

HEALTH CARE PROVISION AND EQUITY

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ABSTRACT

Equity is the absence of avoidable or remediable differences among groups of people that are defined socially, economically, demographically or geographically. It is fundamental to address these determinants in order to achieve equity in health. Health care provision refers to the way inputs such as money, staff, equipment and drugs are combined to deliver health interventions. In the provision of health care for a country, various equity issues has arisen especially with regards to health care services, health care financing, utilization of services, privatization and also the role of state with regards to equity in health care which were explored further in this article. Inequitable health services in terms of access, quality and resource allocation between urban and rural population were major equity issues especially in developing countries. Other than that, issues on equity influences the choice a country makes with regards to their health financing system. Among the sources of health financing are from either taxation, out-of-pocket, social or private health insurances. In utilization of health care services, equity should analyze the actual utilization of health care and inequalities between groups for different needs and different demand curves. As for privatizing health care services, there is risk of replacement of service ethic with profit motive, resulting in inequitable access and more barriers to health care for the poor and those in rural areas. It is undeniable that health care systems have greatly transformed in many countries over the last decades; which results in many roles that should be played by the state if the objective of equity is to be achieved.

Keywords: Health Care Provision, Equity, Access, Quality, Resources, Privatization, Utilization, Government Role.

1. INTRODUCTION

In recent decade, there were efforts made for people to understand the concept of equity especially equity in health as a priority issue for human development (WHO, 1999). There is need to understand the health equity as a public health importance. The growing health disparities between socioeconomic groups, as well as by categories of gender and ethnic origin, suggesting links between health outcomes and social health determinants (WHO, 1999). World Health Organization has defined equity as the absence of avoidable or remediable differences among groups of people, that are defined socially, economically, demographically, or geographically (WHO, 2016). In other words, equity means fairness or justice in the way people are treated (Merriam-Webster, 2016). It is an ethical principle and closely related to human rights principles.

Health equity means social justice in health which means that no one is denied the possibility to be healthy for belonging to a group that has historically been economically or socially disadvantaged (Braveman, 2014). Other dimensions of equity in health is defined as the absence of systematic disparities in health or in the major social determinants of health between groups with different levels of underlying social advantage and disadvantage that is wealth, power, or prestige (Braveman & Gruskin, 2003). Therefore, pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions (Braveman, 2014). However, not all health disparities are unfair. Some conditions or diseases can only occur in males or females such as women has gynaecological problems, while men do not, and young adults are expected to be healthier than the elderly population. Female newborns also tend to have lower birth weights on average than male newborns. Thus, this definition is used for the purposes of measurement and operationalization of equity in health (Braveman & Gruskin, 2003).

On the other hand, health inequities involve more than inequality with respect to health determinants or access to the resources needed to be improved and maintained to achieve health or health outcomes (WHO, 2016). The term 'inequity' has moral and ethical dimensions that refer to the differences which are unnecessary and avoidable, which are also considered unfair and unjust (Whitehead, 1991). Therefore, in order to describe a certain situation as inequitable, the cause to the situation need to be examined and judged to be unfair as a whole considering what is going on with the rest of society (Whitehead, 1991). In addition, it is also important to clearly distinguish the difference between equity and equality in health. The terms equality means sameness, where different groups or individuals are given the same opportunities (Botero et al, 2012). However, it is not equitable because not everyone has the same needs to achieve similar health goals.

Apart from that, describing an equitable situation can be in the form of vertical equity or horizontal equity. The concept of vertical equity is the allocation of different resources for different levels of need, while horizontal equity refers to the allocation of equal or equivalent resources for equal needs (WHO, 1999). It is fundamental to address the social and economic determinants of health in order to achieve vertical and horizontal equity in health. This includes not only access, utilization and quality of health care, but also the living conditions in households and communities, working conditions, politics and policies that affect any of these factors.

Equity in health care refers to fair and equitable deployment and allocation of available resources for the benefit of the whole population (Whitehead, 1991). However, there are different health care needs according to age and social groups and equity may be affected by many such factors (Whitehead, 1991). Further discussions on equity issues in health care will be explored in detail in this manuscript.

