



WORLD HEALTH ORGANIZATION

**Technical Meeting for the Development of a Framework for
Universal Access to HIV/AIDS Prevention, Treatment and
Care in the Health Sector**

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BACKGROUND PAPER ON THE CONCEPT OF UNIVERSAL ACCESS

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Presentation, objectives:

In health care, the concept of "universal access" is mostly applied qualitatively and conceptually. The exercise of applying quantitative targets to that concept raise important questions this paper proposes to address:

- What does "universal" mean?
- What does "access" mean?
- What determines and influences "universal access"?
- How to define targets associated with "universal access" and how to measure them?
- Should a framework for "universal access" be used to communicate the concept holistically or to monitor a limited set of measurable domains pertaining to that concept?

The purpose of this paper is to support technical discussions at international level on how to build up a "universal access framework" for HIV/AIDS prevention, treatment and care. It is not intended to re-open the conceptual debate on universal access or coverage, a debate initiated in the 1970's and which never concluded with strong agreement. Nonetheless, the highlights of that debate deserve recognition as they could serve as guiding tools to translate "universal access to HIV prevention, treatment and care by 2010" into a realistic agenda.

The consensus sought here should be limited, firstly, to basic concepts and definitions surrounding universal access and coverage (a glossary of terms is annexed to this paper) and secondly, how best to tailor them to HIV/AIDS interventions.

Introduction:

The work on coverage is not new and started a few decades ago when it became important for public health professionals to deconstruct as precisely as possible the relationship between seeking care and providing it. In the 1970's, significant work focused on deconstructing the steps in the decision-making process made by a person who is ill and wants to receive treatment. The "Piot-Fransen Model" analyzes these steps in the case of sexually transmitted diseases. Similar conceptual approaches are illustrated by the work of Tanahashi at WHO in 1979, where the concept of "health service coverage" is introduced as an aggregate of availability, accessibility, acceptability, utilization and "effective coverage". These and similar initiatives have consisted of deconstructing the concept of coverage into its main determinants and re-packaging them in a model or a framework whose purpose is to communicate better what coverage means holistically.

In 2003 the discussion took a new turn in which the purpose of elaborating a coverage framework shifted from a communication tool to a monitoring and evaluation instrument. The concept of "effective coverage for health systems" was developed to measure progresses on coverage for a set of core health system's interventions, itself instrumental to assess trends in health gains. "Coverage" was defined as intermediate goal of health systems directly associated with "better public health", the ultimate goal of such system.

As measurement became central to the goal of framing coverage of interventions (or coverage in the aggregate), debates about how to deconstruct the concept were driven by measurability. Any attempt to develop a framework for coverage needed to be simple enough to be easily measurable but comprehensive enough for these measures to capture the important determinants at stake. The latter was the focus of work at WHO in 2002-03 on effective

coverage while the former guided WHO's most recent work on mapping the "availability of services" at district level.

No matter which approach is taken,, there are three related lessons to be drawn from the decades- long debate about coverage:

- There is a general understanding over the terms coverage, access, utilization and other associated terms, however, no overriding consensus on the taxonomy exists. Rather, the terms should be viewed and defined for various contexts to provide clarity when using them. This means that there is now considerable flexibility to make original propositions for a coverage framework that is most suitable for the HIV/AIDS context.
- There is no need to discuss the terminologies at the conceptual level further, since unanimity is not necessary to conduct preliminary debate on universal access for HIV/AIDS interventions.
- What is important to acknowledge is that any framework for coverage will never explain everything but needs to be simple enough to enable an assessment of whether progress on coverage has been achieved or not, and what primarily explains the trends.

The paper is structured in two main sections. The first is an overview of the concepts in general. The second applies them to the context of HIV/AIDS prevention, treatment and care. Each section is divided into sub-sections, the paragraphs of which are numbered §§.

In §§ 1 to 4, the concepts of access, utilization, availability and coverage are introduced. In §§ 5 to 7, the term "universal" is discussed in the context of establishing targets to scale up interventions. Examples of how the concepts are used in international health programs are proposed in §§ 8 to 12. From § 13 to § 25, the paper discusses two strategies for developing a "universal access framework": the "all-inclusive" and the "simplified" approaches. From § 27 to § 30, the concepts are applied to HIV/AIDS. Emerging propositions for discussions are presented in §§ 31 to 34.

A summary table of propositions is presented after each sub-section to facilitate the discussions in plenary sessions and working groups. A glossary of terms is proposed in the annex for clarification and reference purposes. The glossary is taken from the "European Observatory on Health Systems and Policies". It represents the highest level of agreement on health system- associated terms and constitutes the reference for health systems work at WHO.

Overview of the issues associated with the concept of "universal access"

The concepts at stake: access, coverage, availability, utilization, universal, targets, scaling up

1. Defining "**universal access**" requires an understanding of what "**universal**" and "**access**" mean separately. Both terms are subject to multiple interpretations or have, multiple definitions that are more or less inconsistent.
2. **Access, utilization, availability** and **coverage** are often used interchangeably to stand for the general concept that a lay person talking about "universal access" usually has in mind: *are people in need of something for their health actually getting it?*
3. Indeed, these terms are defined either in **supply terms (availability)** or **demand terms (utilization)** or **both (access, coverage)**: being ill demands care and supplying care presupposes illness or risk of being ill. More specifically, supply and demand for health refer to **interventions** (single or multiple interventions, or "**minimum package**") which supposedly result with more or less **effectiveness in health gains**, these interventions being either on the **curative** or **preventive** side of health care. The difference between "access" and "coverage" is conceptually difficult. The former provides a measure of how much a population can reach health services while the latter establishes the share of a population eligible (the beneficiaries) for a set or package of health services. Coverage is therefore a term that includes a health economics (or social security) dimension.
4. The term "**universal**" is also problematic as it can be interpreted in qualitative or quantitative terms, or both. Qualitatively, "universal" offers a dimension of "indivisibility" or "equity", a concept often used to attest rights. It is also often used in the sense of "fairness in financing" or "universal security", as in the World Health Report 2005 where "universal access" for reproductive health is said to be achieved "*when a sufficient supply of services is available for all, financial barriers to the uptake of services are removed and families are given protection against the financial consequences of their use of health care; thus, they are not impoverished as a result of seeking care*". Quantitatively, the term can actually mean a variety of amounts: "everyone", "100%", "reasonably enough people", "likely every one", "almost everyone", "80% and above" or "100% probability". In addition, the quantitative meaning of "universal" may differ depending on whether it is associated with preventive or curative interventions. It is easier to understand "universal access" to "antiretroviral therapy" than to "impregnated treated nets" or to "VCT": effectiveness (quality) can be better established in the former example than in the latter two examples, and its denominator is also much easily measured.
5. An important question about "universal" is how to define and measure it as the denominator of "access". This raises the concept of "**target**", a benchmark measure for tracking program performance. "Universal access" can be expressed in the form of an **ideal target** which can be **global** or **country/context-specific** (and therefore defined at country level). "*At least x% of y's have z*" is a target where y can be "all people", "people at risk", "children under five", "pregnant women", "people with the disease", all representing group of population "in need" of an intervention z. It could also be "*at least x% of districts have z*". In any case, before setting a target **the measurability** of the targeted entity (a population or an administrative area) having "access" or being "covered by" an intervention needs to be considered. In this respect, complex diagnosis techniques may be required (e.g. testing for HIV infection) making the measurability of the target more complex. A percentage of districts covered is likely to be the easiest way to measure

