
Access to Healthcare: A Theoretical Analysis of its Dimensions

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ABSTRACT: This article proposes a theoretical analysis of the dimensions of access to healthcare, in order to highlight the different aspects that need to be taken into account for the purpose of revitalizing the healthcare system and improving access to healthcare. The different dimensions analyzed were service availability, financial affordability and acceptability. Each of these dimensions was clearly defined, and their analysis enabled a better understanding of the theoretical factors essential to achieving access to care in each category. On the one hand, this approach enabled us to recognize that access to care is determined by the characteristics of both demand and supply in each of the dimensions. Moreover, it brought to light two lesser-known but essential dimensions of access to healthcare, namely the availability of services and the acceptability of care.

KEYS WORDS: access, Healthcare, dimensions demand, supply

INTRODUCTION

Access to healthcare has been defended as a fundamental human right since 1948. The Universal Declaration of Human Rights, adopted by the United Nations in 1948, establishes for the first time a set of ~3~ fundamental rights, including *"the right to a standard of living adequate for the health and well-being of oneself and of his family, including food, clothing, housing and medical care, and necessary social services"*¹. The United Nations Millennium Development Goals (MDGs) adopted in 2000, paid particular attention to health, with six out of eight goals directly or indirectly linked to ensuring better health for all². This emphasis on health, which was reaffirmed when the Sustainable Development Goals (SDGs) were adopted, is ample proof that no development can be achieved without measures to effectively protect people's health. As a result, the realization of the right to health is becoming the *"sine qua non"* for the success of development policies within states, a right that can clearly only be ensured through access to healthcare.

The notion of access to healthcare is a recurring theme in debates about our health. It is very often used either to applaud the progress made by our healthcare system or, on the contrary, to denounce its shortcomings or the inequalities it allows to persist or grow. Even though we come into contact with this concept on a daily basis, access to healthcare still carries a heavy polysemic weight. If at first glance we confine ourselves to the notion of 'access' to try and understand the concept as a whole, the tenth edition of Merriam-Webster's Collegiate dictionary defines it as *"the freedom and possibility of obtaining or making use of something"*³. In health terms, this corresponds to an individual's right to obtain care when he or she feels the need. Turning to science to try and elucidate the concept of access to care, Penchansky et al (1981) define access to care as *"a concept representing the degree of concordance between patients and the health system"*³. In other words, access to healthcare can only be achieved if healthcare provision is sufficiently adapted to meet the demand of the populations concerned, with their particular characteristics in terms of health needs. For Cès, it is *"obtaining treatment (in the broad sense) when there is an objective need for care"*⁴. This definition is similar to that of Lurie, who defines access to care as *"the timely use of health services by individuals in order to achieve the best possible health outcome"*⁵. In the light of these definitions, we understand that access to care refers to all the care consumed by the patient in terms of quality and quantity whenever the need arises.

¹ United Nations, 1948, article 25

² Goals 1, 4, 5, 6, 7 and 8 focus respectively on reducing extreme poverty and hunger; reducing child mortality; improving maternal health; combating HIV/AIDS, malaria and other diseases; protecting the environment; and developing a global partnership for development. ³ Merriam-Webster, 2^e edition, p. 7.

³ Penchansky et al, "the concept of access: definition and relationship to consumer satisfaction", in *medical care*, September 1981, n°2, p. 129.

⁴ Cès, S., "access to healthcare: definition and issues" in *mc-informations* n°286 December 2021, p. 6.

⁵ Lurie, "studying access to care in managed care environments", in *health services research*, no. 32, 1997, p. 693.

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In Cameroon, access to healthcare has become a major focus of policies underpinned by the national health strategy, under a different term: universal health coverage (UHC). Officially launched in 2023, UHC has become a benchmark in the government's efforts to improve the health of all sections of the population. However, it has to be said that the success of this UHC depends on the efficiency of the health system, which in turn depends on controlling the factors associated with access to healthcare. It is with this in mind that this article sets out to make a theoretical analysis of the dimensions of access to healthcare. The aim is to dissect these different dimensions in order to highlight the priority theoretical aspects that need to be taken into account in order to improve access to healthcare. In operational terms, we will draw on existing theoretical and empirical work that groups the dimensions of access to care into three main categories (availability of services, financial accessibility and acceptability). This approach enables us to identify and, above all, to better understand the factors that are essential to achieving access to care in each of these categories. The advantage of this approach is that it recognizes that access to care is determined by both demand and supply characteristics. The proposed classification of determinants of access gives a normative definition of each of the dimensions selected, as well as the factors that determine access on both the supply and demand sides.