1.1. Health Care Provision

Health care includes all services dealing with the diagnosis and treatments of disease, or the promotion, maintenance and restoration of health including personal and non-personal health services (WHO, 2016). While provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions (WHO, 2016). Generally, the goal of health care provision is to improve health outcomes in the population and to respond to people's expectations, while reducing inequalities in both health and responsiveness (Adams et. al., 2002). As an example, in the provision of health services in Malaysia, there are nine essential functions of public health which cover six core areas of activities: promoting health and equitable health gain, health protection, combating threats to public health, injury prevention, and disease control and food safety, with the aims to reduce disease prevalence and health inequalities of the population in the country (WHO, 2012).

Apart from that, evidence shows that the major impact on equity of health services particularly regarding their potential to reduce severity is attributable to the strength of primary care resources and services in communities and countries (Starfield, 2004). The provision of a health care system in a country that addresses all the issues of accessibility, affordability, efficiency and quality of care will contribute towards the improvement and rationalizing the equity of health in the population.

The healthcare provision in a country has led to a number of equity issues, thus this manuscript will be focusing on equity in relation to health services in urban and rural areas, utilization of health care and health care financing. Apart from that, the related issues of equity in privatization and the roles of governments in achieving equity will also be discussed.

2. HEALTH CARE SERVICES

Health care service is one of the crucial aspects of health care provision. As mentioned earlier, the ultimate aim is to improve health outcomes and reduce health inequalities (Adams et. al., 2002). There are many inequity issues surrounding the health care services all over the world. This includes health care inequities between urban and rural areas which results from various factors that challenge the health services deliveries.

Urban bias in health care services provisions has been intensified in many countries. Some of the issues identified in the health care services in urban and rural areas are the access, quality of the health care services and inequitable resource allocation (Balarajan, Selvaraj & Subramanian, 2011).

2.1. Access to Health Services Between Urban and Rural Area

Accessibility to health services in urban and rural areas remains to be one of the important issues in health system in its pursuit of equity in service delivery and in the development of a health care system worldwide.

In India, physical access is a major barrier to health services for India's rural population (Balarajan et.al, 2011). The facilities are concentrated in the urban areas as compared to the rural areas where many vulnerable groups tend to be clustered in despite the scarce services. This is exacerbated by the rapid development of the private sectors in urban areas which results in unequal geographical distribution of services. Even if the health services are physically available, this does not ensure equity to the urban and rural population. This is because the cost associated with seeking health services by the rural population may be higher as compared to the urban population.

Similarly, in China, there are isolated geographical locations where 80 percent of the poor population lives such as in the mountainous areas that serve as physical barriers, limiting them from accessing the basic health care (Liu, Hsiao & Eggleston, 1999). Tertiary hospitals are located mostly in the cities and only about 55 percent of villages have functioning health stations. Health care cost in China differs between the rural and urban areas, in which the costs in rural areas are much higher than in the urban areas. This is mostly due to the insurance coverage differences between the urban and rural population. The rural population is largely uninsured. The impact on the increased medical cost is greater in the rural areas because the household income did not grow as quickly as it does if compared to the urban areas. Therefore, the inequality of health care cost between the urban and rural population in China has contributed to the inequity to the health care services access.

In Malaysia, health care provision is undertaken by both the public and private sectors. The public sectors dominate the service provision to the rural population to ensure equity while the private sectors concentrate their services largely in the urban areas where there is demand (Hanafiah Juni M., 1996). By providing health care facilities for every 5 kilometer distance, the geographical and physical accessibility are ensured to both the rural and urban population (Ministry of Health Malaysia, 2015). However, inequity still exists in terms of cost accessibility where the rural may have to pay more in coming to seek for the services. As for the private sector it is primarily profit-motivated and is concentrated in the urban areas. On the other hand, the urban poor population is more likely to get disadvantaged both in-terms of cost-access and time-access, because it is not uncommon for the urban poor to have more than one job that restricts them from accessing government facilities, most of which are limited to official government office hours. This leaves them with no choice but to opt for private health services that offer 24 hour services with pay-for services paying method, costing them a hefty sum of money.

