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Socioeconomic patterns in use of private and public health services in Spain and Britain: implications for equity in health care



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ABSTRACT

This paper estimates the pattern of private and public physician visits and hospitalisation by socioeconomic position in two countries in which private healthcare expenditure constitutes a different proportion of the total amount spent on health care: Britain and Spain. Private physician visits and private hospitalisations were quantitatively more important in Spain than in Britain. In both countries, the use of private services showed a direct socioeconomic gradient. In Spain, the use of public GPs and public specialists tends to favour the worst-off, but no significant differences were observed in public hospitalisation. In Britain, with some exceptions, no significant socioeconomic differences were observed in the use of public health care services. The different pattern observed in the use of public specialist services may be due to the high frequency of visits to private specialists in Spain.

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1. Introduction

Studies carried out in wealthy countries have observed that, after controlling for health status, the probability of consulting a general practitioner (GP) and of hospitalisation either do not vary across income or socioeconomic groups or is somewhat more frequent in persons belonging to lower socioeconomic groups (Roos and Mustard, 1997; Finkelstein, 2001; Van Der Heyden et al., 2003; Sutton et al., 2002; Van Doorslaer et al., 2004b; Morris et al., 2005; Van Doorslaer et al., 2006). In contrast, the probability of consulting a specialist physician is higher among groups with higher income and more education (Roos and Mustard, 1997; Finkelstein, 2001; Van Der Heyden et al., 2003; Van Doorslaer et al., 2006; Whitehead et al., 1997; Dunlop et al., 2000). Based on these findings, some authors have maintained that rich countries are characterised by equity or pro-poor inequity in GP visits and hospitalisation and by pro-rich inequity in visits to specialist physicians (Van Doorslaer et al., 2006; Hurley and Grignon, 2006).

The authors of other studies that have used more recent data have come to the same conclusions as found similar results (Or et al., 2008; Bago d'Uva et al., 2008). Likewise, Or et al. (2008) highlight that degree of social inequities in specialist use is smaller in countries with a tax-based national health system, as United Kingdom, that in social insurance based systems like France, the complexity of the rules for reimbursement for different services could be dissuading certain individuals from using some services. Even in France those having a university degree have a significantly higher use of GP care. Likewise, it has been suggested that deviations from the principle of horizontal equity is observed mainly in countries where out-of-pocket payments are higher because the social inequalities in GP and specialist use are stronger in these countries (Or et al., 2008).

However, it is not appropriate to evaluate equity in the use of health services based on these studies since they consider the use of all health services without differentiating between public and private. The objective of public healthcare systems is to achieve equal use of public healthcare for equal need. This is known as horizontal equity (Culyer, 2001). If we assume equal distribution and ideal quality of public healthcare services, horizontal equity could be achieved independently of the socioeconomic pattern observed in the use of private health services (Rodríguez and

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Stoyanova, 2004). For example, in the United Kingdom (UK) it has been observed that the National Health Service (NHS) has achieved its equity goal of equal care for equal medical need in the case of arthritis care even though patients with better education use private care more frequently than those with less education (Propper et al., 2005).

Indeed, universal public health coverage is not incompatible with the existence of a complementary private health insurance which covers any cost-sharing remaining after basic coverage, a supplementary insurance which provides cover for additional health services not covered by the public scheme, or a duplicative insurance that covers the same services as universal public health coverage but avoid waiting lists because it allows to go to private medical services. In the same way, universal public health coverage is not incompatible with the desire of some patients to use private medical services for any reason, either because they want faster access, because they want to get a second opinion or because they have more confidence in private medical services.

This coexistence of private and public health services means that it is difficult to compare achievement of equity among different countries when both types of health services are combined. For example, a country could show a high degree of pro-poor inequity in the use of public health services due to underuse of these services by high socioeconomic groups rather than overuse by low socioeconomic groups. This may occur in countries where there is considerable use of the private healthcare system, since people who use private health services more often have high socioeconomic position (Propper et al., 2005; Regidor et al., 2008) and many of them probably do not use public health services.