i. Availability of services

The availability of services corresponds to the fact that services exist, can be reached within a reasonable distance (geographical accessibility), within a reasonable time (mobility), with a sufficiently wide range of hours and with easy contact, by the whole population, without discrimination, and under conditions adapted to patients' needs. It also makes it possible to measure whether health services are available in sufficient quantity to meet the needs of the population and the determinants linked to the quality of care (structural quality, availability of medicines, care process, relationship between carer and cared for, perceived quality, user satisfaction).

For example, the availability of services guarantees communication in the patient's own language, or the existence of facilities for people with reduced mobility. It also includes the availability of services for people who are physically or legally unable to travel: urgent and non-urgent care services at home or in collective residences (nursing homes, prisons, psychiatric hospitals). This dimension relates, on the one hand, to the quantitative issue of regulating the supply of healthcare providers according to the needs of the population and, on the other hand, to the organizational and practical aspects of delivering healthcare services (convenience). Availability of services for people with reduced mobility, for the elderly (shared residence) and for the disabled.

Lastly, a new challenge will cross this notion of availability: the development of telemedicine or, more broadly, remote diagnostic or therapeutic capacity. These new tools will probably greatly increase the capacity of services to take account of people's needs, either in their own homes (remote monitoring) or in local facilities. This will mean redefining the notion of accessibility, which will also have to be "virtual". In this respect, the example of Sweden, which, like Canada, Australia and Norway, has long experience of tele-medicine, is quite enlightening in terms of its ability to put in place an organization that integrates virtual consultations and care to resolve not only the issue of geographical accessibility, but also the growing demand for services and monitoring linked to an ageing population.

On the supply side, availability presupposes two main prerequisites: on the one hand, the existence of a sufficient and materially accessible supply and, on the other, the absence of any form of discrimination that prevents or hinders access to services (for example, patients with hospital bill arrears are sometimes refused admission to hospital or refused care for various reasons such as HIV status. Availability is influenced by a range of factors: geographical distribution across the territory, the development of mobile service provision, opening hours, the way appointments are organized, the way services communicate with patients via channels that are accessible and usable by the population as a whole, also including communication to publicize services.

On the demand side, even if services are made sufficiently available, Sophie Cès and Baeten tell us that access to them requires people to be able to reach them. First of all, access requires people to be able to make themselves available for treatment, i.e. to be able to devote time (including travel time, time spent in waiting rooms and appointments) which sometimes has to be taken from time spent on other imperative activities, such as work or childcare, or caring for a dependent relative, etc. Family responsibilities do not always allow people to free up the time they need to take care of themselves, neither do they allow time for appointments or hospital treatment (e.g. for some single-parent households with no social network)⁶. Material living conditions also influence the ability to reach services, particularly the means of transport and communication available. People's general state of health also has an impact on their ability to reach services. A very poor state of health means that people are less able to travel (for a medical examination or to see a specialist).

Drawing on the work of Jespers *et al*, availability may be hampered by demographic, social and morbidity factors, as the elderly, the disadvantaged and/or the chronically ill are more at risk of encountering difficulties in this area because of their reduced ability to reach services, which exacerbates practical difficulties (problems of mobility, physical fatigue, access to information, etc.). Certain mental health problems can also hamper the ability to reach services, understand the healthcare system, access information,

⁶ Sophie Cès and Rita Baeten, *Inequalities in access to healthcare Belgium*, Brussels, European Social Observatory (ESO), 2020, p. 45.

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make contact and organize care⁷. According to Cès, in this respect, the fact of being able to benefit from occasional or regular support from family and friends is sometimes indispensable in accessing healthcare⁸.

On the supply side, it is essential to recognize that the initiative for access to healthcare does not rest entirely with patients because certain objective needs are not perceived (in the absence of symptoms or in cases of neglect or denial). Healthcare providers are responsible for detecting these needs and initiating secondary access: this is the induced demand for healthcare.

