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Gender Inequalities in Access to Health Care among Adults Living in British Columbia, Canada

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A B S T R A C T

Introduction: Existing literature is inconclusive as to whether disparities in access to health care between men and women are mainly driven by socioeconomic or gender inequalities. The aim of this study was to assess whether gender was independently associated with perceived unmet health care needs among a representative sample of British Columbia adults.
Methods: Using data from the 2011/2012 Canadian Community Health Survey, logistic regression analyses were conducted to investigate the independent effect of gender on perceived unmet health care needs adjusting for potential individual and contextual confounders.
Results: Among 12,252 British Columbia adults (51.9% female), the prevalence of perceived unmet health care needs was 12.0%, with a significantly greater percentage among women compared with men (13.7% vs. 10.1%; $p < .001$). After adjusting for multiple confounders, women had independently increased odds of perceived unmet health care needs (adjusted odds ratio, 1.37; 95% CI, 1.11–1.68).
Discussion: The current study found that, among a representative sample of British Columbia adults and adjusting for various individual and contextual factors, female gender was associated independently with an increased odds of perceived unmet health care needs.
Conclusion: These findings suggest that within Canada's universal health system, gender further explains differences in health care access, over and above socioeconomic inequalities. Interventions within and outside the health sector are required to achieve equitable access to health care for all residents in British Columbia.

Appropriate and equitable access to health care is recognized as a key determinant of individual and population health (Solar & Irwin, 2010). Under the Canada Health Act (Canada Health Act, 2012), universal and comprehensive health care should be granted to all Canadians, independent of their ability to pay, socioeconomic status, and place of residence. However, research has shown that many Canadians face barriers when trying to access health services (Access to Health Care Services in Canada 2005, 2006; Sanmartin & Ross, 2006). This is concerning, because individuals who experience barriers to care may postpone or avoid seeking preventive or curative services, placing them at increased risk of morbidity and mortality, as well as further increasing the burden on the health system (Chen, Rizzo, & Rodriguez, 2011; Girardi, Sabin, & Monforte, 2007; Weissman, Stern, Fielding, & Epstein, 1991).

Given the universal nature of the Canadian health system, research on inequalities in access to care in Canada has focused historically on indicators of health services utilization by different social groups (Allan & Cloutier-Fisher, 2006; Glazier, Agha, Moineddin, & Sibley, 2009; Newbold, 2009). However, focusing on utilization as a proxy for access fails to account for the complex interactions between the social–structural, environmental, and individual factors that shape individuals' health care seeking behavior, as well as the difficulties that individuals may experience when trying to obtain the care they need (Levesque, Harris, & Russell, 2013).

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A complementary and increasingly used measure of access to care is "perceived unmet health care needs," defined as the difference between the care felt to be necessary to deal with a particular problem and the services actually received (Sanmartin, Houle, Tremblay, & Berthelot, 2002). According to Statistics Canada, rates of perceived unmet health care needs have been rapidly increasing, with 12.5% of the Canadian population reporting unmet health care needs in 2000/2001, three times higher than in 1994/1995 (Sanmartin et al., 2002). Further, particular vulnerable groups such as recent immigrants, young adults, individuals with lower income, and those with poorer health status seem to be at an increased risk of unmet health care needs (Chen & Hou, 2002; Kasman & Badley, 2004; Marshall, 2011; Wu, Penning, & Schimmele, 2005).

There is conflicting evidence in the literature regarding the role of gender as a determinant of unmet health care needs. Although most studies showed women at increased risk of unmet health care needs (Bryant, Leaver, & Dunn, 2009; Kasman & Badley, 2004; Levesque et al., 2012), others have failed to find such an association (Chen & Hou, 2002; Law et al., 2005). Some of the inconsistency in the evidence for female gender as a determinant of unmet health care needs may relate to the role that socioeconomic status plays as driver of health inequalities between men and women, even in a context like Canada (Cooper, 2002; Denton, Prus, & Walters, 2004). For example, full-time employed women in Canada earn on average 19% less than men (Organisation for Economic Co-operation and Development [OECD], 2014). Lower socioeconomic status, in turn, is a well-known predictor of poorer health status (Adler & Newman, 2002; Marmot et al., 1991), with its associated implications for higher health care needs. Women are also more likely to work part time (OECD, 2014) and consequently less likely to be eligible for full employment benefits, including health services benefits such as prescription drug insurance. Therefore, it is not surprising that rates of unmet health care needs are greater among women. What is less clear is the extent as to which socioeconomic inequalities account for disparities between men and women in unmet health care needs, and whether gender differences persist after adjustment for socioeconomic factors and other potential confounders.