progress against a corresponding target (see limitations in § 23 and applications in §§ 31-34). To begin with, it will become obsolete once interventions are scaled up - see § 7). These are examples of "access to treatment targets" but there are also "outcome targets" (e.g. "at least x% annual survival rate of those on ART") or "access to prevention targets" (e.g. at least x% of high risk population using condoms in concentrated HIV/AIDS epidemics) (see §§ 31-34).

6. A good definition for "universal" is important when it comes to proposing **target-based** programs the purpose of which is **to scale up** interventions using a **public health** approach at country level. **Targets** associated with an intervention become politically contentious when they are missed. This occurs when targets are expressed in the aggregate (for example "global targets") instead of being embedded in **specific contexts** or when targets are unrealistically high. In country A, for example, a "**realistic**" target for accessibility of a given intervention can be higher than for country B, depending on A and B's different scaling up potentials for that intervention. Hence, the concept of target is more relevant when addressed in flexible terms and applied to the country context.
7. "**Scaling up**" refers either to the geographical expansion of existing interventions or to diversification of the range of services. A **public health approach** requires for example the standardization and decentralization of services, integrating them in "**minimum packages**" of interventions and harmonizing ways of reporting on results and monitoring performance.

Key points from §§ 1-7:

- *Use the term universal "access" instead of universal "coverage" (see §3 and glossary in the annex)*
- *The term "universal access" can be completed by its target expressed in "universal access at 80% of coverage" for a specific intervention where "coverage" takes its traditional use in international programs (see next sections 8-12). This will be taken on board also at the end for HIV/AIDS (see conclusions from §§ 31-34)*
- *Measuring "access" may actually measure just one or a few domains of access (like availability, affordability and/or acceptability), but rarely all of them*
- *Avoid benchmarking "universal" in absolute terms*
- *Define country targets in national context instead of focusing on global targets (see §5)*
- *Define target taking into account the measurability of the targeted entity (e.g. district or population)*
- *Use the term "universal access" for advocacy purpose however remain flexible in the way this term will be defined in quantitative terms (targets)*

How these terms are used in different global public health programs

8. Global Alliance for Vaccine and Immunization (GAVI); Expanded Program on Immunization: immunization coverage is expressed as "**percentage of children in need**"

(all children from various age ranges) having received the full course of immunization doses. The term used here is coverage because it is the result of the supply of services and demand for preventive care, itself boosted by immunization awareness campaigns. Immunization coverage is measured through surveys and reported through services. No targets (except for eradication) are proposed globally, however, performance targets exist for specific case management interventions and for each vaccine preventable disease.¹

9. Roll Back Malaria (RBM); Malaria Control Program: This global program has set forth **global targets** for malaria prevalence, but also for basic interventions such as use of effective drugs, use of ITN and uses of prophylaxis for pregnant women. These targets are expressed in terms of "**percentage of people in need**" of these interventions².
10. Stop Tuberculosis Partnership; Tuberculosis Control Program: Tuberculosis uses a variety of target-based measures of coverage. Two global targets for tuberculosis are used: one for case detection coverage under DOTS (the acronym stemming for the strategy of the TB programs) and one for successful treatment coverage using DOTS. Also, the DOTS strategy is monitored in terms of "DOTS coverage", a measure that provides a sense of how DOTS has penetrated at sub-national level. More detailed references are available from the Global Tuberculosis Control Report 2005.³
11. Integrated Management of Childhood Illnesses (IMCI): The strategy includes three main components: a) Improving the case management skills of health-care staff; b) improving overall health systems; c) improving family and community health practices. Each component includes preventive and curative interventions, all being measured in terms of **percentage of coverage (minimum package)** in countries where IMCI has been introduced. No particular targets are used.⁴
12. More recently, "universal access" has been associated with a global commitment on "**reproductive health care**" (see UN World Summit and the Millennium Development Goal, September 2005) or "**water and sanitation**" in the Global Water Supply and Sanitation Assessment 2000 Report. Other examples "such as universal access to **malaria** preventive and curative intervention" exist and should be reviewed as well.

¹ GAVI's website: <http://www.who.int/vaccines-documents/DocsPDF03/www742.pdf>

² Refer to "World Malaria Report" @ <http://rbm.who.int/wmr2005/> in p.3.