This responsibility includes not only the stage of identification of the health problem or risk (through early screening, for example) but also secondary access to healthcare, i.e. the initiation of care. This stage is particularly important when different providers, services or organizations are involved. Organizing communication between the different services and organizations must ensure that follow-up is initiated when an illness is detected.

On the demand side, the identification of healthcare needs will depend on people's ability to perceive their needs. This is influenced not only by the level of health literacy, personal beliefs but also by the person's social network: for example, isolated elderly people are more likely to miss a health problem than those who are couples or have a social network.

The identification of needs also depends on people's ability to discern in the light of their personal circumstances, i.e. the degree to which they are distracted from their health. The sometimes-numerous problems that people have to deal with in other areas - professional, family, financial or other - is a cause of inattention to healthcare needs. Socio-economic insecurity is undoubtedly the situation that presents the greatest risk of neglect because healthcare needs are masked by other, more pressing needs to be met on a daily basis, such as housing or food. In such cases, health problems may be trivialized or denied⁹.

ii. Financial accessibility

Laurent Chambaud analyses financial accessibility as "*the ability of people to pay for services without financial difficulty*"¹⁰. Financial accessibility corresponds to the fact that patients' personal contributions are sufficient, on the one hand, not to discourage recourse to care in case of need and, on another hand, to protect against the risk of being exposed to financial difficulties in case of recourse. It therefore assumes that the opportunity cost of the time and money sacrificed is bearable by the patient.

It is important to stress that this cost is not represented solely by the price of the service (where this is known). It must include what the person has to pay to access the service. This could be the cost of transport, lost earnings from days not worked, the cost of childcare, etc. Affordability can be a major barrier to accessing healthcare and health services. As a result, it is a major factor in inequality and calls into question the universality of the systems in place.

The global survey organised by ISIG-Goma in January 2002 on the socio-economic situation of households in the city of Goma after the volcanic eruption revealed that the majority of Goma residents had a declared monthly income of less than 30 US dollars (68.5% of respondents confirmed this). This declared income seemed very low when considering that in most cases, a household of more than 6 people on average had to live on this income alone. According to the results of this study, more than 68% of households in the lowest income group do not have access to healthcare¹².

This is also confirmed by research conducted by Pierrot Bushala in the Mudja group on the socio-economic situation of the rural population and the impact of income on access to healthcare. The results show that 58.5% of this population have an average monthly income of less than \$50, and as a result 54.2% have no access to primary healthcare because of their low income, compared with 45.8% who pay for primary healthcare with their income. In this same group, the involvement of the state in the provision of healthcare services is not felt: 99.2% of the population take care of themselves, while 99.9% confirm that healthcare is not free. This is the case for the Pygmy population in the Lac-vert, Mugunga and Mudja camps, who are unable to meet their health needs¹¹. The results of these various studies confirm the truth that affordability can hamper access to healthcare.

On the supply side, affordability depends first and foremost on entitlement to mandatory health coverage. People who do not meet the eligibility criteria bear the full cost of healthcare (in the absence of private insurance). For people covered by compulsory health insurance, financial access depends on the financial conditions fixed for using healthcare. Different types of contribution exist:

- ✚ direct payments: payments for health goods or services not covered by compulsory health insurance (possibly covered (in part) by supplementary insurance);
- ✚ the personal co-payment: part of the cost of healthcare covered by compulsory health insurance remains payable by patients (who may be covered (in part) by supplementary insurance);

⁷ Jespers et al, (2021), "Somatic health care in a psychiatric setting. Health Services Research (HSR)", Brussels: Federal Centre for Expertise in Health Care (KCE). KCE Reports, pp. 34-36.

⁸ Sophie Cès, "access to healthcare: definition and issues", in *MC-Informations*, December 2021, n°284, p. 7.

⁹ Laurent Chambaud, "access to healthcare: background information", in national High school of social security "regards", July, n° 53, 2018, pp. 19

¹⁰ Pierrot Bahati Bishangi "Analysis of factors hindering pygmies' access to healthcare in the Goma and Karisimbi area", PhD in Medicine, ISIG, 2009, p. 50. ¹² Ibid. p. 52.

¹¹ 13 Ibid.