2.2. *Quality of Health Services between Urban and Rural Area*

The differences between the health services quality in the urban and rural areas will result in the inequity of health services provided. In India, even though the health facilities are provided in both the urban and rural areas, the quality of the services is debatable. It is documented that there is a low competence among both the private and public sectors in urban areas (Balarajan, et. al, 2011). There are also dissatisfactions with the quality of care in the public sector that leads to patients seeking treatment in the private sector but the quality may still be the same. A study in India's rural areas finds that most private providers are unqualified, with fewer than 40 percent having medical degrees and almost 20 percent with uncompleted medical degrees (Balarajan, et. al, 2011). Therefore, even when the services are there, equity in quality is not ensured.

Similarly, in Malaysia, the availability of health facilities provided to the rural and urban areas may not be able to ensure equity in quality to the population. This is because some of the health clinics in the rural areas are run by medical assistants, while health clinics in urban areas are staffed by Medical Officers (MO) or the Family Medicine Specialists (FMS). In addition, during planning of health facilities, planners purposely allocate certain types of facilities based on geographical factors and population; such as district hospitals with specialist services versus district hospitals without specialist services. Various types of health clinics are also planned based on geographical and population characteristics which result in inequitable quality of services for the population.

2.3. *Inequitable Resource Allocation between Urban and Rural Area*

Another important issue between the urban and rural population is the inequitable resource allocation. In many countries, the allocation of fund and resources of health care are based on the need of the population and they are geographically distributed (Mary, 2008). The efficient allocation of resources to the urban and rural areas is important to ensure equity of the population with equal need (Balarajan, et. al., 2011).

In India, there is an imbalance in the allocation of resources between the states (Balarajan et. al., 2011). A greater proportion of resources are directed towards urban-based services which are compounded by the private sector's bias towards higher level curative services and to be centred in wealthier urban areas (Balarajan et. al., 2011). Therefore, patients with similar need in the urban and rural area may not have equal opportunity for the health service as a result of inequitable resource allocation.

Similarly, in China, it was found that allocation of public resource has skewed towards the urban and tertiary care sectors while public subsidies for rural health care decreased significantly (Liu, et. al., 1999). Hence the inequitable resources will lead to inequity of health services between the rural and urban population.

In Malaysia health care resources also contributes toward urban bias, compounded by private health care providers growth mainly in affluent areas with high economics activities (Hanafiah Juni M., 1996). On the other hand, public sector through the Ministry of Health had

put great effort to achieve equity through public health care resources allocation for the rural population (Mary, 2008), but still there are pockets of under-coverage areas in the country.

3. HEALTH CARE FINANCING

Health care financing can be defined as the function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people in the health systems (WHO, 2000). It is how financial resources are generated, allocated and used in the system (WHO, 2016). Traditionally health systems are financed through four main sources which is taxation, out-of-pocket (OOP) payments, social health insurance and private health insurance (Chai, Whyne & Sach, 2008).

One of the main focuses in choosing a health financing system is according to how it will provide an equitable health service to its country (WHO, 2016). Equitable financing is considered a key objective of a health care system (Chai, Whyne & Sach, 2008). It can be categorized into horizontal equity and vertical equity according to the group of people who will be paying (Mills & Glison, 1988). In horizontal equity, the group of people who pays will be the one who benefits or uses health care such as the sick or potentially sick (Mills & Glison, 1988). However this will likely penalize those who are least able to pay and more likely to be sick within the low-income groups (Mills & Glison, 1988). As for vertical equity, it is an alternative that is fairer where the distribution of the burden paying for health care should reflect differences in ability to pay (Mills & Glison, 1988). One of the tools for assessment of equitable financing is the Kakwani's progressivity index (Chai, Whyne & Sach, 2008).

General tax revenue is one of the most important sources of financing in the developing countries and used in a large number of countries in the world to finance health care (Mills & Glison, 1988). It can come from a variety of taxes such as income and profit taxes, value-added and sales taxes, taxes on imports and taxes on profits from sale of natural (The World Bank Group, 2013). However it is sometimes insufficient by itself to support health care even though tax ratios tend to increase in line with development (Mills & Glison, 1988). It has a high degree of political accountability in democratic political systems through regular legislative budget processes but can lead to favoritism and corruption in states with weak governance and accountability in handling and controlling general revenues (The World Bank Group, 2013). It may also not be the most reliable source of finance because it may be given low political priority in national budget decisions (Mills & Glison, 1988). The equity impact of tax systems depends on both the proportional burden of taxation and on the use of the revenue (Mills & Glison, 1988). Tax systems can be progressive, falling more heavily on the rich than the poor and, therefore, equitable; but they may also be regressive, falling more heavily on the poor than the rich, and inequitable (Mills & Glison, 1988). Apart from that, tax revenue is often used inequitably in health systems. This is seen where the health systems are dominated by high-technology urban-based care obtained through tax revenue while the rural populations have in-adequate access to any form of care (Mills & Glison, 1988).