³ Global Tuberculosis Control 2005.
http://www.who.int/tb/publications/global_report/2005/download_centre/en/

⁴ IMCI Website: <http://www.who.int/child-adolescent-health/integr.htm>

Key points from §§ 8-12:

- *The concept of "universal access" is not widely used across international health programs, except for advocacy purposes, although recently (RH and malaria) the concept seems to gain momentum in recent WHO/UN governing body resolutions.*
- *Quantitatively, programs use the term "coverage" associated with outcome indicators*
- *The concepts explained in the first sub-section (§§ 1-7) are not rigorously used across programs.*

Conceptualizing universal access: all-inclusive versus simplified approaches

13. A framework for universal access should look at a variety of interventions and a variety of determinants that can influence access. Inclusion criteria about these parameters depend on how complex or simple the framework is. Complex universal access frameworks may be impractical to conceive, communicate and measure. Examples of this now follow.
14. The process of developing a universal access framework can take two paths: first, an **all inclusive approach** which tends to disaggregate all the components of supply and demand for care (the whole spectrum of care from prevention to treatment) and put them together in a logical sequence; alternatively, a **simplified approach** focusing on those determinants of supply and demand that really matter in practice.
15. The first path often seduces because it stimulates endless debates in which everyone has an opinion: seeking care is a very human behaviour which everyone experiences and can talk about; personal feelings are thus often given prominence in the discussions. One person will emphasize the experience of "need" while another will be concerned with the cost of care or the walking distance to the hospital. However, as stimulating as such discussions can be, the logic of seeking care and finding it is complex and a function of many **influences** and **determinants**. Debates about access or coverage determinants are bound to distract from the initial objective of conceptualizing "universal access", as mentioned in § 2: how to attest that everyone gets what he/she needs from the health system in terms of prevention, treatment and care?
16. Despite the constraints of the all-inclusive approach, this is the path taken by WHO in 2002 following the publication of the World Health Report 2000 on Improving Health Systems. In a chapter purposely labelled "*Beyond access and utilization*" Shenghelia et al.⁵ discuss the concept of *ex ante* (before the fact) **effective coverage** which is defined as "the **probability** of receiving a necessary [and effective] health intervention, conditional on a health care need⁶". It further attempts to capture seven **individual** or **health systems factors** that may influence that probability. Effective coverage is a probability function of

⁵ Shenghelia B. et al. *Beyond Access and Utilization: Defining and Measuring Health System Coverage*. In: Murray CJL and Evans D. *Health System Performance Assessment: Debates, Methods and Empiricisms*. WHO, Geneva, 2003, chap.20.

[http://whqlibdoc.who.int/publications/2003/9241562455_\(part4\)_chp16-24\).pdf](http://whqlibdoc.who.int/publications/2003/9241562455_(part4)_chp16-24).pdf)

⁶ Ibid

seven variables: resource availability, physical accessibility, affordability, cultural acceptability, provider quality, adherence, strategic choice.

17. This ambitious framework has the merit of capturing a maximum of individual and systemic variables, and of proposing an *ex-ante* approach rendered in probabilistic terms. The downside is obviously measurement. A **health system effective coverage index** requires a variety of data, ranging from "effectiveness measures" expressed in "health gains, "quantified needs of a health intervention" based on" epidemiological and demographic characteristics", to "measures of health risks" or "probability of being sick" and as well as the "quantification of several determinants that influence supply and demand of care". All these data require complex data collection strategies and even more complex statistical procedures for their analysis.
18. This makes an all-inclusive approach to the concept of "universal access" quite academic and of very limited use in practice, especially in countries with poorly performing health information systems, that is, the very countries where it is proposed that universal access to HIV/AIDS interventions be measured between now and 2010.
19. If there is consensus about the serious difficulty of using an all-inclusive approach to measuring universal access (although this consensus may involve lengthy debate, as explained in § 15), **simplified approaches** become more attractive.
20. After many years of looking at how people interact with health systems it is reasonable to focus on the issues that are of most practical importance: resources for health are scarce which makes interventions more or less rare commodities within and across countries; people cannot pay for them so they withdraw from care, and the care received does not meet people's needs or expectations.
21. In brief, what matters most today are **availability**, **affordability** and the **acceptability** of interventions.
22. To what extent these three factors capture everything that comes to mind when people think about "universal access" is debatable. The apparent confusion between "universal access", "universal coverage" or even "universal access and coverage" is not necessarily amenable to academic clarification. Nonetheless, it is necessary to develop consensus about the minimum set of variables that a framework for universal access must capture. **The tripod "availability", "affordability" and "acceptability"** is one example, but it can be simplified even further.
23. Such a simplified - but not simple - approach was taken recently by WHO with the **Service Availability Mapping Program (SAM)**.⁷ SAM looks at coverage **only in terms of availability**, assuming that when interventions are "*there*" at **district level**, the population of the district is reachable and that, conversely, all people "*have access*" to them. To take "district" as a proxy unit for "population in need" may become problematic when districts are very large and populated, or where districts have very low population density.
24. Such a simplified approach also makes measurement easier. The SAM program involves posing a series of questions about whether this or that intervention is being delivered at district level. The questionnaire includes items about the reasons why an intervention may or may not be present. It also includes whether health systems components such as human resources, information systems, technologies, knowledge are in place. In some countries,

⁷ SAM Web-page: <http://www.who.int/healthinfo/systems/serviceavailabilitymapping/en/index.html>

the program extends down to **facility level** and reviews not only all districts of a country but all the health facilities as well.

25. The outcome of SAM is a series of national and sub-national maps that show the availability gaps for basic interventions, a powerful tool for health system planning. Availability information can be computerized with baseline epidemiological and population density data and translated into quantitative terms such as proportion of districts uncovered by ARVs; number of people with no access to broad-based HIV prevention; neglected geographical areas; or neglected population groups.
26. "SAM" and "Health System Effective Coverage" are two symmetric paths converging towards same concept of access as enunciated in §2. The tripod proposed lays somewhere in the middle. Measures of availability (reachable within a district or municipality) can be completed by measures of affordability often equated with free services and acceptability which is survey based. An incremental approach towards more complex measurement models should feed in the academic debate. This debate should also include research on how better integrate geographical and metric data in one data model.

Key points from §§ 13-26:

- *Set the objective of the framework: either communicating what are the determinants influencing universal access, tracking progress and measuring achievements towards universal access, or both. The first objective requires a comprehensive framework explicitly including the determinants and their influences on access. For the second objective, the framework should be limited to measurable determinants.*
- *As a consequence, it is advisable to consider a simplified approach to building a framework for universal access, while being aware that "simplified" does not necessarily mean "simple".*
- *It is advisable to focus on "availability" of core interventions in the area of prevention, treatment and care, at least at district level (SAM concept)*
- *Define the steps to be taken if additional factors are to be included: "acceptability" could be measured for just a few countries using population or facility based surveys; "affordability" could be measured through household surveys for a few countries or equated to the implementation of free services policies at districts level (§26)*
- *Promote academic debate and undertake research on how to extract more comprehensive measures from SAM generated data (§ 26).*

Application of the discussion to HIV prevention, treatment and care and emerging propositions

