Evidence suggests that certain socially disadvantaged groups tend to use health services less, although these groups may need health services more. This phenomenon, sometimes referred to as "inverse care law", can partly be explained by the fact that disadvantaged groups typically face multiple barriers in accessing services. This includes financial barriers, such as direct and indirect costs of accessing services, geographical and socio-cultural barriers.

Health care coverage through health financial protection can promote access to medical goods and services, and provides financial security against unexpected or serious illness (OECD, 2004). The financial protection coverage, however, may not guarantee access to all essential health services because certain services may not be covered and cost-sharing rules may still result in high costs for patients and their families.

There is a huge divide in health financial protection coverage between OECD and non-OECD countries in the Asia-Pacific region (Figure 3.26). OECD countries have achieved universal coverage of health care for a set of services, which usually include consultations with doctors and specialists, tests and examinations, surgical and therapeutic procedures and pharmaceutical drugs, while dental care is not covered in Australia and New Zealand (Paris et al., 2010). These countries have maintained universal health coverage already for over a few decades; for example, Japan attained universal health coverage in 1961. On the other hand, health financial protection coverage is still low in non-OECD countries in the region and it is less than 10% in the Solomon Islands, India and Cambodia.

Access to care may also be influenced by socio-cultural factors, such as ethnicity and gender. A significant proportion of women reported unmet needs for health care in non-OECD countries in the Asia-Pacific region. In Cambodia, the Solomon Islands, the Philippines and Nepal, more than 70% of women with the lowest household income have difficulties in accessing health care due to financial reasons when they are sick (Figure 3.27). In Cambodia and the Solomon Islands, over 40% of women from households with the highest income also have problems with access to care due to financial reasons, while in India, Sri Lanka, Indonesia and Pakistan, less than 10% of women from household in the richest quintile have unmet care needs due to cost. These data are not available for many countries in the Asia-Pacific region, but given the large share of out-of-pocket payments (see indicator "Financing of health care" in Chapter 4), access to care may also be problematic due to cost in some other countries such as Myanmar, Bangladesh and Pakistan. There are also gender-related reasons for not accessing care. A notable share of women reported that they do not access health care because of difficulties in getting permission (Figure 3.28). The proportion is high in Cambodia, and in the Solomon Islands and Pakistan, about a third of poor women do not receive care because of difficulties in getting permission. Furthermore, in some countries such as India and the Philippines, about 20% of women do not seek care when needed due to concerns about not having female health care professionals (DHS, 2006; DHS 2013).

A third area relates to geographical access barriers: adequate numbers and appropriate distribution of health service providers are needed to ensure access to health care for a country's entire population. Distance to providers is an issue for accessing health care among many women in non-OECD countries in the Asia-Pacific region (Figure 3.29). The share of women with unmet care needs due to distance is consistently larger in rural areas than urban areas, suggesting that health care resources are less adequate in rural areas. Many women with the lowest household wealth also have serious problems with health care access due to distance. In Nepal, the Solomon Islands and Pakistan, about 70% of women from households in the poorest quintile reported having unmet care needs due to distance.

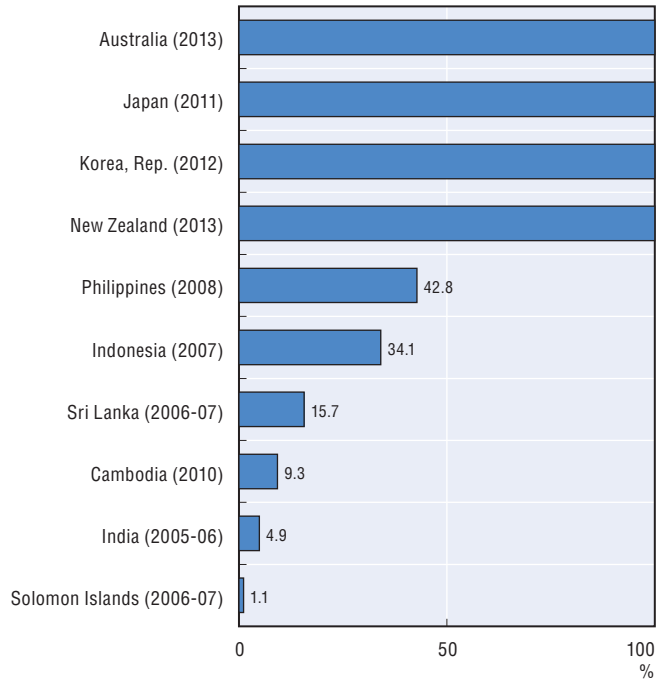
In addition, lack of knowledge and awareness can hinder groups from accessing care. Poor quality or lack of responsiveness of the health system may also present barriers. An important starting point to identify and tackle access barriers to care is to collect appropriately disaggregated health information to identify those population groups that have been left behind and inform equity-focused analysis and action.

Definition and comparability

Data on health financial protection coverage are available only for a limited number of countries. For several countries, national averages are estimated based on the data for males and females, and female coverage is used as the national average if data are not available for male. The range of services covered by health insurance and the degree of cost-sharing applied to these services vary across countries, so it should be noted that the insurance coverage *per se* does not guarantee the same level of access to health care across countries.

