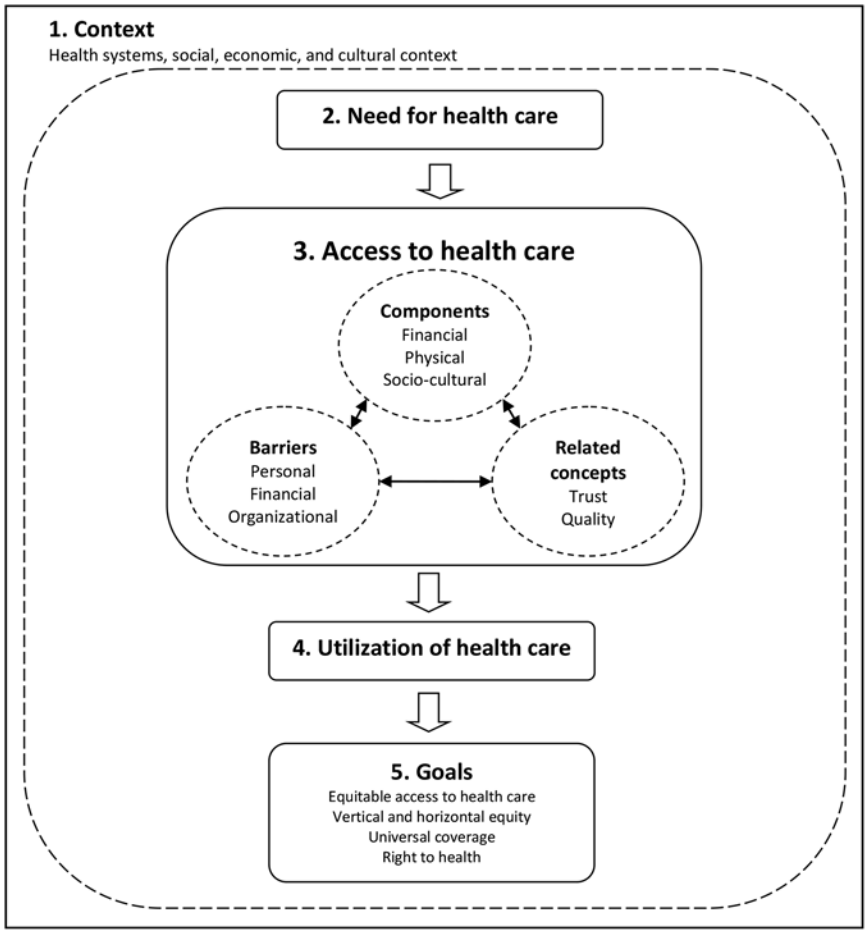

Figure 1. A framework of access to health care and related concepts for LMICs.

authors and consultation with experts. In order to develop the framework, we considered the following questions: (*a*) What are the key concepts related to access to health care for LMICs?; (*b*) How have theoretical models organized components of access, their interrelations, and underlying mechanisms?; and (*c*) How can key concepts be organized to provide a clear structure for the glossary and show their interrelations?

The diagram aims to provide a structure for analysis of key terms, as seen through an individual's experience of accessing the health care system, starting from a health care need to final goals in health care. The framework was organized into the five sections: (*a*) context, (*b*) need for health care, (*c*) access to health care

(access, barriers to access, and related concepts), (*d*) utilization of health care, and (*e*) goals in health care. Given the complexity of this topic, the concepts tended to overlap. When this happened, we made a decision on which was the most suitable place to locate the concept and discussed the linkages with other parts of the framework.

THEORETICAL MODELS OF ACCESS TO HEALTH CARE APPLIED TO LOW- AND MIDDLE-INCOME COUNTRIES

Theoretical models that have been developed to understand access to health care have taken a range of different approaches. This section provides an overview of seven theoretical models that have been widely applied to LMICs and three emerging ones.

An early and influential framework for the study of access to health care was Aday and Andersen's framework, with a focus on utilization of services (18). Further adaptations of the framework have since been presented, including greater focus on the behavioral aspects of access (for example, 19). Variants of this model have been very widely applied in the international literature, including in an analysis of maternal and child health-seeking behavior in Bangladesh (20).