Issues at stake in developing a universal access framework for HIV/AIDS

27. HIV interventions cover a continuum from prevention to treatment and involve the contributions of many actors and sectors. A framework for universal access that includes dozens of interventions may be difficult to conceptualize, communicate and monitor (see § 13). Because the number of interventions is numerous, for the purpose of assessing "universal access" it may be relevant to focus on those which are considered most essential. Conversely, it may be difficult to select interventions applicable everywhere in all contexts. It is challenging but necessary to find the right balance between a generic set of **"core" HIV interventions (or a "minimum" or "essential" package of interventions)** and a set of interventions that takes into account the **epidemiological and health system specificities at country level**. Nonetheless, given the complex nature of the infection and the disease, a minimum package for HIV/AIDS will inevitably include many preventive and curative interventions. One approach may be to group the interventions according to their primary **"locus"**: hospital, health centre and community based interventions. Using this approach, availability is determined by "loci" and not by individual intervention on the assumption that if a locus covers at least one or two HIV/AIDS interventions (whether curative or preventive) it would also by necessity cover all the other interventions required at that locus.
28. Determinants of supply and demand of HIV/AIDS interventions are also numerous: **availability** (quality service delivery points established); **accessibility** (distance, time); **affordability** (monetary and other costs, opportunity costs); **acceptability** (gender, ethnicity, language); **perceived needs** (perception of a disease or health risk, belief that the intervention will make a difference); **perceived quality of care** (diagnosis ability, choice of interventions, adherence). An all-inclusive approach considering such a broad band of variables should be avoided in developing a framework for universal access to HIV interventions as this would lead to serious measurement and monitoring pitfalls (see §§ 16-18). However, reference should be made to the upcoming data collection efforts particularly the next round of Multiple Indicator Cluster Survey (MICS) implemented by UNICEF and scheduled for 2006 (results in 2007-8). This is a population based survey looking at HIV/AIDS items, among many others. MICS takes place in countries not covered by demographic and health surveys (DHS).
29. A simplified approach such as the "tripod of determinants" presented above (§§ 20-22) could be useful for HIV/AIDS: **availability, affordability, acceptability. Measurement should focus on availability only (§§ 23-25) discounted "arbitrarily" for resilience criteria** such as those mentioned in § 27. In other words, 100% availability is not reasonable because non-quantified aspects of coverage must be taken into consideration and discounted, making 80% availability more realistic if taken as a target.
30. A measurable target for **"access to treatment"** could be expressed in "basic intervention or service availability" where there is a need for it. In generalized epidemics, the target could be "percentage of facilities in every district offering the intervention"; or "minimum number of facilities per population in need *or* per district"; or "distribution of facilities linked to population density levels". For concentrated epidemics, the focus is on groups at risk, mostly urban. For prevention targets, reference can be made to the Millennium Development Goals (and the HIV/AIDS related indicators) and to the targets defined by the United Nations General Assembly Special Session on HIV/AIDS in 2001 (UNGASS).

Key points from §§ 27-30:

- *Build a framework for HIV/AIDS prevention, treatment and care using a core set of interventions covering the four primary loci of delivery: hospital, health centre, community, home*
- *Define country targets in terms of availability for these interventions at district level*
- *Borrow preventive targets from the Millennium Development Goal and UNGASS*
- *Rely on SAM for extracting measures of availability and coordinate with MICS and DHS to obtain additional measures on access (especially for preventive interventions)*

Emerging measurement propositions (pending additional consultations)

31. A first proposition for "universal access to treatment" could emerge as: ***"at least 80 % of people receiving ART among those in need (number of people on treatment, estimated needs)"***. 100% is not realistic if we take into account issues of acceptability, affordability and perceived needs (see reasoning in § 29).
32. A second proposition: "percentage of population in need receiving quality care" which translates into either ***"at least 90% adherence"*** or ***"80-90% annual survival after the first 3 months"***
33. Measurable targets for **"access to prevention"** could borrow from UNGASS M&E framework, for example: ***"percentage of patients with STI at health care facilities who are appropriately diagnosed, treated and counselled"***; or ***"Percentage of HIV infected pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT"***; or ***"Percentage of IDU who have adopted behaviours that reduce transmission of HIV"***; or ***"Percentage of young people aged 15-24 using a condom for non regular sex"***; or ***"Percentage of young people aged 15-24 with correct knowledge"***.
34. Measuring the population in need of preventive interventions is difficult. For example, how often does someone "need" to be tested? Other propositions for "access to prevention" could be expressed as ***"Percentage availability of the intervention at district level"*** or ***"Minimum number of facilities offering the preventive intervention per population in need (estimated)"***.

Key points from §§ 31-34 (and from previous §§ 3, 21, 22, 26):

- *Universal access for treatment is treatment that is reachable, affordable and acceptable to all those in need.*
- *The measurement issues have already been addressed in the previous sections (§§ 20-26).*
- *Also from §§ 1-7 (and second key point bullet) propose "universal access at least 80% coverage for a given intervention" or even further, "all districts should have at least 80% coverage, all sub (risk) populations at least 80% coverage"*
- *Build up prevention along the same lines as for treatment: key prevention services should be reachable, affordable and acceptable to all those who need it: "all districts should have VCT, PMTCT, condoms, sex & AIDS education (general public, schools)", target population programs, which could be specified and could be measured*
- *"Coverage" could only be worked out for condoms, pregnant women, knowledge, knowing that using too many indicators may impose unnecessary burden on measurement*
- *Discuss the targets proposed in italic in these §§*

Annex: Glossary of terms⁸

Acceptability

- Core definition:** Degree to which a service meets the cultural needs and standards of a community. This in turn will affect utilization of that service.
- Source:** Witter, 1997.
- Example/s:** A family planning service staffed only by male doctors may not be acceptable to a Muslim community.

Accessibility of health care

- Core definition:** A measure of the proportion of a population that reaches appropriate health services.
- Source:** WHO, 1998.
- Notes:** **Financial accessibility** measures the extent to which people are able to pay for care, usually measured through a community-based willingness and ability to pay survey. **Geographical accessibility** measures the extent to which services are available and accessible to the population. It is, of course, linked to the distribution of infrastructure in a given region but also to the actual offering of these services at these facilities. Geographical accessibility will vary according to local means of transportation, as well as the local topography. **Cultural accessibility** considers whether access to health services is impeded by cultural taboos. Three examples are provided: (i) Can women use reproductive health services if all the physicians in the facility are male? (ii) Will persons who belong to an ethnic minority use services that are staffed by the majority population? (iii) Will persons use health services for processes that are considered natural, that is without the need for health intervention (such as pregnancy?) (WHO, 2000).
- Example/s:** The community's accessibility of health care is very poor, as they are situated far away from any health care utility and there are limited community services that attend to the major health care problems of the population.

