Equality in Health: Access to Health Care and Right of Access to Health Care for Children in the Central Bosnia Canton

Amra Mehmedbegovic-Zivanovic
Public Health Institute of Central Bosnia Canton, Travnik, Bosnia and Herzegovina

SUMMARY
Every child has the right to the highest level of health care and access to health and medical services, with special emphasis on primary and preventive health care, public health and education and reduced infant mortality. Ensuring equity in health is a very important determinant of any public health policy. The aim of this paper is to establish the degree of realization of the right to health care from the aspect of equity in health and to establish the degree of realization of these rights in relation to access to health care. The study was descriptive cross-sectional study conducted on a sample survey of 1020 children aged 0-6 years in all the municipalities of Central Bosnia Canton. We studied the geographic, time, personnel and economic access to health care. The existence of the certified birth certificate and child health booklets are indicators for the right to access to health care. We also explored the social factors that may affect the realization of the given rights. The results show a significant violation of the children rights, especially when it comes to equality in health. We found significant differences in social status of urban and rural families. Rural population is much shakier on the basis of level of education of mother and termination of mother´s employment. Rural population threatened by inadequate geographical, time and personnel, availability of health care. A particular problem is the weak economic approach, as is evident from the fact that 66% of families live below the poverty line of 185 KM per household per month. 70.5% of all respondents have paid some of the health care services. However, members of the urban population are more vulnerable to this issue than rural. The right to access health care, which is based on the birth certificate, is not achieved for 1.5% of children, but on the basis of health insurance for 11.9%. We have shown that social and economic factors have significantly affected on the possession of the birth certificate and health insurance. Analysis of the results obtained, regulatory requirements and guidelines indicates that there is disparity between the goals, the situation in practice and opportunities for their realization. Amendments to the Law of health insurance, by the introduction of a unique program of measures, by development of family medicine, and especially the development of visiting activity can be at least partly overcome the existing disparities in the realization of children's rights to health care.

Keywords: children rights, health care, equality in health, access to health care

1. INTRODUCTION

The right to life and health is a fundamental human right, regardless of nationality, religion, political belief, social and economic status. Any child according to Convention on the Rights of children have an inalienable right to the highest level of health care and access to health and medical services, public health education and reduced infant mortality (1, 2).

Health Protection Act allows children free preventive, curative and rehabilitation care, and protection of women regarding family planning, pregnancy, childbirth and maternity through compulsory health insurance. The issue of health care of children whose parents are unsecured was not regulated until April 2009 when is established the basic package of health rights, which for unsecured people under 18 years of age guarantees the same rights as insured. About the effective implementation of this decision into action is still early to say.

The strategy of primary health care focused on "health for all" through equity and access to health care. Access to health care can be seen through several variables: geographic accessibility, availability of personnel, continuity of treatment, economic access, while access to health care provided by the existence of health insurance and the existence of valid health card (3, 4).

2. GOAL

The aim of this study was to establish the degree of realization of the right to health care from the aspect of equity in health and to establish the degree of realization of these rights in relation to access to health care.

3. METHODOLOGY

The study was descriptive cross-sectional study conducted on a sample of 1020 children aged 0-6 years in all municipalities of Middle Bosnia Canton.

The availability of health care is investigated by several variables. Geographic availability, we observed the dis-

tance from health facilities, where we took the optimal distance in urban areas up to 700 m, and rural up to 2000 m.

Availability of personnel, we observed the existence of adequate personnel to provide health care (doctors of general medicine, family medicine, specialist pediatricians), and continuity in the treatment as time continuity of health care facilities.

Economic availability is determined on the basis of economic status of families where the defined poverty threshold was the amount of 185 KM per capita per month, and personal participation in the payment of health services.

The existence of a certified birth certificate and child health identification card were indicators for the right of access to health care.

4. RESULTS

Surveyed is a total of 1020 children aged 0-6 years, from which 265 (26%) lives in urban and 755 (74%) in rural areas. The average age of the children was 2.66 ± 1.86 years.

Through research, we track the status of education, and employment of mothers, as an important factor in the realization of social rights to health care. With lower levels of education (no school, elementary or unfinished elementary school) are 27.5% of mothers, while 50.3% of mothers were housewives or unemployed.

Statistically significant number of these women lives in rural areas.

Health care for 33.3% of the population is available 24 hours, and 49.4% of the population lives from the nearest medical institution up to 1500m. Optimal distance in urban areas is 46.8% while for the rural population is 57.4%.

Figure 1. Optimal geographic distance to nearest health institution

Largest number of inhabitants (40.1%) has a dedicated health care every day in the period between 7-14 hours, while the 24-hour availability of services has 33.5% of the population.

Permanently assigned doctor for the child have 84.9% of parents and it is mainly a specialist pediatrician (89.7%). In the study we found a statistically significant difference between urban and rural environment in the assignment of a permanent doctor, as well as the type of selected physician specialty ($X^2 = 8.82$ DF = 2, $p < 0.05$). The obtained result does not mean that the population has assigned pediatrician at the nearest available clinic. Parents seeking services in the central health center or other medical institution which provides pediatric care.