Goddard and Smith proposed a theoretical framework to examine equity of access, with a focus on the United Kingdom (21). They did not pay specific attention to acceptability and demand-side issues as important dimensions of access. This framework has mostly been applied to high-income country contexts, although some studies have applied concepts to LMICs, such as a recent analysis of inequalities in health care in India (22).

Penchansky proposed dimensions of access that describe the fit between the patient and the health system. Later updates focused on the relationship between its components and consumer satisfaction (23). This has been an influential conceptualization of access, but more frequently used in high-income countries (1).

McIntyre, Thiede, and Birch's conceptual framework for access to health care for LMICs also focused on interaction and the degree of fit (5, 24). They defined access as the empowerment of an individual to use health care. The framework has been applied to understand access to health care in a variety of LMICs, including a study of barriers to malaria treatment in Kenya (25).

In their discussion of the concept of equity in access to health care, Oliver and Mossialos included the dimensions of access, need, demand side, and supply side (2). They suggested access should be an operational policy objective, such as through the development of minimum and maximum acceptable levels for factors in their model. There has been limited application of Oliver and Mossialos's conceptualization of equity in health care in LMICs.

Recently, a number of frameworks have been developed to consider access to health care in relation to poverty, specifically. Obrist and colleagues developed

a health access livelihood framework that combines public health approaches with understanding of individuals' circumstances, poverty alleviation, and livelihoods (26). A recent study applied the health access livelihood framework to examine utilization of health services in Uganda (27). Peters and colleagues reviewed factors that affect access to health services in developing countries, focusing on the role of poverty (28). It has been very widely used to assess access to health care in LMICs, including in a study of factors influencing utilization of health services in Uganda (27).

Finally, there are a number of very recent frameworks that have not yet been widely used in LMICs, but provide alternative views on access to health care. In 2010, Vargas and colleagues (29) proposed a model on barriers to health care, based on the managed competition of alternative delivery systems model by Enthoven (30). The authors applied the framework in Colombia and found wide structural and organizational barriers of access to care in this country. In 2011, Fortney and colleagues suggested a shift in the paradigm for access to health care, from its conventional nature to a digital perspective (31). Although discussed, no direct application of this model to LMICs has been conducted so far. In 2012, Irfan and colleagues (32) proposed a "Health Care Barrier Model," incorporating Andersen's behavioral model of health services utilization (33) along with the "health systems" concept (34). They assessed the usefulness of this model through a systematic review of barriers to surgical care in Pakistan as a case study.

GLOSSARY OF TERMS

Context

Low- and Middle-Income Countries (LMICs). The World Bank's widely used definition classifies countries by gross national income per capita (all figures in U.S. dollars). These groups are, according to 2010 gross national income per capita: (*a*) low income, $1,005 or less; (*b*) lower middle income, $1,006–$3,975; (*c*) upper middle income, $3,976–$12,275; and (*d*) high income, $12,276 or more (35). Although they are grouped in terms of the size of their economy, there are differences in terms of development trajectories and economic policies. There is also great diversity in terms of geography and sociocultural contexts.

Health Systems. The widely-used World Health Organization definition of health systems states that they "carry out the functions of providing or delivering personal and non-personal health services; generating the necessary human and physical resources to make that possible; raising and pooling the revenues used to purchase services; and acting as the overall stewards of the resources, powers and expectations entrusted to them" (36, p. xii). Health systems in LMICs can be particularly complex, with a mix of public, private for-profit, and not-for-profit provision, and roles played by governments, donors, and international

organizations. Chile, for example, maintains significant inequities in access to health care, which are largely due to people's ability to pay (37).

Need

Need for Health Care. An individual's need for health care has been defined as the ability to benefit from care (38). Capacity to benefit exists when there is evidence that care provides benefits among similar individuals with the particular condition (38). Need for care is therefore linked with evidence of effectiveness of health care interventions (21). However, given scarce resources and high burdens of disease in LMICs, health systems cannot meet all needs for health care (5). The individual's perceived need for health care could be thought of as the first step to access (Figure 1). Different dimensions of need have been described, including differences between normative (defined by an expert relative to a norm or standard), felt (perceived or wanted by a person or population), expressed (when a felt need is self-reported/acted on), and comparative need (if an individual has similar characteristics to a group that is receiving care) (2, 39) and between perceived (self-identified) versus evaluated (judged by a professional) need (19).