Affordability

- Core definition:** Extent to which the intended clients of a service can pay for it.
- Source:** Witter, 1997.
- Notes:** This will depend on their income distribution, the cost of services and the financing mechanism (e.g. whether risks are pooled; whether exemptions exist for the low-paid etc.).
- Example/s:** Subsidized coverage for dental care, which was not previously covered by the public health service, increased affordability for these services a great deal.

Availability

- Core definition:** Identifies the presence or absence of needed health care services.
- Source:** USAID, 1999.
- Example/s:** Since primary health care reform, the availability of primary health care services is very good throughout the country: thanks to financial incentives

⁸ Source: "The European Observatory on Health Systems and Policies", the glossary of health system related terms used at WHO. Available at:

<http://www.euro.who.int/observatory/Glossary/TopPage?term=1>

provided to providers for relocating in remote areas, all health care dispensaries have a general practitioner, and all facilities are required to offer a basic package of services.

Baseline

Core definition:	An observation or value that represents the background level of a measurable quantity.
Source:	USAID, 1999.
Supplementary definition:	Baseline information is often used to compare with new data, to determine progress or regression.
Example/s:	Since the reform of the health care system that was completed in 2000, access to primary health care has improved greatly compared with baseline data from 1997.

Benchmarking, see [Best practice](#)

Core definition:	A process of measuring another organization's product or service according to specified standards in order to compare it with and improve one's own product or service.
Source:	USAID, 1999.
Notes:	Specified standards for benchmarking are often the average.
Supplementary definition:	Benchmarking is a systematic approach described as "the search for best practices that will lead to superior performance" (European Commission, 1999, from Camp 1989). Benchmarks may be established within the same organization (internal benchmarking), outside of the organization with another organization that produces the same product or service (external benchmarking), or with reference to a similar function or process in another industry (functional benchmarking) (USAID, 1999).
Example/s:	Through a benchmarking exercise, hospitals with high mortality rates tried to identify which factors differentiated the service provision in hospitals with lower mortality rates from their own standards.

Best practice, see [Benchmarking](#)

Core definition:	An examination of the methods by which optimal outcomes are achieved.
Source:	USAID, 1999.
Notes:	Best practice, alongside with benchmarking, is an organizational concept deployed in the industrial sector and increasingly related to management and administration. In this context, "best practice" is referred to as a process-oriented concept to achieve improvements within individual agencies or settings over time. Improvements are characterized by measurement of quality, effectiveness, cost-effectiveness, and productive output (European Commission, 1999).
Example/s:	Best practice, which consists of examining methods for achieving optimal outcomes, is increasingly being used to improve quality and effectiveness of health programmes.

Catchment area

Core definition:	A geographic area defined and served by a health plan or a health care provider.
Source:	European Observatory on Health Care Systems, 2001
Notes:	Sometimes called health service area. Catchment area is a geographic area that can be outlined on a map.

Example/s: Primary health care units were responsible for providing basic services to populations in their designated catchment areas.

Catchment population

Core definition: Estimate of the population served by a hospital or other health service unit or facility.

Source: NAHAT, 1991.

Notes: The catchment population is the population in the * catchment area.

Example/s: The availability of primary health care services for the health centre's catchment population was very good, although due to perceived poor quality, utilization rates were very low.

Coverage

Core definition: Share of population eligible for health care benefits (in-kind) under public programmes.

Source: OECD, 2000b.

Notes: In addition to the notion of coverage being how many people have benefits, the notion of the kinds and extent of benefits is used. The latter definition is explained further under * benefits package.

Example/s: The national health care system's coverage was 100%, including not only citizens, but the resident and immigrant populations as well.

Effectiveness, see [efficacy](#) , [community effectiveness](#)

Core definition: The extent to which a specific intervention, procedure, regimen of service ... does what it is intended to do for a defined population.

Source: Modified Witter, 1997.

Notes: There are two kinds of effectiveness: * efficacy and * community effectiveness. Often effectiveness is used to mean the latter.

Supplementary definition: The extent to which objectives are achieved (WHO, 2000d).

Example/s: Clinical guidelines were provided for physicians to improve the effectiveness, or intended use, of the care provided.

Efficacy

Core definition: The benefit of using a technology for a particular problem under ideal conditions, for example, in a laboratory setting, with in the protocol of a carefully managed randomized controlled trial, or at a "center of excellence."

Source: National Information Center on Health Services Research & Health Care Technology, 2001.

Notes: Ideally, the determination of efficacy is based on the results of a randomised controlled trial. In comparison with community effectiveness, efficacy takes place under ideal, controlled conditions. The question is "can it work" and not necessarily "will it work" (Busse, 1998).

Example/s: As demonstrated through clinical trials, the efficacy of the new vaccine was high, leading to its widespread marketing and distribution.

Efficiency

Core definition: The extent to which objectives are achieved by minimising the use of resources.

Source: WHO, 2000d.

Notes: There are two types of efficiency, technical and allocative.

Supplementary definition:	Efficiency is obtaining the best possible value for the resources used (Alban & Christiansen, 1995). Technical efficiency means producing the maximum possible sustained output from a given set of inputs; allocative efficiency is when resources are allocated in such a way that any change to the amounts or types of outputs currently being produced (which might make someone better off) would make someone worse off (World Bank, 2000). Allocative efficiency requires that an economy provides its members with the amounts and types of goods and services that they most prefer. Allocative efficiency is sometimes called “Pareto efficiency.”
Example/s:	The intervention’s efficiency - obtaining the best possible value for the resources used - was evaluated by an outside team to determine whether it would make sense to introduce it throughout the country or not.

Equality

Core definition:	Principle by which all persons or things under consideration are treated in the same way.
Source:	WHO 2000c.
Example/s:	The government’s promise to use the principle of equality turned out to be counter-productive as the peoples’ characteristics and conditions (age, sex, rural vs. urban, rich vs. poor etc.) were simply so different that treating everybody equal actually increased inequities.