Area	General practice		General practice specialist		Specialist pediatrician	
	Number	%	Number	%	Number	%
Urban	12	4.5	6	2.3	247	93.2
Rural	77	10.2	10	1.3	668	88.5
Total	89	8.7	16	1.6	915	89.7

Table 1. Specialty of selected dedicated child doctor

Follow up during pregnancy did not had 2.5% of mothers, and those are women living in rural areas (80.8%), with low education (84.6%), by occupation, housewives or unemployed (73.1%) which live in multi-member households.

Economic availability is determined by the economic status of families and personal involvement in the payment of health services.

Average monthly income per household member was 122.7 KM, and range from 10.9 to 358.4 KM. Research has shown that significant number of households in urban areas have higher monthly income than households in rural areas ($X^2 = 65.60$ df = 7 $p < 0.01$).

Number of households that have a minimum income up to 200 km is 13.3%. If we look at income in relation to the number of members living in the household, we will find that the number of people living below the poverty line of 185 KM per month per household member is 66%.

Health services for their child paid 716 (70.5%) respondents, with a significant number of those who paid for services live in urban areas ($X^2 = 7.03$ DF = 1 $p < 0.01$). In primary health care respondents usually paid medication, medical examinations and diagnostic services.

Type of service	Min.	Max.	Mean
Examination	5	250	20
Medication	5	250	20
Orthopedic aid	30	5500	325
Diagnostics	5	200	20
Vaccine	20	100	30
Referral/Certificate	10	80	12.5

Table 2. Average amount of paid services in primary health care

Respondents paid for certain services in the hospital care: from 116 children during last year that stayed in hospital 33.6% had paid for some service.

Type of service	Min.	Max.	Mean
Hospitalization	40	1200	80
Diagnostics	30	80	50
Therapy	10	250	67.5
Surgery	100	3.000	150
Other	30	140	100

Table 3. Average amounts paid for hospital services in KM

Dental services paid 47.1% from 137 children who visited a dentist at least once, out of which 20.4% paid in the public service institution. We found a statistically significant difference in the payment of dental services in the public sector in relation to health insurance status ($X^2 = 8.89$ DF = 1 $p < 0.01$).

In our study, we found the 14 children (1.5%) are without a birth certificate, out of which 36% of newborn children, while the others are older than a month. Children without a birth certificate have poor social status:

- 92% live in rural areas,
- 57.1% of mothers have lower education,
- 78.6% of mothers were housewives,
- 49.9% live in families with 5 or more members.

There is a statistically significant difference in existence of birth certificate among children whose mothers have lower or higher education, as well as regarding their employment status ($X^2 = 6.23$ df = 1 $p < 0.05$).

Without health insurance is 11.9% of respondents, the most common reason (57.7%) is that parents do not work and are not reported to the bureau of labor, while 37.4% of companies do not pay health insurance. We found a statistically significant difference in the health insurance status between urban and rural areas ($X^2 = 5.31$ DF = 1 $p < 0.05$).

Lack of health insurance caused that 8.3% of health workers refused to provide health services ($X^2 = 24.27$ DF = 1 $p < 0.01$), from which 5.0% were doctors and 3.3% nurses.

5. DISCUSSION

The actual situation for children in Bosnia and Herzegovina is a reflection of the specific political and economic situation. Although everyone agrees that the rights of children and improving their health should be a priority of any society, they are not respected and implement to desired extent. This research has shown that there are significant differences in the realization of the right to equality in health and that their implementation is affected by social and economic status of families and access to health care (5, 6, 7).

Research worldwide has shown that none of the health system so far managed to provide adequate personnel and geographical access to health care. Geographically accessible primary health care will result in its frequent use and better access to health information is an essential factor for maintaining and improving children's health. This study showed that respondents who had adequate access more frequently used services of primary health care, as well as children whose mothers had a better socioeconomic status. Availability of postnatal care is one of the first steps in achieving the goal of "a healthy start in life". Our research has shown that mothers from lower social economic status have less used prenatal care (8, 9, 10).

From 2.5 million doctors and 4 million nurses, as it is now estimated to work in the world, one third works in underdeveloped countries where more than 2/3 of the total population lives. Also notable and significant difference is in the concentration and quality of health facilities that provide antenatal protection. In most countries, and countries of our environment, these services are located in large medical centers, and many are excluded from the primary level of care (8, 11).

Although the reform of health care in terms of shift to family medicine has reached its peak in many parts of our country, in Central Bosnia Canton is still in its infancy. This is particularly reflected in the accessibility of adequate personnel especially in rural areas. Availability of pediatric services in relation to the normative health care personnel to meet the needs in this area (1816 per team: 2900-normative). However, pediatric services are concentrated in the central health centers, while in rural areas are working general practitioners with lack of education on health care of preschool children.

Economic accessibility is one of the main factors affecting the achievement of equality in health. Poverty in Canton is particularly pronounced in rural areas and households with multiple members. Payment of health services, which is significantly expressed in primary health care, further reducing access to health care, resulting in worse health of the children in the Canton (12, 13, 14, 15).

