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Failure to seek needed medical care: Results from a national health survey of Icelanders

Runar Vilhjalmsson*

Faculty of Nursing, University of Iceland, Eirbergi, Eiriksgotu 34, IS-101 Reykjavik, Iceland

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Abstract

The study focuses on access to outpatient medical care in Iceland—a socialized health care system. As in other systems of this sort, equal access to needed services (equity) is a fundamental principle. Despite governmental claims that access to health services is "easy" and "roughly equal", the study indicates substantial and rather extensive variations in equity of care. More specifically, younger individuals, the non-widowed, the economically troubled, individuals with inflexible daily schedules, the chronically ill, those who had incurred high out-of-pocket costs relative to their family income, and those who didn't have a physician care discount card, were more likely than others to postpone or cancel an MD visit they thought they needed. Furthermore, younger age, economic troubles, chronic medical conditions, no family physician, and no physician care discount card, were all related to under-utilization, based on medical specialist criteria of recommended medical care for symptoms. Although the results show that access problems originate in part outside the health care system, they also suggest revision of current health policy, in order to adequately address existent inequities in service delivery.

Keywords: Physician visits; Access to medical care; Equity; Health system; Iceland

Introduction

Health systems in OECD countries fall broadly into three categories—private (e.g. USA), socialized (e.g. the Nordic countries and Great Britain), and national health insurance systems (e.g. Germany and the Netherlands). Unlike their private counterpart, socialized and national health insurance systems purport to guarantee citizens equal access to health services at time of need (Cockerham, 2004). According to a frequently used definition, health systems are said to be equitable if realized access (use of health services) is based on people's needs for services (Aday & Andersen, 1981; van Doorslaer et al., 2000; van Doorslaer, Koolman, & Puffer, 2002). Such needs can be approached both subjectively by having individuals assess their own service needs, and objectively in terms of professional assessment of needs for specific services given certain conditions. However, if access to medical care is largely determined by predisposing factors (e.g. education or knowledge about symptoms or health service options), or by enabling factors (e.g. income or a regular source of care), health systems are said to be inequitable (see Andersen, 1995).

Public health expenditures rose steadily in most OECD countries during the second half of the 20th century, both in terms of real amounts, health expenditures per person, health expenditures as percentage of GDP, and health expenditures as percentage of total

*Tel.: +354 525 4960; fax: +354 525 4963.
E-mail address: runarv@hi.is.

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public expenditures (OECD, 2004). In an attempt to contain health system demands on governmental budgets, state and local governments have in recent years implemented various measures, including budgetary controls, supply constraints, restrictions on government payments for physician services and prescription drugs, and privatization of services (Saltman & Figueras, 1997). As a consequence, patient out-of-pocked health care costs have risen year by year in most OECD countries (OECD, 2004). This development has raised concerns about (emerging) health care inequities (Donelan, Blendon, Schoen, Davis, & Binns, 1999). Recent research indicates that such concerns are warranted, as substantial proportion of the population does not get needed care, and there are significant and substantial differences in health care utilization levels between population groups, even when need for services is taken into account (Burström, 2002; Schoen, Davis, DesRoches, Donelan, & Blendon, 2000; Whitehead, Evandrou, Haglund, & Diderichsen, 1997).

Factors related to access to needed outpatient services

Sociodemographic background

Numerous studies in Western countries have documented sociodemographic variations in access to needed outpatient services. For example, the elderly are more likely to respond to acute and chronic conditions by visiting the doctor (Adams & Benson, 1992, p. 25; Marcus & Siegel, 1982), and older age is positively related to physician utilization when need variables are controlled (Benzeval & Judge, 1996; Eyles, Birch, & Newbold, 1995).

As for gender, US studies show that women are more likely to respond to acute symptoms by visiting a physician (Adams & Benson, 1992, p. 26). Furthermore, women with hypertension use physicians more than their male counterparts, but there appear to be no gender differences in the promptness of medical care contact for cancer or myocardial disease (Marshall, Gregorio, & Walsh, 1982; Waldron, 1988). Furthermore, other studies show that female gender remains positively related to physician utilization, when need variables are taken into account (Benzeval & Judge, 1996; Cleary, Mechanic, & Greenley, 1982; Eyles et al., 1995; Marcus & Siegel, 1982; Sharp, Ross, & Cockerham, 1983).

Few studies have looked at marital status differences in access to care, but there is some evidence that the married and widowed have the best realized access, and the divorced the worst, when controlling for need (Benzeval & Judge, 1996; Eyles et al., 1995).

There are indications that working parents (mothers) with children in the home visit physicians more than others (Benzeval & Judge, 1996; Evandrou, Falkingham, Le Grand, & Winter, 1992), but the opposite is true in other studies (Vilhjalmsson, Olafsson, Sigurdsson, & Herbertsson, 2001a). It is not clear whether observed parental status differences reflect variations in service needs, or inequities in access to care due to predisposing or enabling factors.

Some US studies (Aday & Andersen, 1983), but not others (Berk, Schur, & Cantor, 1995) find residential differences in access favoring urban area residents. Major reasons for this may be geographic distance, limited physician supply, and absence of regular source of care in rural areas (e.g. Aday, Fleming, & Andersen, 1984, p. 45; Nemet & Bailey, 2000).

Furthermore, there is evidence that the employed are less likely to contact the doctor in chronic illness (Marcus & Siegel, 1982), perhaps because the employed have less time to tend their illness, or because they are healthier that the non-employed (Siebert, Rothenbacher, Daniel, & Brenner, 2001).

Income tends to be inversely related to physician use in private (fee-for-service) and socialized health systems alike (Cockerham, 2004). When need variables are taken into account, greater utilization by low income groups disappears or is reversed in the US (Adams & Benson, 1992, pp. 28–29; Dutton, 1986; Marcus & Siegel, 1982), but in Britain and Sweden, low socioeconomic groups have the highest overall utilization rates, even after controlling for health status (Benzeval & Judge, 1996; Gerdtham & Sundberg, 1998; Whitehead et al., 1997). At the same time, studies in a number of OECD countries show that low income individuals tend to use fee-for-service physicians and specialists less than other income groups, when need is taken into account (van Doorslaer et al., 2000, 2002; Dunlop, Coyte, & McIssac, 2000; Schofield, 1999). Furthermore, low income individuals are more likely to report having postponed or cancelled a needed physician visit in general (Aday et al., 1984, p. 93; Berk et al., 1995; Burström, 2002; Halldorsson, 1998), and because of high costs in particular (Olafsson & Arnason, 1998). These results suggest that low income individuals are disadvantaged, especially in fee-for-service systems, despite their high overall utilization rates. Unlike income, education appears to have limited effect on physician utilization in general (Dunlop et al., 2000; Vilhjalmsson et al., 2001a), or physician visits net of health status (Eyles et al., 1995). Nevertheless, there are indications that lower education is related to fewer visits to specialists, and underutilization of preventive physician care (Dunlop et al., 2000; Vilhjalmsson et al., 2001a).

Roles and attitudes

People differ in the way their daily roles are fixed vs. flexible, and this may affect their access to health services. In a US study by Marcus and Siegel (1982), the