Equity

Core definition:	Principle of being fair to all, with reference to a defined and recognized set of values.
Source:	WHO, 2000b.
Notes:	Equity in health implies that ideally everyone should have a fair opportunity attain their full health potential and more pragmatically, that no one should be disadvantaged from achieving this potential, i.e. everyone should have geographical and financial access to available resources in health care (WHO, 1998a; Witter, 1997).
Supplementary definition:	There are two kinds of equity: Horizontal equity is the principle that says that those who are in identical or similar circumstances should pay similar amounts in taxes (or contributions) and should receive similar amounts in benefits; vertical equity is the principle that says that those who are in different circumstances with respect to a characteristic of concern for equity should, correspondingly, be treated differently, e.g., those with greater economic capacity to pay more; those with greater need should receive more (World Bank, 2000).
Example/s:	Equity under the reformed system needed further attention, as co-payments for some necessary services still led to the exclusion of some people who were unable to pay.

Fee-for-service, see [reimbursement](#) , [payment](#) , in contrast to [capitation](#)

Core definition:	Payments to a provider for each act or service rendered.
Source:	OECD, 1992
Supplementary definition:	A payment mechanism whereby a provider or health care organization receives a payment each time a reimbursable service is provided (e.g., office visit, surgical procedure, diagnostic test, etc.) (World Bank, 2000). Refers to a method of reimbursing the provider, the provider is paid for each separate service to a patient according to a list of fees. (WHO, 1998a; Alban &

Christiansen, 1995).
Example/s: The fee-for-service system encouraged physicians to provide more care than necessary in order to increase their income, as they were paid for each service or procedure they provided.

Financing

Core definition: Raising revenue to pay for a good or service.
Source: World Bank, 2000.
Supplementary definition: Function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system (WHO, 2000b).
Example/s: The whole process of health care finance, i.e. where the money came from, how it was collected, pooled and re-distributed to the third-party payers and finally used to pay the providers for their services, was so complicated that even experts found it difficult to describe.

Goal , see [objective](#)

Core definition: A general aim towards which to strive; a statement of a desired future state, condition, or purpose.
Source: WHO, 1998a; USAID, 1999
Notes: A goal differs from an objective by having a broader deadline, and usually by being long-range rather than short range. Within the health sector, WHO has defined the goal of Health for all by the year 2000, which means the pursuit of the goal that “as a minimum all people in all countries should have at least such a level of health that they are capable of working productively and participating actively in the social life of the country in which they live”. Moreover WHO recognizes “that to attain such a level of health every individual should have access to primary health care and through it to all levels of a comprehensive health system”. Within the WHO strategy, targets have been defined with indicators to assess progress towards the overall health goal. Member States of WHO have generally endorsed the health goal and the adoption of the targets and the use of the indicators system for assessing progress in health development (WHO, 1998a, USAID, 1999). Health goal: Health goals summarize the health outcomes which, in the light of existing knowledge and resources, a country or community might hope to achieve in a defined period of time (WHO, 1998b).
Example/s: The goal of the reformed system was to increase effectiveness and quality of care while maintaining equity.

Governance

Core definition: The exercise of political, economic and administrative authority in the management of a country's affairs at all levels.
Source: WHO, 2000b.
Notes: Since the advent of the term *stewardship, the term “governance” is sometimes restricted to the relationship between the owners(s) and the management of an organization, i.e. governance of a private hospital would be exercised by its owners (interested, for example, in making profit) while the government's stewardship role would aim at ensuring, for example, access and socially acceptable costs. [Both governance and stewardship are, however, not easily translated into other languages.]
Example/s: Good governance is said to exist when managers are closely pursuing the owners' objectives.

Health care system

Core definition:	A formal structure for a defined population, whose finance, management, scope and content is defined by law and regulations. It provides for services to be delivered to people to contribute to their health...delivered in defined settings such as homes, educational institutions, workplaces, public places, communities, hospitals and clinics.
Source:	WHO, 1998a
Notes:	Health care (delivery) system refers to health care services performed in the primary, secondary and tertiary health care sector; it is the system to deal with the medical and therapeutic measures intended to preserve or improve the health condition of a patient (WHO, 2000b).
Supplementary definition:	Set of elements and their relations in a complex whole, designed to serve the health needs of the population.
Example/s:	The health care system changed greatly from a centralised, hierarchically-managed system to a decentralised one.

Health centre

Core definition:	A facility that provides (ambulatory) medical and sanitary services to a specific group in a population.
Source:	USAID, 1999
Notes:	Ideally, the services should include a) medical and sanitary care (both preventive and health-promoting) for individuals, families, other specific groups and society as a whole; b) medical care for patients both within a health centre itself and at home; and c) rehabilitation services together with the social welfare institutions. In eastern Europe, these used to be dispensaries and polyclinics. In the West, these may be physician practices or community centres.
Example/s:	Primary health care services, including basic preventive and curative care and health promotion activities, are provided at the health centre level.

Health gain

Core definition:	An increase in the measured health of an individual or population, including length and quality of life.
Source:	WHO, 1998a.
Example/s:	The reforms implemented in primary health care in 1990 yielded positive results, illustrated through the improved health gain witnessed, for example, in the higher immunization rate for measles in 2000.

Health indicator

Core definition:	A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time).
Source:	WHO, 1998b
Example/s:	Health indicators, such as childhood immunization rates and life expectancy, were poor.

Health services

Core definition:	Any service which can contribute to improved health or the diagnosis, treatment and rehabilitation of sick people and not necessarily limited to medical or
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health-care services.
Source: WHO, 1998a
Notes: Often used more limited as referring to health care services, i.e., those within the health care system.
Example/s: The provision of health services was decentralized to the local municipal level, although the basic package of services was defined at national level.

Health status

Core definition: Term for the state of health of an individual, group or population measured against defined standards/indicators.
Source: WHO, 1998a
Example/s: The health status of the population greatly improved during the 1980s and 1990s, as illustrated through the increase in life expectancy for both men and women.

Health system also , see [Health care system](#)

Core definition: The people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health.
Source: WHO, 2000b
Notes: Health system is a broad term which encompasses both the health care system and other activities whose primary purchase is to promote, restore or maintain health (e.g., environmental safety, seat belts).
Example/s: The health system was affected a great deal by the weakened economy, and efforts to contain costs became a large priority.