Individuals' perceptions of health needs may be shaped by factors including health beliefs and awareness, which may in turn affect care-seeking and health care access. For example, a recent qualitative study in Ibadan, Nigeria, investigated factors that influence utilization of cervical cancer screening. One of the main findings was that women were not aware of cervical cancer or the screening process and therefore did not recognize their need for screening (40). The needs of a population may change over time and between different subgroups. Furthermore, there might be mismatches in perceived needs, between different decision makers and different actors (e.g., government, nongovernment organizations, international institutions), with implications for health care provision and access.

Access to Health Care

Access to health care is a complex and multidimensional definition that has evolved over time. One of the first and most widely used definitions of this concept refers to the *ability to reach*, obtain, or afford entrance to services (41). This definition focused on the "demand side," that is, the population needing care. A focus on the "supplier side," that is, the providers of health care, was developed by defining access as the *availability of services*, or opportunity to use services (42). Other authors have suggested that the presence of health services alone does not imply access to health care; rather, access has should be conceptualized in terms of *utilization of services* (18, 43). This conceptualization of access incorporates two dimensions, the supply side and the demand side. More recently, access has been viewed as *the fit or interactions* between the individual's needs and the

health system's ability to meet needs (23). McIntyre and colleagues define access as "a multidimensional concept based on the interaction between health care systems and individuals," in which the dimensions of availability, affordability, and acceptability interact to affect people's *empowerment* (5, p. 180). The concept of access needs to be interpreted within the particular economic, sociocultural, geographic, and health system context of LMICs.

Components of Access

Physical or Geographical Access (Availability of Health Care). Availability of health care reflects whether the appropriate health care providers/services are supplied in the right place and at the right time to meet the health needs of the population (1, 5). Health care may be unavailable if there are insufficient or inappropriate services to meet the population's needs or if services are concentrated in particular areas, with insufficient service provision in other areas with need (e.g., in poor, rural, geographically isolated communities) (28). An example is the inequitable distribution of services for mental health in many LMICs, with a focus on hospital care in large cities and lack of community-based and rural services (44).

Financial Access (Affordability of Health Care). Affordability incorporates the full costs to the individual of using the service and the individual's ability to pay in the context of the household budget and other demands on that budget. Costs may include direct costs of care, such as fees, the cost of drugs, transport costs, and indirect costs, such as the loss of wages while seeking care. Ability to pay also impacts on household expenditure (5, 45). A striking example of research into affordability has shown that purchasing medicines leads to the impoverishment of large numbers of people in LMICs (46).

Sociocultural Access (Acceptability of Health Care). Acceptability has been defined as the "fit between provider and patient's attitudes toward and expectations of each other" (5, p. 187). Provider attitudes toward patients' characteristics, such as demographic characteristics or perceived behaviors, and patients' expectations, such as referral processes, provider respect, and health care beliefs, influence the individual's ability to use care (5). On the other hand, individuals' beliefs, expectations, attitudes, and subjective norms toward health and health care also determine acceptability and utilization of health care. In Chile, the *Mapuche* minority ethnic tribes have their own understanding of what causes and cures HIV/AIDS and, therefore, their responsiveness to its prevention and screening in primary health care centers is relatively low (47). Another recent example from Andean communities in Latin America reported the relevance of local cultural values to access and use of health care (48).

Barriers to Access

Barriers to access are factors that prevent people from accessing care. They can occur at different points on the pathway to access, from recognition of health needs to utilization of effective, appropriate, and acceptable services and attainment of desired or appropriate outcomes. Barriers include both "supply-side" factors relating to the costs and organization of services, as well as "demand-side" factors, such as knowledge, cultural beliefs and attitudes concerning medical conditions, and patient preferences and priorities. Different types of barriers are presented in the following paragraphs.

Personal Barriers to Health Care. Personal barriers to health care can be physical; emotional/mental; related to degree of knowledge and ability to navigate the system; related to religious/beliefs; or based on past experiences, traditions, attitudes, self-efficacy, and subjective social norms (19, 49–51). Personal barriers in LMICs include, for example, awareness (52), fear of stigma and discrimination (53), and perceived lack of information (54).