Insurance as a method of health care financing is becoming popular in developing countries. It is defined as a contract between the insured and the insurer to the effect that in the event of

specified events (determined in the insurance contract) occurring the insurer will pay compensation either to the insured person or to the health service provider (WHO, 2003). Two major forms of health insurance is the Social Health Insurance (SHI) where society's risk are pooled, with contributions by individuals usually dependent on their capacity to pay and the Private Health Insurance (PHI) in which premiums are based on individual or group risks (The World Bank Group, 2013).

For SHI, it is a compulsory insurance scheme where everyone in an eligible group must enroll and pay a specified premium (The World Bank Group, 2013). Often premium is a percentage of one's wage (The World Bank Group, 2013). In low-income countries SHI would only cover workers in the formal sector and only pools the health risks of its enrollees (The World Bank Group, 2013). Governments may also contribute to the premiums of social insurance beneficiaries for example in using general tax revenue to subsidize pensioners, the unemployed, the poor, workers in the informal sector and some small businessmen and farmers (The World Bank Group, 2013). The main problems of SHI related to the issues of equity are with regards to coverage (Mills & Glison, 1988). It is only easy to cover those in regular employment and there are often marked inequalities in the quantity and quality of services available to those covered by insurance relative to those who are not (Mills & Glison, 1988). It also reinforces maldistribution of resources between rural and urban areas in developing countries. It provides extra funds for largely urban, employed workers but leaves the large rural populations or the informally employed urban population at an even more disadvantaged position compared to the other groups (Mills & Glison, 1988).

As for PHI, the premium charged is not based on pooled risk of a large population, but on a personal risk characteristics and the likelihood of illness in the individual or group covered (Mills & Glison, 1988). Insurers are able to favor enrolling the healthier groups in a population, and leave out those more likely to be sick and incur higher health expenditure (The World Bank Group, 2013). The sick may also be charged a very high fee by the insurer. Private insurance is not subjected to the political allocation process and may channel extra funds into the health sector (Mills & Glison, 1988). However it is considered inappropriate for developing countries due to the low coverage because of its cost and the enhanced inequity as it excludes poor health risks.

Out-of-pocket (OPP) financing occurred when treatment are paid directly by patients for the services rendered. It is usually not reimbursable. It is often the largest type of healthcare financing in low income countries as it is simple, decentralized and easy to understand (The World Bank Group, 2013). However, issues may arise as low-income groups tend to delay use of health services until illness is severe, presumably in part to avoid payment, but such delay actually increases the necessary expenditure (Mills & Glison, 1988). High health care bills may sufficiently undermine their economic position to push them further into poverty and besides, health care expenditure can displace expenditure for other basic necessities of life such as food because there is only limited ability to pay for the range of household needs.

4. UTILIZATION OF SERVICES

Equity of health can be seen as an equal access to treatment (Money, et al, 1992). However, equity should also analyze the actual utilization of health care and inequalities between groups because different levels of health care are utilized according to different demand curves. This could be due to income differences despite having equal need (Culyer & Wagstaff, 1992). However, income and wealth should not influence utilization to health care as it is a right (Williams, 1993).

Health care in Ireland is delivered mostly through private provision. As of 2004, there were 28.4% fully eligible residents who hold a medical card for free public health service while others were private patients with limited free public health services (Nolan, 2007). Residents who faced hardship or aged 70 years and above were granted medical card automatically. In 2005, the general practitioner (GP) card was started. Medical card holders received free consultations but private patients did not. However, it was noted that more than half (58%) of the residents were covered by private health insurance by 2004 as it covered both public and private hospital care (Nolan, 2007). Average number of GP visits in 2001 was 3.3 with 73.8% visited GP at least once within the previous 12 months. Residents with higher education level had less GP visit with only 2.3 average numbers of visits. Medical card holders utilized GP more than those who were non-medical card holders in 2001. Therefore, this country shows presence of inequity in utilization of health service.