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- ✚ fee supplements: these are charges billed in addition to the co-payments defined by the regulations for healthcare provided by healthcare providers who do not adhere to the medical-mutual agreement (possibly covered (in part) by supplementary insurance);
- ✚ having to pay in advance for reimbursed healthcare costs also influences access to healthcare.

The financial participation of patients in care covered by health insurance finds its justification in the ex-post moral hazard hypothesis. Beyond the desired insurance effect, i.e. the solvency of the demand for essential and costly care through the pooling of financial risk, a certain proportion of the demand for care would not be justified from a clinical point of view and would correspond to a waste of healthcare, which would not bring any health benefit. The co-payment is therefore a financial incentive to make the insured more responsible. This contribution would have the dual advantage of moderating healthcare consumption while providing a source of financing for healthcare covered by health insurance.

It should be noted, however, that the risk of over-use at the patient's initiative remains limited to certain healthcare services that can be accessed directly by patients, such as medical consultations and visits or emergency services. In addition, the intended limiting effect of co-payments depends on people's level of income: those with low income are less likely to seek healthcare, even in justified cases, while people with better financial resources will have little incentive to modify their use of healthcare. Certain indicators confirm the greater use of certain types of healthcare by people of higher income: the number of visits to specialists is on average significantly higher among people of higher income, regardless of health status.

While private voluntary insurance can reduce the out-of-pocket healthcare costs of patients, it cannot meet the need for financial protection for disadvantaged socio-economic groups and for categories with a high health risk. On the one hand, the amount of premiums varies according to the nature of the contract (group, negotiated by the employer or individual). Secondly, the amount may depend on the level of health risk: premiums increase with health risk, and in particular with age. When the amount does not depend on the risk, the flat-rate premium is less accessible to people with limited financial resources. These methods of calculating the premium contravene the principle of equity that prevails in healthcare systems at the European level: the guarantee of equal access for all according to need, irrespective of their financial capacity¹². Thus, the development of the private insurance market to cover essential healthcare risks reinforcing inequalities in access to care between advantaged and disadvantaged groups, and widening further the perennial social inequalities in health.

This is why it is essential to ensure that compulsory health insurance covers a sufficiently wide range of healthcare needs for the entire population, not only in terms of the choice of treatments essential to health that are reimbursed, but also in terms of the size of the personal co-payment required. In fact, compulsory health insurance makes it possible to guarantee fair financial access through a dual solidarity mechanism¹⁵: because it is compulsory, people with a low health risk contribute to the financing of care and therefore to the pooling of risks between sick and healthy people (ex-post solidarity between risk classes). The fact that certain compulsory levies financing health insurance are progressive, means that an existing redistribution between income levels can be achieved overall (calculations made for 2015, this is solidarity between income levels ex ante)¹³.

Budgetary choices in the context of compulsory health insurance not only have direct implications for the level of out-of-pocket expenses for patients, but also for the development of the private health insurance market. Implicit societal choices in terms of social justice are the result. In particular, the fixation of a norm for real annual growth in the healthcare budget at a level below the 'natural' increase in healthcare expenditure (mainly due to the ageing of the population, changes in the prevalence of chronic diseases and medical progress) risks causing a lasting and significant deterioration in access to healthcare and, by the same token, in the equity of the healthcare system.

On the demand side, the ability to pay includes the ability to bear the costs of healthcare, transport costs and any opportunity costs associated with loss of income (for time spent in care). Income level and health cover are determining factors, but they are not the only ones. The social and family network also plays a role, particularly in the event of a serious health problem. Within families, financial solidarity between members can play a part in covering healthcare costs on a regular or more occasional basis (Cès and Baeten, 2020)¹⁴. This is why isolated people who have no social network are more at risk of financial difficulties in accessing healthcare. They have less direct financial capacity (only one disposable income) and do not benefit from family solidarity in the event of major needs. It should be noted, however, that socio-economic inequalities persist when it comes to family solidarity: economic and financial capital at family level remains unequally distributed between advantaged and disadvantaged groups. The opportunities for financial support in disadvantaged groups are likely to be more limited than in more financially well-off categories.

iii. Acceptability

In his doctoral thesis, Pierrot Bahati Bishangi likens this dimension to the socio-cultural factor that influences access to healthcare. According to him, acceptability can be understood as the set of social representations of the use of healthcare, including patients'

¹² Sophie Cès, " access to healthcare: background information ", p. 11. ¹⁵ Ibid. p. 12.