Financial Barriers to Health Care. Financial barriers are related to user charges and other costs of accessing care (see *affordability*) that deter people from accessing care. Although there are financial barriers to health care worldwide, they are particularly widespread and important in LMICs. For example, Luong and colleagues found that people from poor households in Vietnam often do not seek care for diarrheal diseases, largely because the costs of care are unaffordable (55). In recognition of the negative consequences of financial barriers to access in LMICs, a range of strategies have been implemented to remove or reduce financial costs of care. There has recently been a focus on the removal of user charges for health care, which has been followed by increased utilization of health services in many African countries (56). There has also been a commitment to expanding social insurance coverage in many LMICs, with cross-subsidies between wealthier and poorer groups. A range of smaller scale initiatives have also been implemented in Tanzania, using mobile phones (57).

Organizational Barriers to Health Care. These include aspects of structure and process of the health care system and its multiple interacting providers (29, 34). Barriers such as long waiting lists and waiting times may result from insufficient resources or their inefficient use. Inadequate referral processes may also act as a barrier to care (1). Inadequate health care workers (in terms of the number and skill level) and their inappropriate distribution are important components of this issue, which are particularly challenging in LMICs. Mavalankar and Rosenfield note that women in India must often travel for emergency obstetric care provided by obstetricians in higher level facilities and proposed further training for health workers at lower levels (58).

Physical/Geographic Barriers to Care. Factors such as the distance to appropriate health care facilities and insufficient transport to reach services may act as physical barriers to care. This term overlaps with components of organizational barriers to care. A recent study in Burkina Faso, for example, found that under-five mortality rates were considerably higher in villages that were at least four hours' walk from a health facility, highlighting the importance of geographical barriers to access for health outcomes (59).

Related Concepts

Trust in Health Care. Trust is a complex and multidimensional concept consisting of cognitive (rational judgments) and affective (relationships and affective bonds) factors. This may include confidence in health workers' competence (e.g., skill and knowledge that a health worker has to promote and restore a person's ill health) and belief that the health worker is working in the person's best interests (60–62). In urban Sri Lanka, poor relationships with health workers acted as an access barrier in the public sector. Although public-sector health care was free, people were willing to pay for private health care, where they felt that doctors listened and the interpersonal quality of care was better (63).

Quality in Health Care. Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (64, 65). The concept of quality in health care is multidimensional. It can encompass the following aspects: (*a*) quality of structural aspects, including the building, equipment, and drugs; (*b*) quality in delivery of care, including patient satisfaction, waiting times, and confidentiality; and (*c*) technical quality, including competence of staff and adherence to standards and guidelines (66). An evaluation of quality of care provided to patients with chronic noncommunicable diseases in Ethiopia found that the majority of diabetes and hypertension patients were not receiving the recommended components of care (67). Also, Baltussen and colleagues investigated patients' views on different dimensions of the quality of health care in Burkina Faso, in order to identify policy priorities to improve utilization (68).

Utilization

Utilization (Realized Access to Health Care). Realized access is the actual use of services. Health systems can be said to be utilized by the population when they show a proper "fit" between clients and the health system. Some authors have distinguished between having access (availability, or having the potential for using health services) and gaining access (health care utilization, or overcoming barriers) (1, 19).

Potential Access to Health Care. Anderson used the term "potential access" to describe "the presence of enabling resources," which increase the likelihood of use of services (19, p. 4). He termed actual use of health services "realized access." Studies in LMICs suggest that enabling resources are financial cost and resources, socioeconomic class, region, and transportation. These dimensions have been widely explored in the past, but mostly seen as barriers to access to health care, and the term "potential access" has not been widely used.

Goals

Equality and Equity in Access to Health Care. The most frequently used definition of equity in health care is fairness in access and delivery of health care for different groups in a population (42, 69). Equitable access occurs when the majority of variance in health service use is accounted for by "fair" or need variables (e.g., being sick, genetic predisposition) (33). Inequitable access occurs when other factors, such as the social structure (e.g., ethnicity), health beliefs, and enabling resources (e.g., income) determine who gets medical care ("unfair" or non-need factors) (33).

Vertical Equity in Access to Health Care. Vertical equity is the provision of unequal health care for people with unequal needs. For example, disabled people have a higher use rate of chronic health care programs than individuals without such conditions in Chile (70).

Horizontal Equity in Access to Health Care. Horizontal access is the provision of equal health care for people with equal health care needs (42, 71, 72). One example is the underutilization of chronic health care programs by disabled international immigrants when compared to the disabled Chilean-born population (70).