Health target also , see [Goal](#)

Core definition: Health targets state, for a given population, the amount of change (using a health indicator) which could be reasonably expected within a defined period of time.
Source: WHO, 1998b
Notes: Targets are generally based on specific and measurable changes in (intermediate) health outcomes.
Example/s: Local level decision makers met with regional decision makers every six months to determine reasonable health targets or goals for the given time period.

Home care

Core definition: Medical and paramedical services delivered to patients at home.
Source: OECD, 2000b
Notes: Included are obstetric services at home, home dialysis, telematic services, etc.; excluded are the consumption of medical goods (pharmaceuticals, other medical goods) dispensed to outpatients as part of private household consumption (OECD, 2000b).
Example/s: Home care was placed under greater demand through the ageing of the population.

Hospital

Core definition:	Residential establishment equipped with inpatient facilities for 24-hour medical and nursing care, diagnosis, treatment and rehabilitation of the sick and injured, usually for both medical and surgical conditions, and staffed with at least one physician. The hospital may also provide outpatient services.
Source:	WHO, 2000a
Notes:	Different ways exist to sub-categorize hospitals: The OECD system of health accounts, for example, divides hospitals into 1. general hospitals, 2. mental health and substance abuse hospitals and 3. other speciality hospitals. Another traditional classification differentiates between public, private not-for-profit and private for profit but it does not capture the current variety of intermediate variants (and is no longer used in the OECD Health Data).
Example/s:	People went directly to the hospital for even minor and basic health care, as the primary care system was essentially non-existent.

Impact

Core definition:	The total, direct and indirect, effects of a programme, service or institution on health status and overall health and socio-economic development.
Source:	WHO, 2000b
Example/s:	The impact of the reforms was starting to be felt, as illustrated by improved patient satisfaction and utilization of ambulatory care services.

Indicators

Core definition:	Identified and measured variables which help to show changes directly and indirectly relevant to goals, objectives and targets.
Source:	WHO, 1998a
Example/s:	Local decision makers identified a series of indicators for measuring health progress, such as immunization rates and prenatal visits.

Input also , see [Health resources](#)

Core definition:	A quantified amount of a resource put in a process.
Source:	WHO, 2000b
Notes:	In health services research, inputs into the production of health care, for example, hospital beds, physicians, pharmaceuticals, etc.
Supplementary definition:	Refers to the use of resources in a production process (Alban & Christiansen, 1995).
Example/s:	The government started to worry when in spite of increasing inputs into the health care system year after year, neither life expectancy nor population satisfaction increased

Intervention

Core definition:	An activity or set of activities aimed at modifying a process, course of action or sequence of events, in order to change one or several of their characteristics such as performance or expected outcome.
Source:	WHO, 2000b
Example/s:	The health intervention, which consisted of identifying community representatives to focus on health promotion, was deemed successful, as illustrated through an increased utilization of health services and higher immunization rates.

Monitoring

Core definition: The continuous oversight of an activity to assist in its supervision and to see that it proceeds according to plan.
Source: WHO, 1998a
Supplementary definition: Monitoring involves the specification of methods to measure activity, use of resources, and response to services against agreed criteria.
Example/s: Although decision-making was decentralised to local level, periodic monitoring by district level was commonplace to ensure that standards were met.

Need

Core definition: What a person requires in terms of health care.
Source: Witter, 1997
Notes: A pre-requisite for need to exist is that an individual has the ability to benefit from receipt of a health care service at the individual level. Judged subjectively this is often called wants, to distinguish it from an objective judgement about appropriate treatment. These are distinguished from what is actually purchased, which is demand. For societal level judgements, other factors such as resource constraints and cultural norms may influence judgements of what constitutes health care need, especially what needs can be met from the public purse (World Bank, 2000; Witter, 1997).
Example/s: The basic package of services was outlined at national level, although local level was responsible for the actual provision of services and these were determined according to assessed need.

Objective also , see [Goal](#)

Core definition: A measurable condition or level of achievement at each stage of progression toward a goal.
Source: USAID, 1999
Notes: Objectives carry with them a relevant timeframe within which the objectives should be met (USAID, 1999).
Supplementary definition: The end result a programme, a project or an institution seeks to achieve (WHO, 2000b).
Example/s: The objective of the campaign was to immunize 90% of children against DPT in 2001.

Outcome, see also clinical/ economic outcome; see also output

Core definition: A change to a situation resulting from an action.
Source: WHO, 2000b
Supplementary definition: Refers to the final result of a production process or activity, for example increased health (Alban & Christiansen, 1995).
Example/s: The health outcome of the intervention – a reduction in the number of positive cases – was very positive, leading to a replication of the pilot test throughout the country.

Output also , see [Outcome](#)

Core definition: The result of a process.
Source: WHO, 2000b
Supplementary definition: Refers to the immediate product or service from a production process or activity, for example the results of a medical procedure (Alban & Christiansen, 1995).

Example/s: Output by health personnel, as illustrated through shorter, more productive patient consultations, was deemed better and of higher quality as a result of the new clinical guidelines.

Patients' rights

Core definition: A set of rights, responsibilities and duties under which individuals seek and receive health care services.

Source: USAID, 1999

Notes: Because patients' rights are often not explicit, the composition of the set varies from country to country and over time.

Example/s: The reforms included many new measures in favour of patients, such as explicit patients' rights enabling them to file claims if their rights are not upheld.

Primary health care (PHC), see also secondary/tertiary health care

Core definition: The first level contact with people taking action to improve health in a community.

Source: WHO, 1998a

Notes: In a system with a gatekeeper, all initial (non-emergency) consultations with doctors, nurses or other health staff are termed primary health care, as opposed to secondary health care or referral services. In systems with direct access to specialists, the distinction is usually based on facilities, with polyclinics, for example, providing primary care and hospitals secondary care (Witter, 1997; Getzen, 1997).

Supplementary definition: Primary Health Care is essential health care made accessible at a cost which the country and community can afford, with methods that are practical, scientifically sound and socially acceptable (WHO, 1998b).

Example/s: Primary health care was strengthened to ensure that priority essential health services were provided at the first point of care by general practitioners.

Process

Core definition: A continuous and regular action or succession of actions, taking place or being carried out in a definite manner, and leading to the accomplishment of some results.