¹³ Laurent Chambaud, " access to healthcare: background information ", p. 24.

¹⁴ Sophie Cès and Rita Baeten, *Inequalities in access to healthcare Belgium*, Brussels, European social observatory (ESO), 2020, p. 45.

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level of education and literacy, beliefs, traditions, culture and family status. In this way, acceptability corresponds to the ability to provide care that meets the minimum perceived quality requirement for people to agree to use healthcare. In practice, the aim is to gain a better understanding of the many factors other than geographical or financial barriers that play a part in the decision to seek care. These may be of different kinds. Some determinants are linked to social structure. Age, gender, profession, family network, socio-cultural group and place of residence can all influence the use of healthcare services. The degree of knowledge and acculturation to the complexity of healthcare provision is also a factor that can make a difference. In their study of the social and cultural determinants that directly influence access to healthcare, Herzlich and Pierret¹⁵ enable us to understand, for example, the conditions for good or bad healthcare use, as well as the behavior of users of the healthcare system. The culture of origin can also strongly influence both intimate recognition of the pathology and contact with health services. The sensitive issue of health care for migrants shows the combination of economic and social vulnerability, but also a lack of recognition of the cultural aspects specific to each community. In acceptability, the level of education has a huge impact on the use of health services.

The social representation of illness and its causes influence the type of services used. Illnesses attributed to supernatural factors (convulsions, delirium, insanity), the transgression of a taboo or bad luck (sterility, abortion), can only be treated by traditional medicine. In this situation, recourse to healers or diviners remains the preferred option for people who do not seek so called modern medicine. This may help to explain the low level of use of health services by the population. We can therefore understand that even if availability and affordability are met, acceptability can be a barrier to access to healthcare.

Another area in which acceptability applies is people's awareness of the various healthcare services on offer. In fact, the degree of information, the ability to read, understand and use information has a considerable influence on people's use of healthcare services. Pierrot Bahati Bishangi tells us that the failure of pygmies to access healthcare is largely due to this parameter. The lack of information and, above all, the community's ignorance of health services contribute to their marginalization in terms of access to care. Pygmies are still well known for their use of traditional medicine (medicinal plants) to alleviate some illnesses. This community still expresses a great mistrust of so-called modern medical techniques (illness being considered a curse in the Pygmy collective imagination) and retains a strong belief in traditional values and witchcraft, which seem to exclude this people from modern health services.

However, acceptability also depends on the way in which services are organized. An example of this is the way in which primary care is currently evolving. Until recently, the local medical service was represented by the "family doctor", who is a self-employed doctor often working alone in an office, and whose almost permanent availability was guaranteed. This model is giving way to more collective forms (health centres, multi-professional health centres, health clusters, etc.), in which the personal touch of the practitioner is no longer as present. This new model may not sit well with some people, particularly those who have been accustomed to a highly individualized approach to healthcare.

On the demand side, this match is achieved when the conditions under which care is provided meet certain social needs:

- ✚ The need to respect certain social norms, such as the rules of politeness, or certain cultural and spiritual expectations, which may be more pronounced at certain stages of life, such as childbirth or the end of life;
- ✚ The need to respect certain choices relating to the practical organization of care or the provision of care itself (e.g. home care);
- ✚ The need to receive sufficient communication tailored to the individual situation, i.e. communication that is both comprehensible and complete (relating to the health risks involved, health literacy, the need for further tests, diagnosis, preventive and curative treatment options, the benefit/risk ratio, the cost of treatment and other expenses, etc.) in order to encourage adherence to treatment and to circumscribe the possibilities for adaptations. This includes not only the need to access relevant information, but also to be listened to sufficiently to ensure quality interaction between providers and patients, who differ in their ability to communicate about their health problems or in other areas. Devoting more effort to communication is all the more important as the difficulties in other dimensions are significant (for example, in the case of treatment that is costly for the patient or for a health problem that is not felt by the patient).