Right of access to health care is achieved primarily through the registration of a newborn child in a registry office and then having health insurance. Children who are not registered lose the right to name and nationality, and happiness with many barriers in realizing their rights, including rights to health care. Other research showed that the rate of registration is under the influence of place of residence, maternal education, and household income. Parent's employment or registration in the Employment Service is a way of obtaining health insurance. In this study 11.9% of children had no health insurance just because they did not achieved the conditions for obtaining it, which in turn resulted in 8.3% cases of refusal of medical services by health workers (11, 14, 16).

6. CONCLUSION

Numerous international documents on children's rights, the constitutional and other legal support, give the belief that the rights of children in our country are effectively applied. However, this study showed that there were serious violations in the realization of children's rights, especially when it comes to equality in health.

Socio-economic status of the family is unsatisfactory, particularly in rural areas, which has a direct impact on achieving equity in health. This is particularly reflected in the realization of basic rights of children, such as the right to register and be entitled to health insurance. Rural areas are particularly threatened by inadequate geographical and personnel availability (17, 18).

Our results indicate that there is a large discrepancy between the goals, the situation in practice and opportunities for their realization. The implementation of the rights of children to health care is not and cannot be just a matter of health sector. Fulfilling Children's rights seeks a broad political and social action that will be realistically in accordance with international documents. The new basis package of health services should regulate the issue of realization of the right to health care for children without health insurance. However, that part will be financed from the budgets of cantons or municipalities, which again is placed under the sign of equality issues in child health.

With amendments to the Law on health insurance, the introduction of a unique program of health care, the development of family medicine, and especially development of home visits activities, it is possible at least to partly overcome the existing disparities in the realization of children's rights to health care.

7. REFERENCES

1. UNICEF. All Rights for all Children. UNICEF Regional Office for CEE/CIS, Geneva, 2006.
2. UNICEF. Excluded and Invisible. The State of the World`s Children 2006. UNICEF, New York, 2006.
3. UNICEF. Women and Children Situation analysis 1997. UNICEF, Sarajevo, 1998.
4. Deklaracija o primarnoj zdravstvenoj zaštiti iz Alma-Ate. Institut za

socijalnu medicinu i organizaciju zdravstvene zaštite. Publikacija br.83. Medicinski fakultet, Sarajevo, 1978.
5. UNICEF. Ulaganje u djecu- Obaveza izgradnje pravednog društva. Popratni materijal. Second Itergovernmental Conference "Making Europe and Central Asia Fit for Children". UNICEF, Sarajevo, 2004.
6. Udruženje humanitarna organizacija za zaštitu i ostvarivanje prava djeteta "Naša djeca", NVO "Zdravo da ste". Izvještaj nevladinih organizacija o stanju prava djece u BiH. De-spot, Sarajevo, 2004.
7. Smajkić A. i sur. Ljudska prava na život, zdravlje i socijalnu egzistenciju u Bosni i Hercegovini. Zavod za zdravstvenu zaštitu BiH, Edicija "Zdravlje za sve", Fokus-medical dd, Sarajevo, 2004.
8. WHO. The World Health Report 2005: Make every mother and child count. WHO, Geneva, 2005.
9. WHO/UNICEF. Antenatal Care in Developing Countries. WHO, Geneva, 2003.
10. Lilford RJ, Chard T. Problems and pitfalls of risk assessment in antenatal care. British Journal of Obstetrics and Gynaecology, 1983; 90: 507-10.
11. Fajth G. Regional Monitoring of Child and Family Well-Being: UNICEF´s MONEE Project in CEE and CIS in a Comparative Perspective. Innocenti Working Papers. Economic and Social Policy Series no. 72. UNICEF Innocenti Research Centre, Florence, 2000: 1-42.
12. UNDP. Izvještaj o humanom razvoju. Socijalna uključenost u Bosni i Hercegovini. UNDP, Sarajevo, 2007.
13. UNICEF. Social Monitor 2002. UNICEF Innocenti Research Centre, Florence, 2002: 1-126.
14. Rodriguez J.A. Health and social inequities in Spain. Social sciens a medicine 1990; 31: 351-8.
15. Keith R, Shackleton P. Paying with their Lives. The cost of illness for children in Africa. Save the Children, London, 2006: 1-30.
16. UNICEF. The "rights" start to life. A statistical analysis of birth registration. UNICEF, New York, 2005: 1-35.
17. Živanović A, Nikšić D, Mašić I. Kriteriji za evaluaciju zaštite zdravlja žena, djece i mladih u timu obiteljske medicine. Rad objavljen na Prvom Kongresu socijalne medicine-javnog zdravstva u BiH. Sarajevo; 2001.
18. Živanović A, Nikšić D, Mašić I. Model organizacije zdravstvene zaštite žena, djece i mladih u BiH. Mat Soc Med, 2000; 12(3-4): 81-3.

Corresponding author: Amra Mehmedbegovic-Zivanovic, MD. Public health institute of Middle Bosnia Canton, Travnik. Tel.:00 387 61 786 423..