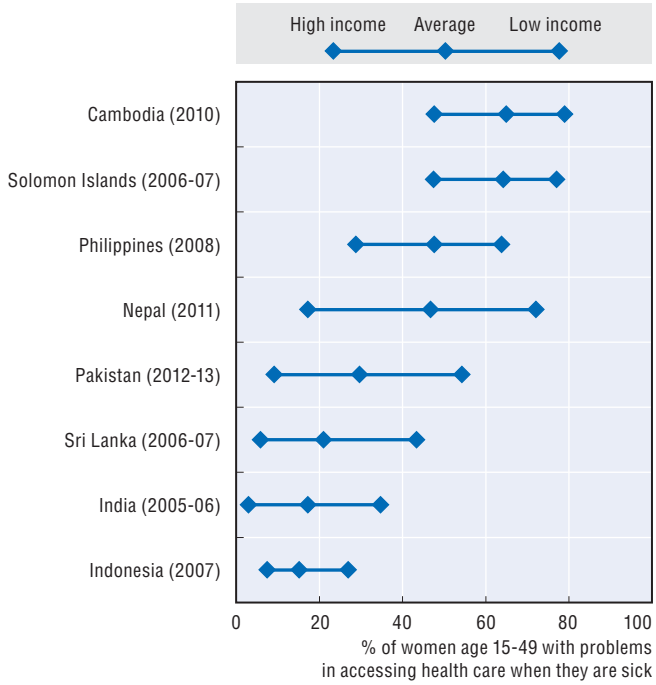
Data on problems with access to care are based on data collected through DHS. These questions were asked of women aged 15-49, who reported that they had serious problems in accessing health care when they were sick. Equivalent data for men are not collected in the survey.

3.26. Health care insurance coverage, latest year available



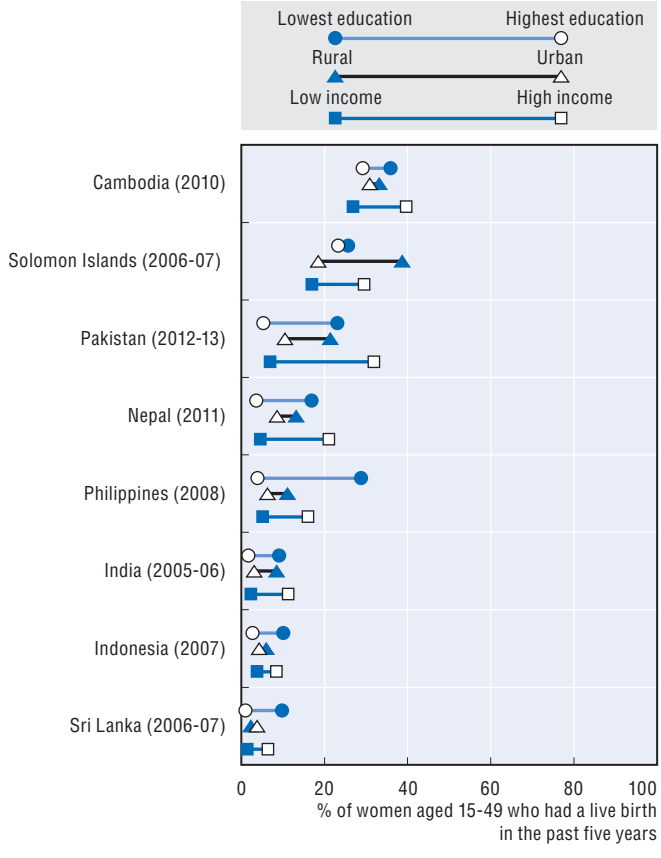
Source: *OECD Health Statistics 2016*; DHS & MICS surveys 2005-15.

3.27. Problems in accessing care due to financial reason, latest year available



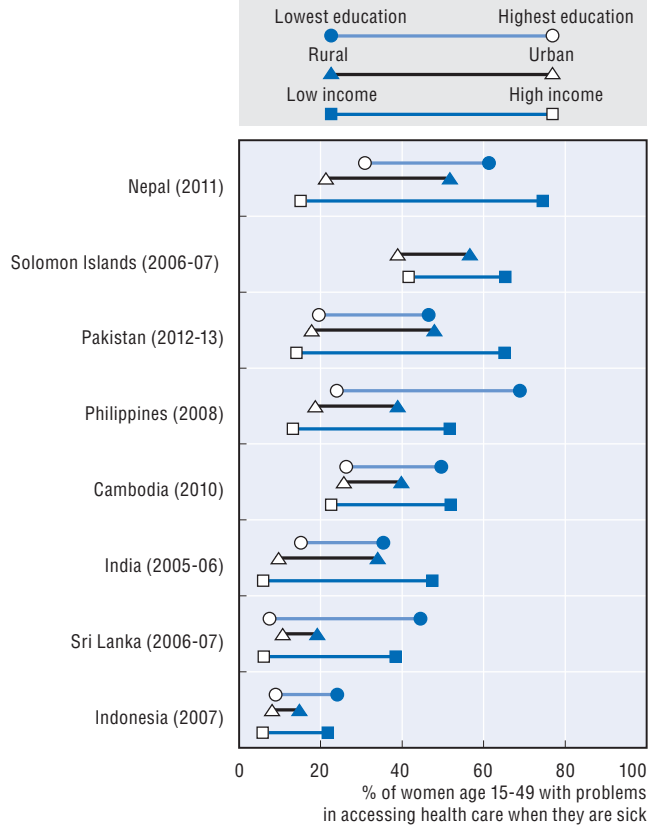
Source: DHS & MICS surveys 2005-15.

3.28. Problems in accessing care due to difficulties in getting permission, latest year available



Source: DHS & MICS surveys 2005-15.

3.29. Problems in accessing care due to distance, latest year available



Source: DHS & MICS surveys 2005-15.

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