



# Inequities in health care utilization by people aged 50+: Evidence from 12 European countries



Marco Terraneo

Department of Sociology and Social Research, University of Milano-Bicocca, Via Bicocca degli Arcimboldi, 8, 20126, Milano, Italy

## ARTICLE INFO

### Article history:

Available online 24 December 2014

### Keywords:

Health care services  
Health inequities  
Healthcare system  
Welfare regimes  
Educational disparities  
SHARE project  
Fixed effects approach  
European countries

## ABSTRACT

The aim of this study is to describe the magnitude of educational inequities in the use of health care services, by people aged 50+, in 12 European countries, controlling for country-level heterogeneity. We consider four services: having seen or talked to 1) a general practitioner (GP) or 2) specialist, 3) having been hospitalized, and 4) having visited a dentist (only for prevention). Data derived from the SHARE (Survey of Health, Ageing and Retirement in Europe) project, a cross-national panel that collects information from individuals aged 50 and over. A Fixed Effects approach is applied, which is a valuable alternative to the application of conventional multilevel models in country-comparative analysis. The main findings of this study confirm that there is substantial educational inequity in the use of health care, although relevant differences arise between services. A clear pro-educated gradient is found for specialists and dentist visits, whereas no evidence of educational disparities was found for GP use. On the other hand, less clear results emerge regarding hospitalizations. However, the analysis shows that micro-level dimensions, i.e. individual needs and predisposing and enabling population characteristics, and macro level factors, i.e. health care system and welfare regime, interact to determine people's use of health services. It can be concluded that people with more education level have more resources (cognitive, communicative, relational) that allow them to make more informed choices and take more effective actions for their health goals, however, the institutional context may modify this relationship.

© 2014 Elsevier Ltd. All rights reserved.

## 1. Introduction

The World Health Organization (WHO) recognizes the right to access to health care as an essential part of human rights. European health systems are based on the principle of equity (Kelley and Hurst, 2006), understood as the provision of equal care for equal needs – horizontal equity – both as different treatments for people with different needs – vertical equity –. In order to attain this goal, most European countries have achieved universal (or near-universal) coverage of health care costs for a core set of services, which usually include consultations with doctors and specialists, tests and examinations, and surgical and therapeutic procedures. Generally, dental care is partially covered (Paris et al., 2010).

Nevertheless, although most countries aim at offering a universal and equal healthcare system, this does not easily translate into equal utilization of care services (European Commission, 2008, p. 75). Many studies have shown that important differences persist

in health care services utilization related to individuals' demographic and socioeconomic characteristics. If some population groups systematically receive different levels of care for the same needs, then we can talk about inequity in health care (Braveman, 2003). In this work we use the concept of inequity rather than inequality. Whitehead (1992) claims that the term 'inequity' refers to differences that are unnecessary and avoidable but, in addition, are also considered unfair and unjust.

A substantial number of studies has documented income-related inequities (Devaux, 2013; Devaux and de Loooper, 2012; Manderbacka et al., 2009; Masseria and Giannoni, 2010; van Doorslaer and Masseria, 2004, van Doorslaer et al., 2006), educational disparities (Alberts et al., 1997; Or et al., 2008; Stirbu et al., 2011), social class inequalities (Palencia et al., 2013), or a combination of these and other factors, such as ethnic group or place of residence (Regidor et al., 2008), in utilization of health care services. These findings confirm those of studies that have focused on socio-economic status (SES) as health determinants (Mackenbach et al., 2003; Wilkinson and Marmot, 2003).

According to the theory of "fundamental causes" (Link and

E-mail address: [marco.terraneo@unimib.it](mailto:marco.terraneo@unimib.it).

Phelan, 1995; Phelan et al., 2010), SES is related to disease outcomes because individuals deploy resources (such as knowledge, money, power, etc.) to avoid risks and to adopt protective strategies. Therefore, we can assume that people with greater resources are better able to use health care services in order to improve their health than people with lower SES. A lesser utilization of certain health services may result in poorer health status for the population affected. Inequities in the use of health care services enhance the risk of disease and increase social disparities in health, as well as having serious effects in social financial terms (Dahlgren and Whitehead, 2007). In this perspective, a key resource is education that we already know to be an excellent predictor of health conditions (Marmot, 2005; Muller, 2002; Ross and Wu, 1996). Less educated patients would face cultural and informational barriers and have a lack of incentives, which explain their reluctance to use health care (Alberts et al., 1997; Couffinhal et al., 2005).

At the same time, a comparative analysis shows that the degree of inequity in health care use seems to vary among countries according to different models of healthcare systems and welfare regimes (Eikemo et al., 2008). Therefore, not only the individual level but also the contextual level plays an important role in studying health care services inequities. An efficient health care system, i.e. its policy, resources and organization, can contribute to the crucial goal of societal well-being (Figueras et al., 2009). Wendt (2009), for example, identifies three fundamental dimensions and related indicators to construct a typology of healthcare systems: financing, health service provision and regulation. The construction of types helps to better explain how healthcare systems differ from each other and, more interesting, it shows how access to healthcare is related to institutional characteristics that vary among countries (Wendt, 2009, p. 433).