Therefore, the objectives of this study were to provide an updated, population-based estimate of the prevalence of perceived unmet health care needs among adults living in British Columbia, Canada; and to explore whether female gender was associated independently with an increased risk of perceived unmet health care needs among this population.

Methods

Study Design

Data for this study was obtained from the 2011/2012 Canadian Community Health Survey (CCHS). Briefly, the CCHS is an ongoing, annual, cross-sectional survey that collects information regarding health status, health care utilization, and health determinants of the Canadian population. The sampling frame is generated using a multistage, stratified cluster design, and includes individuals aged 12 years and older living in private dwellings in the 115 health regions from all provinces and territories of Canada; the CCHS excludes individuals living on Indian Reserves and on Crown Lands, institutional residents, full-time members of the Canadian Forces, and residents of certain remote regions. Thus, the CCHS is representative of approximately 98% of the Canadian population at the level of age and sex groups within provincial health regions. All questionnaires are administered using either in-person or telephone computer-assisted interviewing. A detailed description of the survey and methodology is available elsewhere (CCHS, 2013). Ethical approval for this study was covered by the publicly available data clause (Item 7.10.3) governing the use of public release data set under the University of British Columbia's Policy #89: Research Involving Human Participants (Board of Governors, 2012).

Study Sample

The study sample was restricted to respondents (≥18 years old) living in the province of British Columbia for which optional survey content modules on both perceived unmet health care needs and access to health care services (e.g., having a regular family doctor) were available. For the 2011/2012 CCHS, the overall response rate for British Columbia was 86.7%, resulting in the inclusion of 15,413 participants from this province. Individuals with invalid responses (i.e., refusal, do not know, not stated) to the study outcome (i.e., unmet needs), the explanatory variable (i.e., gender), or potential confounders were excluded. Figure 1 shows the sample selection process for this study. Of the 14,250 eligible respondents, 27 were excluded for invalid responses to unmet needs, and a further 1,971 for invalid responses to potential confounders. Thus, the final analytic sample comprised 12,252 British Columbia adults.

Measures

For the current analysis, the main outcome of interest was perceived unmet health care needs, defined as answering "yes" to the question: "During the past 12 months, was there ever a time when you felt you needed health care, but you did not receive it?" The primary explanatory variable of interest was the self-reported gender of the participant (female vs. male).

Based on prior literature examining access to health care (Allin, Grignon, & Le Grand, 2010; Andersen, 1995; Cavalieri, 2013; Chen & Hou, 2002; Law et al., 2005; Levesque et al., 2012; Marshall, 2011; Sanmartin et al., 2002; Shi & Stevens, 2005; Wu et al., 2005), other individual and contextual factors that were hypothesized to confound the relationship between gender and perceived unmet health care needs were also considered. The selection of these variables was informed by Andersen's Behavioral Model of health service use (Andersen,

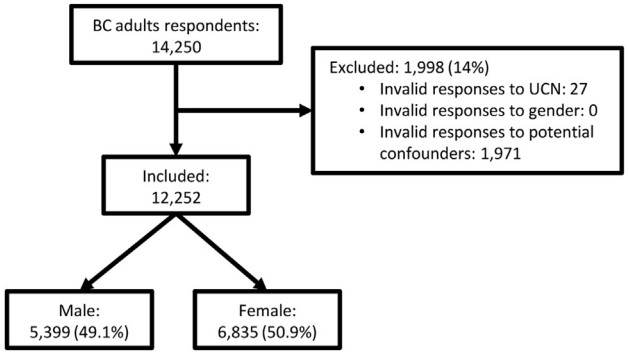

Figure 1. Derivation of the final analytic sample for an investigation of gender and unmet health care needs among adults in British Columbia, CCHS 2011/2012. Invalid responses included don't know, refusal, not stated. BC, British Columbia; CCHS, Canadian Community Health Survey; UCN, unmet health care needs.