In China a study had revealed that there is an increased annual inpatient days per 1000 urban population but decreased hospital utilization among rural population during reform era. Income inequalities most likely contribute to inequality of health status and hence the inequalities in health care utilization in China (Liu, Y. et. al., 1999). Other than that, there is inequity in utilization of services in Canada as the rural residents were least likely to utilize health care services such as vaccination and specialist physician services. These services are utilized more by those with higher level of education and higher income (Sibley and Weiner, 2011).

In Malaysia, there is no significant difference in the proportion of outpatient and inpatient utilization among urban and rural population or among income level groups (NHMS, 2015). In general, public rural health services are of no charge and each rural clinic covers around 2000 to 4000 population. Public urban health services and hospitals use requires a small fee in comparison to the true value (Hanafiah Juni M, 1996). On the other hand, private health services are for those who can afford to pay as services are charged without subsidies. The public sector has 80 percent occupancy for their third class beds (Hanafiah Juni M., 1996). 72.2% of government inpatient care was utilized while 27.8% by private despite longer travel time and further distance to reach government facilities in some areas (NHMS, 2015).

5. PRIVATIZATION

Health care systems have greatly transformed since the 1980s, especially in less-developed nations, as neoliberal development strategies call for a reduction in public provisions and increased privatization, along with a host of other reforms seeking to generate economic growth and efficiency through deregulation, commodification and financialization. Privatization involves the transfer of assets, responsibilities or functions from the government sector to a non-governmental organization which may be either a voluntary agency or a private company. Narrow definitions of privatization have focused on sale or transfer of assets from the public to the private sector (Saltman, 2003). Indeed, the privatization of health care and social services represents a polarized debate in the broader global and public health fields (Basu et. al., 2012; Collyer & White, 2011), as well as in international development literatures (Arrieta et. al., 2011; Herrera, 2014). Perspectives and ideologies rooted in economic modernization and liberalization argue that economic growth and privatization represent the best ways to improve health in poor nations, and some studies indeed demonstrate private clinics may have shorter wait times and are more attentive to patient needs than public providers in less-developed nations (Basu et. al., 2012). However, the upswing in healthcare privatization and claims of enhanced efficiency do not appear to be trickling down to reductions in health inequalities (Collyer & White, 2011; Obeng-Odoom, 2012). In fact, a growing body of evidence questions the quality of private healthcare services, especially in developing nations, including issues with lack of regulation, the prescribing of unnecessary antibiotics or treatments, and poor knowledge and diagnosis of common infectious diseases among health workers (Basu et. al., 2012; Gbotosho et. al., 2009).

5.1. *The Rationale for Privatization*

Proponents of privatization argue that the process helps a government to fulfil a number of objectives, for example, reduce administrative and financial burdens with respect to providing public services, increase efficiency and effectiveness of services to achieve value-for-money, encourage innovation, and develop more user-sensitive services appropriate for a particular community or context (Nellis & Shirley, 1992). This is because privatization aligns the interests of the principal (the government) and the agent (the manager) thereby improving performance. A further rationale for privatization is to give the purchasers and consumers a stronger voice through increased choice and competition (Beesley & Littlechild, 1983). Moreover, a basic premise of supporters of privatization is that the state is an inherently inefficient service provider, that the civil service ethos of state organizations hampers effective management and that the public sector represents a "public burden" because of its largely unproductive nature. Privatization makes service providers more accountable and responsible to consumers, allows innovation, and reduces the financial burden on the state which, in turn, fosters capital formation and promotes economic development (Barraclough, 2000).

In Malaysia, similar arguments have been proffered as a rationale for privatization. Operational efficiency has been the principal rationale for privatization. In the case of the privatization of the government's pharmaceutical laboratory and central store, the then Health Minister indicated his hope that privatization would lead to greater efficiency. This was despite the fact that the government had, only a year before, claimed as an "achievement" its

modernization of stores management and control and the implementation of an integrated medical store system. However, it is not clear to what extent these benefits, which are based on experience and economic analyses of non-health sectors, can be extrapolated to the health sector.