Even different assets of welfare regimes established at the national level can be associated with macro-economic characteristics and can be accountable for improving (or not) people's health. Welfare regimes may "decommodify" individuals to varying degrees and mitigate social vulnerabilities (Esping-Andersen, 1990; Layte and Whelan, 2002), a condition of weakness exposing individuals to different risk factors, such as illness, unemployment, etc.

This study focuses on the principle of horizontal equity in the utilization of health care services. In particular, the aim is to describe the magnitude of educational disparities in having seen or talked to a general practitioner (GP) or specialist, having been hospitalized and having visited a dentist (only for routine control or prevention) by people aged 50+, in 12 European countries, controlling for country-level heterogeneity.

Operationalization of variables and analysis of this work are based on Andersen's model of health care utilization behavior, which was initially developed in the 1960s (Andersen, 1968), later revised and supplemented (Aday and Awe, 1997; Aday et al., 2004; Andersen, 1995). This perspective suggests that people's use of health services is a function of their predisposition to use services factors, which enable or impede use, and their need of care (Andersen, 1995, p. 1). In this context, micro-level dimensions, that is predisposing (i.e. age, gender, etc.) and enabling (i.e. education, income, etc.) population characteristics, individual needs (i.e. health status), personal health practice (i.e. smoking, drinking, etc.) and macro-level factors, such as healthcare system organization, interact to determine people's use of health services.

The present paper differs in some respects from previous analysis on this issue. First, it uses data derived from the SHARE (Survey of Health, Ageing and Retirement in Europe) project, which provides ex-ante and ex-post harmonized data, whereas many comparative studies on health care utilization use data from national health interview surveys (Devaux and de Loooper, 2012;

Stirbu et al., 2011; van Doorslaer and Masseria, 2004, van Doorslaer et al., 2006). Second, the sample of the study is composed of individuals aged 50 and over. It is well documented in the literature that more socio-economically vulnerable people, as are the elderly, have more frequent health demand (Dalstra et al., 2005) and this may play a role in structuring health inequalities. Third, it extends the range of variables specified in the models investigated to include past period of ill-health and personal health practices such as physical activity, smoking, drinking, or self care such as regular blood test or blood pressure check, which may affect the chance of using health care services. Finally, given the limited number of countries available, it applies a Fixed Effects approach, which is a valuable alternative to the application of conventional multilevel models in country-comparative analysis. This approach is useful in analyzing data from international surveys with a low number of country-level unit and it avoids the country-level omitted variable bias by controlling for country-level heterogeneity (Möring, 2012).

## 2. Data

We used data from SHARE, a cross-national panel database of micro data on health, socio-economic status and social and family networks of individuals aged 50 and over. We merged 2007 wave 2, which makes available the highest and complete set of questions on respondent's health, health care use and socio-economic status and 2009 wave 3 (SHERLIFE), a retrospective survey, which has collected data on people's life histories interviewed in previous waves. Our sample covers 12 countries: Sweden, Netherlands, Denmark, Germany, France, Switzerland, Belgium, Spain, Italy, Greece, Czech Republic and Poland.

Individuals retention rate varies among countries (about 60% in Germany and about 90% in Greece), but no consistent gender or age attrition bias has been found across SHARE countries (Blom and Schröder, 2011).

As known, the reliability of any retrospective survey is based on the accuracy of collected information. Memory bias can constitute a serious problem in the analysis of retrospective data. Analysis conducted by Garrouste and Paccagnella (2011) highlight SHARE-LIFE data is overall strongly consistent with the information reported at the time of occurrence of the events (with less than 10% recall errors over all events).

After deleting missing cases on the variables of interest, there are 16,431 cases available for analysis (samples used in analysis by country are shown in Table 1A of the online Appendix accompanying this article).

## 3. Methods

In the models, the dependent variables are respondent's contacts with general practitioner and specialist (seen or talk, therefore some of the visits may have included telephone consultations), with a dentist (seen) only for routine controls or prevention and overnight hospitalization in specialized wards (medical, surgical, psychiatric) in the last 12 months. All four dependent variables are dichotomous (yes, no).

It must be emphasized that country comparison in utilization of different care services requires caution, because some of them are usually guaranteed by the National Health Service (NHS), such as visits to a GP, whereas others are not always guaranteed, for example dentist visits. Moreover, some services can be freely chosen, such as dentist control visit, while others, such as emergency hospitalization, cannot be always planned.

It should also be noted that while individuals may self-refer for primary care services, specialty health services usually require referral from a GP. In this case, a GP operates as a gatekeeper for

Download English Version:

<https://daneshyari.com/en/article/7333639>

Download Persian Version:

<https://daneshyari.com/article/7333639>

[Daneshyari.com](https://daneshyari.com)