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# Inequity in healthcare use among older people after 2008: The case of southern European countries

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## ABSTRACT

Despite the sizeable cuts in public healthcare spending, which were part of the austerity measures recently undertaken in Southern European countries, little attention has been devoted to monitoring its distributional consequences in terms of healthcare use. This study aims at measuring socioeconomic inequities in primary and secondary healthcare use experienced some time after the crisis onset in Italy, Spain and Portugal. The analysis, based on data drawn from the Survey of Health, Ageing and Retirement in Europe (SHARE), focuses on older people, who generally face significantly higher healthcare needs, and whose health appeared to have worsened in the aftermath of the crisis. The Horizontal Inequity indexes reveal remarkable socioeconomic inequities in older people's access to secondary healthcare in all three countries. In Portugal, the one country facing most severe healthcare budget cuts and where user charges apply also to GP visits, even access to primary care exhibits a significant pro-rich concentration. If reducing inequities in older people's access to healthcare remains a policy objective, austerity measures maybe pulling the Olive belt countries further away from achieving it.

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## 1. Introduction

The cost of healthcare provision is expected to increase substantially due to population ageing. As ageing is by definition a process of increasing morbidity [1], the need for healthcare rises as individuals age; the associated epidemic of chronic diseases entails substantial long-term health and social care costs [2,3]. In recent years, this has been a major cause of policy concern in Europe [4] also because the economic crisis has strengthened the pressure for controlling public spending. Several studies have already documented the detrimental effect of the economic crisis on health and health services supply [e.g. 5,6,7]. However, less attention has been devoted to monitoring the distributional consequences of the crisis in terms of healthcare use [8], a key input into the health production function.

Older people represent a particularly vulnerable group, especially the elderly with chronic diseases because they are more likely to experience a catastrophic health expenditure [9]. Moreover,

older people's health appears to have worsened in the aftermath of the crisis in Europe [e.g. 10,11] – in contrast to evidence of a counter-cyclical health pattern found for the overall population [12]. This raises the concern that the consequences of the economic crisis could accentuate the socioeconomic gradient in 'compressed morbidity' [13], reducing even further the ability of less advantaged individuals to live healthily the extra-years of life gained from increased life-expectancy.

Alongside the health divide between Eastern and Western Europe [14], there is a 'North-South' divide within Western Europe attributable to ingrained institutional, economic and cultural differences [15]. These differences, evident in Esping-Andersen's welfare regime typology [16], render common the clustering of the Southern European countries into the same group of Olive-belt countries. These countries were severely affected by the economic crisis and pressured to undertake austerity measures. This raises particular concern as the health expenditure per capita in countries like Portugal, Spain and Italy has been generally lower than in the EU-15 – even though trend-wise it has been higher overall than quite a few other European countries, namely the majority of newer Member states. A thorough assessment of the health and healthcare effects of austerity measures in hardly hit countries has been indeed already advocated [17,18]. In fact, although universal healthcare

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represents the prevailing model in Europe, the renowned right to public healthcare does not always materialize. On the one hand, there might be supply shortages. In Portugal, for example, 15% of those enrolled in primary care units in 2009 did not have a family doctor [19]. On the other hand, entitlement to access does not necessarily translate into horizontal equity in healthcare use – which would be achieved if individuals with the same healthcare needs were using the same amount of healthcare services, irrespective of non-need-related individual characteristics [20,21], namely the capability to afford the co-payments required to access healthcare services or to purchase them privately, thereby avoiding the delays implied by public queues.

While the study of horizontal equity in access to healthcare is undoubtedly not new in the literature [see for example 22,23], previous comparative studies including the Olive belt countries date back to pre-crisis times in terms of data coverage. These studies generally found either evidence of pro-poor inequity or no evidence of inequity in primary care (GP visits), and pro-rich inequity in secondary care (specialists visits) [e.g. 24–28]. They show how the presence and extent of inequity depends on the type of care analysed, reflecting the specific access mechanisms applying to primary and secondary care. Whereas access to the GP is usually free of charge in the public system, secondary healthcare is either provided under co-payment schemes in the public system or bought privately possibly through private insurance schemes.

Motivated by the above-mentioned concerns, this study offers a picture of the inequities in both primary and secondary healthcare use in three Olive-belt countries, Italy, Spain and Portugal, in the aftermath of the crisis. These three countries share many similarities in their healthcare systems: timing of creation, sizeable share of private expenditure and poorer perceived quality of public health services, when compared to northern countries [29]. In all three countries the GPs act as gatekeepers to secondary care, although in Portugal and Spain hospital emergency visits are very often used to bypass waiting lists for specialist consultations in the public sector.