Other aspects of the quality of care can also be considered, such as the need to have confidence in the skills of providers, the quality of equipment, or the need to have a minimum level of comfort (subjectively perceived), and so

On the supply side, acceptability is influenced by a varied set of factors, such as the quality of infrastructure and equipment, the training of providers, particularly relating to how to communicate with patients and awareness of how to combat discriminatory behavior, the opportunities to interact differently according to the profile of patients, in particular, the possibility of devoting more time to certain patients during contacts. This is a particularly important dimension for people with chronic health

¹⁵ Christian Herzlich et al, "Au croisement de plusieurs mondes : la constitution de la sociologie de la santé en France (1950-1985)", *Revue française de sociologie*, vol. 51, January 2010, p. 123.

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problems or loss of autonomy (for example, nursing care at home with the problem of care delivery times which are sometimes difficult to reconcile with the pace of life of dependent elderly people)¹⁶.

This dimension refers to the need to ensure, above all, a relationship of confidence between providers and patients so that the role of each can be exercised to best effect in promoting access to care. Beyond the question of the strategic healthcare choices that individuals must be able to make (an issue that goes beyond the scope of this article), the ability to adapt care processes to certain specific needs is a major challenge for the healthcare system, as it implies implementing a framework that is sufficiently flexible to be able to differentiate care according to the patient, and sometimes even to adapt the resources devoted according to the profile of the individual. This is tantamount to acknowledging the fact that patients with equal care needs are not treated equally according to considerations that go beyond the medical sphere. This possibility should not only be explicitly recognized, but also evaluated, in particular the obstacles to the minimum adaptability required to provide sufficiently acceptable care to all types of public. It should be noted, however, that acceptability is distinct from satisfaction in the sense that it corresponds to the minimum threshold of satisfaction below which healthcare will not be sought. In short, the table below summarises the various aspects that need to be taken into account to improve access to care on both the supply and demand sides.

Dimension	Supply	demand
Service availability	Existence of health care services, health care facilities (laboratory, general medicine, pharmacy, etc.), availability of drinking water for healthcare services, availability of electrical infrastructure for healthcare services, availability of a back-up energy source, availability of human resources (depending on the category), availability of hospital beds, availability of road infrastructure, absence of discrimination/stigmatisation, availability of mobile services (ambulance), means of communication between services and patients, speed of service, etc.	Availability to come to the care offered (working time, childcare time or other important responsibilities), time spent in the waiting room, Means of transport used, means of communication, general state of health, socio-demographic factors (age, morbidity, mobility), mental health problems, regular support from a relative, level of health literacy, patient's social network, etc.
Financial affordability	CSU, state subsidies on services, drugs, employer-provided insurance	Expenses for the service received, transport costs, childcare costs, private health insurance, income level, social network
Acceptability	Quality of infrastructure, quality of equipment, communication methods, discrimination/stigmatisation, staff absenteeism	Educational level, patients' literacy level, beliefs, traditions, culture Sociodemographic characteristics

CONCLUSION

Since the Universal Declaration of Human Rights in 1948, access to healthcare has been a concern historically anchored in the construction of social protection. At the end of this analysis, we can see that access to healthcare is a dynamic and complex process that gives rise to a wide range of interpretations. Notwithstanding these plural approaches, this study has dissected the dimensions of access to care into three main dimensions: availability of services, affordability and acceptability. Through these three dimensions, the challenge of this theoretical framework is to highlight the extent of the field of possible actions to improve access by including all of its determinants as exhaustively as possible. Particularly, it highlights two lesser-known but no less essential dimensions for achieving access: the availability of services to meet healthcare needs and the acceptability of care. It also shows the interdependence of each of these dimensions in achieving access as a dynamic process, both on the supply side and on the demand side. It thus offers a more comprehensive reflexion framework to better understand all the explanatory factors of inequalities in access.

While there are many determinants of social inequalities in health, the persistence of difficult access to healthcare for the vulnerable population contributes significantly to the worsening of these inequalities in Cameroon. Given the diversity of mechanisms that influence access to healthcare and the complexity of the interdependencies between all the components of access, policies in favour of Universal Health Coverage should be thought through in a holistic and participatory manner, in the form of a comprehensive plan so that healthcare can reach more of those who need it most and significantly reduce social inequalities in health. The right of access to health care for all must be defended as a fundamental value of the health system and be affirmed as a constitutive prerequisite of any health policy.

¹⁶ Sophie Cès et al, " Family carers of elderly people living at home in Belgium: an essential and complex role ", Brussels, King Baudouin Foundation, p. 18.

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