The objective of this investigation was to show the relation between socioeconomic position and the use of private and public health services in two countries in which private health expenditure constitutes a different share of total health expenditure: Spain, where private health expenditure around 2005 was 29% of the total amount spent on health, and the UK, where this percentage was 18% (Organisation for Economic Co-operation and Development. OECD. Health data 2011). According to the aforementioned hypothesis, Spain may show greater pro-poor inequity than the UK in the use of public health services, since the higher expenditure on private health services would be expected to correspond to persons in high socioeconomic position.

2. Methods

2.1. Data sources

The Spanish data were taken from the 2006 National Health Survey carried out by the Ministry of Health and the National Statistics Institute. The sampling framework was made up of the Spanish non-institutionalised population aged 16 or over. The survey had a two-stage sample design. The first-stage units were the census sections and the second-stage units were the households in each of the sections selected. The households were selected by simple random selection, and an adult aged 16 or over was selected in each household. The non-response rate was 4%. The UK study was conducted using information for Britain. Specifically, the data were taken from the 2004–2005 General Household Survey (GHS), an annual multipurpose survey carried out by the Office for National Statistics in a sample of the general population resident in private, that is, non-institutional households in Britain. The GHS uses a two-stage sample design. The primary sampling units are postcode sectors, and the addresses are randomly selected within each primary sampling unit. The GHS aims to interview all adults aged 16 or over in the household at the sampled address. The non-response rate was 30%.

2.2. Study variables

The health services investigated were GP visits and hospitalisation in each country, specialist visits in Spain, and outpatient visits in Britain. In Spain, 98.6% of citizens are covered by the public healthcare system and therefore have the right to use any services provided by the National Health System (National Statistics Institute, 2011a, 2011b). The entire British public has access to free care in the National Health Service (NHS). In both countries, public GPs are responsible for delivering primary care and are the gatekeepers to public secondary care – specialists or hospitalisation. In general, patients cannot gain access to public secondary care unless they are referred by a public GP, except in emergencies.

In the Spanish National Health Survey, respondents were interviewed about the frequency of their physician visits. Those who had any physician visit in the last 4 weeks were asked if the physician consulted at the most recent visit was a GP or a specialist. They were then asked if the physician whom they consulted was in the public healthcare system, was from a private health insurance company, or whether the patient paid directly for the consultation. In the first case, GP or specialist visits were considered to be a public visit, while in the latter two cases the visit was considered to be private. Respondents were also asked if they had been hospitalised for at least one night in the year before the interview. Those who had been hospitalised were then asked if the cost of the last hospital admission had been covered by the public health system, by any type of private health insurance, or had been paid directly by the patient. In the first case the hospitalisation was considered to be a public hospitalisation, while in the later two cases it was considered to be private. Respondents were also asked about the reason for the last hospital admission: surgery, diagnostic study, medical treatment, birth or other. For purposes of the present analysis we excluded hospital admissions for birth.

In the GHS, respondents were asked if they had visited any physician in the last 2 weeks. Those who replied affirmatively were asked for each visit if the consultation was under the NHS or was paid for privately and, subsequently, if the visit was made to a GP or to any other physician. They were considered to have visited a public GP if the last visit was made to a GP in the NHS, and to have visited a private GP if the last visit had been paid for privately. Respondents were also asked if they had consulted as a patient in any hospital outpatient department in the last 3 months. Outpatient visits were considered to be public if they were all made under the NHS and were considered to be private if any of the visits were paid for privately. In addition, respondents were asked if they had been admitted to a hospital for at least one night during the last year. The hospitalisation was considered to be public when the last hospital admission was under the NHS and was considered to be private when the last hospital admission was as a private patient. Patients were also asked if the reason for the hospitalisation was for birth, and such admissions were excluded from the present analysis.

The measure of socioeconomic position was socioeconomic group based on the occupation of the reference person in the household. In both the Spanish National Health Survey and the GHS, the reference person was the primary wage earner in the household. Socioeconomic group was classified in the following four categories: professionals and managers, lower non-manual, skilled manual and unskilled manual workers (Box 1).

Self-rated health and limiting long-standing illness were used as measures of the need for health care. In the Spanish health survey, self-perceived health was measured by the following question: “over the last 12 months would you say your health has on the whole been very good, good, fair, poor or very poor”. In the GHS the same reference period was used but the alternatives

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