Among the three countries, Portugal calls for special attention. The crisis is bearing a particularly grave impact in the country, the only one among the three that was under an EU/IMF Financial Assistance Programme – which targeted the healthcare sector as one of the main intervention areas [30]. Although less pronounced than in Greece or Ireland, the decrease in the annual average growth rate in per capita health expenditure between 2009 and 2011 was bigger in Portugal (2.2%) than in Spain or Italy (0.5 and 0.4%, respectively) [31]. Great part of this decrease resulted from cuts in healthcare budgets, which increased even further the private share of total health expenditure – 11 p.p. higher than the EU15 average (23.4%), and higher than in Spain (27.1%) and Italy (22.2%) [31]. As a result, the possibility of incurring in catastrophic healthcare expenditure represents a considerable issue in Portugal, especially for older people [32,33].

Our analysis exploits data from the Survey of Health, Ageing and Retirement in Europe (SHARE) whose strength, with respect to data employed in previous comparative studies, is the very detailed set of health and healthcare usage information collected under a cross-country comparable framework. As Portugal only joined the survey in wave four, and subsequent waves including the three countries do not have information on GP and specialist visits, the analysis only uses that wave. As such, the analysis is cross sectional and does not look at the evolution of inequities. It does not look either at the causality between austerity measures and the inequalities observed. Rather, we study and compare the case of the three Olive belt countries in 2011, i.e. a time when they were still struggling to overcome the crisis.

The rest of the paper is organized as follows. The next section describes in more detail the SHARE survey and the variables used in the analysis. The following one presents the methodology

used to measure and explain inequity in health care utilization, and describes its implementation. The fourth section presents the results, covering both the inequity indices and the analysis of specific factors' contributions to the observed inequity, which are then discussed in the following section. The final section concludes.

## 2. Data

The Survey of Health, Ageing and Retirement in Europe (SHARE) is a multidisciplinary cross-national panel study representative of individuals aged 50 and over and their partners in Europe [34]. The survey collects information on a wide range of topics, including socio-demographic characteristics, labour market activity, family composition, social networks, income and assets held, health, as well as information on healthcare use and health behaviours. Using data from wave four precludes including Greece as it did not participate in that wave. The sample for analysis includes all individuals aged 50 or older in the three countries covered, leading to a total sample of 9049 individuals, of which 3521 Italian, 2022 Portuguese and 3506 Spanish.

The variables we use to measure the use of healthcare services (in the last 12 months) are the number of GP contacts and the number of different specialists consulted from a list of 14 categories (specialist for heart disease, pulmonary, gastroenterology, diabetes or endocrine diseases; dermatologist; neurologist; ophthalmologist; ear, nose and throat specialist; rheumatologist or physiatrist; orthopaedist; surgeon; psychiatrist; gynaecologist; urologist; oncologist; geriatrician; or other specialist). Lower levels of healthcare use could simply reflect lower healthcare needs stemming from country-specific patterns of prevalence for specific health conditions. Therefore, a crucial step in the assessment of inequity in access to healthcare requires accounting for the 'legitimate' drivers of differences in healthcare use, i.e. differential need [35]. In empirical studies, need for healthcare is typically proxied by age, sex and a set of health indicators [36]. The use of insufficient health indicators in the need measurement may lead to an underestimation of pro-rich inequity and an overestimation of pro-poor inequity [24]. Fortunately, in this study we can rely on a rich set of physical and mental health variables. We use some of the so-called quasi-objective measures of health such as diagnosed conditions and functional indicators [37]. This limits the chance of downward biases that may result from socioeconomic inequalities in self-perceived health [38–42]. In more detail, we use the number of diagnosed chronic conditions (up to 11), the number of symptoms (up to 13), binary indicators for whether the respondent reports having a long standing illness and experiencing limitations in activities of daily living, such as functional limitations in self-care or mobility. Finally, non-physical aspects of health are captured by the euro-d depression measure, a 12 points scale indicator constructed from a battery of questions related to mental health [43]. Other potentially available health indicators (grip strength, body mass index, cognitive abilities) have not been used in the main analysis due to the non-trivial proportion of missing values. Their inclusion would have resulted in significant reductions in sample size, threatening representativeness for inequity measurement purposes. However, we use imputed values on these variables to run robustness checks.

Further control variables, the non-need variables, include demographic variables (whether the individual lives alone and the number of children – which may indicate the availability of informal care); socioeconomic indicators (including labour market participation, home ownership, years of education and an indicator for 'ability to make ends meet' measured on a 4-points scale ranging from 'with great difficulty' to 'easily'); and an indicator of physical inactivity meant to capture health related behaviours. Again, other

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