Source: WHO, 2000

Example/s: The budgeting process was actually carried out at local level, although training and supervision were provided from regional level.

Provider

Core definition: Professionals and institutions providing health care services to patients.

Source: European Observatory on Health Care Systems, 2001

Example/s: Under the new health care system, patients were able to choose their health care providers and were then placed on his/her patient list.

Quality

Core definition: A character, characteristic, or property of anything that makes it good or bad, commendable or reprehensible; thus, the degree of excellence that a thing possesses.

Source: USAID, 1999

Notes: The totality of features and characteristics of a product or service that bear on its ability to satisfy stated or implied needs (USAID, 1999).

Example/s: Salaries were low, providers were unmotivated, and, thus, the overall quality of health services was poor.

Quality of medical care

Core definition: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Source: USAID, 1999

Supplementary definition: Quality of care is that component of the difference between efficacy and effectiveness that can be attributed to care providers, taking account of the environment in which they work (Busse 1998, from Brook and Lohr, 1985).

Example/s: While the overall quality of medical care was good, patient/provider contact was considered too short and matter-of-fact.

Risk

Core definition: The chance of probability that an event will occur.

Source: Getzen, 1997

Supplementary definition: Risk factors are factors which increase risk.

Example/s: Health insurance included coverage for the risk of occupational accidents.

Risk pooling

Core definition: Forming a group so that individual risks can be shared among many people.

Source: Getzen, 1997

Supplementary definition: Trans-actors each facing possible large losses agree to contribute a small premium payment to a common pool, to be used to compensate whichever of them actually suffers the loss. Contributions must cover losses plus administration costs (World Bank, 2000).

Example/s: Risk pooling was carried out by the insurance company by making it mandatory for all family members to join the same insurance fund.

Secondary health care, see also primary health care and tertiary health care

Core definition: Specialized ambulatory medical services and commonplace hospital care (outpatient and inpatient services). Access is often via referral from primary health care services.

Source: European Observatory on Health Care Systems, 2000

Notes: Does not include highly specialized, technical inpatient medical services (which is tertiary health care).

Supplementary definition: Care provided by medical specialists, usually in a hospital setting, but also some specialist services provided in the community (Witter, 1997).

Example/s: Secondary health care was often used inappropriately, as it was directly accessed with no referral from primary care level.

Social care

Core definition: Services related to long-term inpatient care plus community care services, such as day care centres and social services for the chronically ill, the elderly and other groups with special needs such as the mentally ill, mentally handicapped and the physically handicapped.

Source: European Observatory on Health Care Systems, 2001

Notes: The borderline between health care and social care varies from country to country, especially regarding social services which involve a significant, but not dominant health care component such as, for example, long-term care for dependent older people.

Example/s: The integration of social care and health care was becoming especially important because of the ageing of the population.

Social health insurance

Core definition: Social health insurance is an insurance programme which meets at least one of the following three conditions: participation in the programme is compulsory either by law or by the conditions of employment; the programme is operated on behalf of a group and restricted to group members; or an employer makes a contribution to the programme on behalf of an employee.

Source: OECD, 2000b

Notes: Insured individuals make regular, mostly income-related contributions which are not tied to the cost of the services they use. The contributions are administered by one or more quasi-independent public body(ies), normally with “statutory” responsibilities (usually called “sickness funds”), which act as the payers/purchasers of care. The actual collection of the contributions can also be organized through a governmental institution. If social health insurance is mandated by government, it is also called statutory health insurance.

Example/s: Besides Germany, typical social health insurance countries, with a mandatory health insurance system and contributions unrelated to risk, include Austria, the Netherlands, France and Belgium.

Social safety net

Core definition: Basic arrangement to ensure that any person in a society can obtain financial and material help from the state to avoid absolute poverty and ensure survival.

Source: WHO, 1998a

Example/s: The state provided a social safety net which included comprehensive health and medical coverage for the needy population.

Social security

Core definition: The provision of social protection against a number of risks, such as incapacity to work resulting from disease or disability, unemployment, old age, or family maintenance.

Source: WHO, 1998a

Example/s: The country’s social security system was very generous, covering a wide range of social protection services for the population that included such areas as unemployment, disability and elderly benefits and child care.

Supply

Core definition: The amount of a product made available for sale at a particular price.

Source: WHO, 1998a

Notes: In a wider sense, often used for inputs, i.e. including all health resources. Supplementary.

Example/s: The supply of pharmaceuticals was tightly restricted, leading to high prices.

Surveillance

Core definition: Ongoing collection of information on developments within a sector.

Source: WHO, 2000c

Notes: Not to be confused with environmental scanning, in which information is gathered about developments external to the sector (WHO, 2000c).
Supplementary.

Example/s: Epidemiological surveillance to track the course of different diseases was carried out by a specific unit within the Ministry of Health.

Survey

Core definition: The process of collecting information by canvassing a chosen group.
Source: WHO, 2000c
Notes: Normally involves the distribution of a written questionnaire. Supplementary.
Example/s: A specific survey on primary health care carried out after the reforms showed that satisfaction had increased by 50%.

Sustainability

Core definition: The capacity to meet the needs of the present without compromising the ability to meet future needs.
Source: WHO, 1998a
Example/s: The sustainability of the project was questionable, and efforts were being undertaken to determine how sufficient resources could be generated locally to meet future needs.

Tertiary health care, see also primary and secondary health care

Core definition: Refers to medical and related services of high complexity and usually high cost.
Source: WHO, 1998a
Notes: Those referred from secondary care for diagnosis and treatment, and which is not available in primary and secondary care. Tertiary care is generally only available at national or international referral centres (European Observatory on Health Care Systems, 2000).
Example/s: There were four hospitals providing technologically advanced tertiary care in the country: two were located in the capital and the other two were situated in the country's largest metropolitan areas.

Universal Health Insurance

Core definition: A national plan providing health insurance or services to all citizens, or to all residents.
Source: Getzen, 1997
Example/s: Ninety-five percent of the population was covered in 1997, but it was not until a law was passed in 1999 providing universal health insurance that the entire population was covered.

Utilization

Core definition: The number of health services used, often expressed per 1000 persons per month or year.
Source: Getzen, 1997
Example/s: Utilization of PHC services increased dramatically after the reforms, and now reducing waiting time became a major concern.