5.2. *The Drivers for Privatization*

Traditional models or organizations tend to see structures as relatively stable entities that adapt to internal and external forces. Systems assume that structures are stable simply because traditionally we have always assumed them to be so. Anthony Giddens' "Structuration Theory" challenges this way of thinking and views structures as fluid entities. Structures themselves can constrain activity but can also encourage activity that creates new structures (Giddens, 1979).

Hence, large systems and structures have their own trajectory, with restructuring, such as greater involvement of the private sector, public-private partnerships and privatization, being part of this broad process. In Europe, in the period 1980 to 2005, one can observe an attempt to "reinvent the government" (Martinez et. al., 1993), e.g. downsize the state to a set of core activities and tasks, introduce "market-type mechanisms" with greater competition (especially on the provider side), and to encourage greater involvement of the private sector. A number of contextual factors influenced these changes, such as globalization, new public management, managerialization using information technology (IT), changes in views of organizational roles, and changing societal expectations, and these substantially affected the health sector.

5.3 *Issues in Health Sector Privatization*

Privatization in the Malaysian health sector has raised a number of issues, some of which have been discussed in public and some of which remain latent. From time to time, questions have been raised in Parliament about equity issues and services to rural areas, and a number of interest groups have criticized aspects of the privatization of health services, including the replacement of the service ethic with the profit motive. Equity has always been a major concern in any privatization process. The Malaysian Government has sought to reiterate its commitment to providing health care access for the poor in its public statements about privatization.

The provision of subsidized health services has been a potent latent political issue which has become increasingly overt on the political agenda, since Malaysians have grown accustomed to the government's dominant role in providing low-cost services. Moreover, the sensitivity of privatization in the health sector is evident in the reluctance of the government to make its detailed plans public or to encourage public debate on the issue. It has also sent mixed and confusing signals, at one time denying that it had immediate plans to privatize health services and at other times indicating that this was precisely its intention (Barraclough, 2000).

6. ROLE OF GOVERNMENT

The government has responsibilities and roles to play in ensuring the success of achieving equity in health and indeed better health governance (Siddiqi et. al., 2009). This requires demanding accountability, transparency and better leadership and partnerships within the health system, together with systematic assessment and analysis of health system governance. For example, in Malaysia at independence, almost 90% of the population were poor and urban-rural income inequity ratio in 1970 was 1:2.14. Inequities persist among ethnic groups and by geographic location (Kamaliah & Safurah, 2011). During post-independence era, focus of the development plans was on rural development. The Malaysian government had initiated the New Economic Policy (1970-1990) for economic growth in national development and social restructuring given the ethnic configurations of Malaysia's patterns of economic occupations and wealth ownership at that point in time (Kamaliah & Safurah, 2011). The poverty reduction approaches placed a strong emphasis on rural socio-economic development addressing the social determinants of health. This is implemented through Malaysia's legal, policy and institutional framework of the federal system of governance and administration (Kamaliah & Safurah, 2011).

Since health policy and implementation manifestly operate within the broader political context, defining iterative strategies for key players to maintain political priority for the equity in health agenda is necessary to champion this issue. This is particularly important because the potential beneficiaries represent a less powerful and less organized group, who are consequently less able to influence these reforms (Olson Jr., 1971). The role of civil society and the need to engage, empower and build capacity within civil society had been highlighted to demand equity in health and better quality of health care at reasonable costs. Although the evidence to support this may be slight, example such as China's experience of public dissatisfaction with the fairness of its health system, demonstrates how civil society can effect change in health reform. Ten case studies published by the Commission of Social Determinants of Health (CSDH), a commission establish by the WHO to support countries and global health partners in addressing social factors leading to ill health and health inequities also highlighted the role of civil society in promoting health equity (Gilson et. al., 2007).

7. CONCLUSION

Provision of a health care system in a country should address issues of accessibility, affordability, efficiency and quality of care which will contribute towards the improvement and rationalizing the equity in health of the population. Assessing health equity requires comparing health and its social determinants of health among advantaged and disadvantaged social groups so that resources can be equally distributed to achieve both vertical and horizontal equities. The government plays an important role in improving health care provisions of a country and thus, moving its country towards greater health equity for the population it serves.

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