Universal Coverage in Health Care. Universal coverage of health services is achieved when all people have access to needed health services without suffering financial hardship (73). In doing this, a major challenge for many countries is to move away from out-of-pocket payments (56, 74). There has been a growing commitment to achieving universal coverage in LMICs (73). However, universal coverage is very difficult to attain and many gaps in coverage remain.

Right to Health and Health Care. The "enjoyment of the highest attainable standard of health" was first recognized as a "fundamental right" in the Constitution of the World Health Organization in 1946 (75, 76). The concept of right to health has been further articulated in the Universal Declaration of Human Rights in 1946 and the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1966 (77). The ICESCR identified a number of

"core obligations," including to "ensure the right of access to health facilities, goods and services on a non-discriminatory basis" and to provide essential drugs (77). Both high-income countries and LMICs face challenges in the effective implementation of right to access among immigrants (78), people living with HIV and AIDS (79), and people living with learning disabilities (80).

DISCUSSION AND CONCLUSION

Understanding of the context in which people face barriers to access health care is fundamental. Societies create their health care systems, so the way they are shaped, in their structure, process, and expected outcomes, entirely depends on what each society defines as relevant, meaningful, approachable, and sustainable. Research on access to health care in LMICs is therefore highly context-specific; different frameworks and concepts may be relevant, depending on the context. Furthermore, the interpretation of different concepts in the glossary is likely to be influenced by the context. For example, financial access has a different interpretation in a country with universal health care provided free of charge compared to a country with user charges. Other factors such as the organization of the health system, national income, geography, education, and other socio-cultural factors are important for choice of framework and the interpretation of concepts outlined in this glossary.

Access to health care is an important, multidimensional, and complex social construct. Different approaches to access to health care have contributed to our current understanding of this topic, but the range of overlapping terms used risks misinterpretations at a theoretical, empirical, and policy level. Recent development in the concepts and research evidence of access to health care in LMICs is innovative and useful, but also challenging. The existence of several new theoretical models on access to health care is a good example of this. These aspects are relevant to every country in the world, but are particularly complex in LMICs. Despite these developments, significant challenges in the application of frameworks and concepts related to access to health care in LMICs still exist.

Our analysis of frameworks and concepts related to access to health care in LMICs has identified some key considerations. The first of these concerns the research evidence base. Growing evidence on access to health care in LMICs reveals inequities in access, both between countries and within, with the most vulnerable facing the greatest barriers to care. However, the quantity of evidence on access to health care from LMICs remains modest relative to evidence from high-income countries. Further research and policy responses are needed to expose and address inequities in access to care in LMICs. International organizations, research funders, and academic institutions with an interest in global public health and equity could promote high-quality research in LMICs in order to further understanding of barriers and facilitators to access and develop policy responses.

We have confirmed that despite wide use of the concept of access, it continues to be defined and measured in very different ways. The use of frameworks and glossaries can help researchers to develop thorough and theoretically driven research. Such tools can help researchers to identify the components of access, classify concepts and manage their complexity, and identify their inter-linkages. They also provide structure and common ground for cross-national comparative research. Study findings, in turn, can feed into the further development of definitions and theory. Further research should be guided by clear understanding of the theory and concepts, as outlined in this glossary. The use of a glossary and frameworks could also help global public health practitioners gain an overview of the range of concepts related to access and of their definitions, linkages, and relevance to LMIC contexts in order to develop thorough and theory-based policy approaches.

Finally, our focus on LMICs reflected similarities between these groups of countries, yet we also acknowledge the many distinctions between LMICs. Hence, particularities and distinctions in access to health care between poor and upper-middle-income countries need further attention from researchers and public health practitioners.

This glossary has provided a summary of the key concepts related to access to health care, with a description of some examples and key challenges in LMICs. We considered access to health care in relation to five domains: (*a*) context, including national and international level; (*b*) need for health care; (*c*) access to health care, including the components of access, barriers to access, and related concepts; (*d*) utilization of health care; and (*e*) goals, including different approaches to equity in access. We analyzed and interpreted concepts with consideration of the contextual differences in LMICs and provided relevant examples.

This glossary can be used as an overview of the key concepts related to access to health care that have been or could be transferred to LMICs. It can also be used as a pointer for future reading on access to health care in LMICs. We believe this review could become a relevant tool for policymakers or researchers aiming to study or improve their understanding on the complex concept of access to health care and its significance to LMICs.

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