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Education-Related Inequity in Health Care with Heterogeneous Reporting of Health

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Objectivos (Objectives): Throughout most of Europe there is a stated policy aspiration to equitable provision of health care. This is often interpreted as the horizontal equity principle of equal treatment for equal need. In empirical work, the prevailing approach is to measure horizontal inequity by the degree to which utilisation is related to socioeconomic status (SES) after controlling for differences in needs. Existing European evidence reveals a bias favouring those of low SES in the distribution of primary care but inequity to the advantage of higher socioeconomic groups in specialist care. The validity of this evidence is contingent on the adequacy of the measures of need employed. As comprehensive, objective health measures are seldom available in the general population surveys that provide data on health care utilisation and SES, researchers must usually rely on self-reported categorical health indicators. If health perceptions vary with socioeconomic status, then self-reported health will not provide an unbiased benchmark of needs against which to measure inequity in health care utilisation. Then, as argued by van Doorslaer et al (2004), evidence of higher rates of utilisation of General Practitioner (GP) services in Europe among those of lower SES may not be indicative of inequity favouring the poor but, rather, a tendency of more disadvantaged groups to under-report morbidity. This has long been recognised but, hitherto, it has been difficult to do much about it. This study aims at identifying differences in the reporting of health by education (and also by age, gender and country) and determining the impact of correcting for such differences on the measurement of education-related inequity in the utilisation of primary and specialist medical care. On the basis of previous evidence, we can predict that an observed education gradient in the response of health care demand to a given reported level of health will understate the true extent to which the better educated make greater use of health care for a given health condition. In this paper, we estimate the magnitude of this bias.

Metodologia (Methodology): We identify reporting behaviour directly through survey respondents' ratings of case vignettes that describe fixed levels of functioning within a given health domain. Systematic differences in these ratings by socio-demographic characteristics provide evidence of heterogeneity in reporting thresholds. Under assumptions, these differences in reporting styles can then be purged from the ratings of own health. We use data on GP and specialist visits, and self-reports and vignettes in six health domains for elderly individuals in eight Europeans, taken from SHARE 2004.

Resultados (Results): Our analysis confirms that it is likely that bias is present in studies that use self-rated health as a proxy for need with the goal of estimating inequity in the distribution of doctor visits. Correcting for the observed tendency of the more highly educated to rate their health more negatively generally shifts the distribution of health care conditional on measured need in the direction of inequality favouring more highly educated groups. On average, measured inequity in the utilisation of primary care changes from being apparently in favour of the lower educated to being in favour of the higher educated. Specialist care displays inequity to the advantage of the better educated even without any correction for reporting bias, but the disparity becomes even larger once the differential reporting thresholds are taken into account.

Conclusões (Conclusions): These results are a warning against complacency in the equity performance of European health systems. The distribution of primary care is perhaps not as equitable as is often believed and specialist care is even less equitably distributed than has hitherto been realised.