

EQUITY IN HEALTH CARE ACROSS FIVE NATIONS: SUMMARY FINDINGS FROM AN INTERNATIONAL HEALTH POLICY SURVEY

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Despite all the sophisticated medical technology and advanced procedures available in the United States, Americans with low incomes have a hard time getting health care and often receive low-quality care. The wealthy, on the other hand, enjoy ready access to high-quality care and insurance to help defray the cost.

A common assumption is that access to care is more equitably distributed among income groups in countries that provide universal, publicly funded health insurance than in countries that do not. But does universal health coverage really eliminate disparities among income groups? Findings from *The Commonwealth Fund 1998 International Health Policy Survey* suggest that countries with universal coverage that require patient user fees and allow a substantial role for private insurance also experience inequities in access to care.

For the full text of the article, see: Cathy Schoen, Karen Davis, Catherine DesRoches, Karen Donelan, and Robert J. Blendon, "Health Insurance Markets and Income Inequality: Findings from an International Health Policy Survey," *Health Policy* 51 (April 2000):67–85.

This issue brief outlines major findings presented for the first time in "Health Insurance Markets and Income Inequality: Findings from an International Health Policy Survey," published in the April 2000 issue of the journal *Health Policy*. The survey assessed disparities in access to health care, the financial burden of care, and perceived quality of care between people with above-average incomes and those with below-average incomes in five nations: Australia, Canada, Great Britain, New Zealand, and the United States.

Analysis of the survey revealed a pattern of inequitable access to care between lower- and higher-income groups in three of the five countries surveyed. In Britain and Canada there were no significant access disparities between income groups.

Private Health Insurance and Patient Cost-Sharing

The health care systems in the countries surveyed differ in the role of private insurance, patient responsibility for out-of-pocket expenses, and health care system financing. The United States, with its strong reliance on a private health insurance system and lack of universal coverage, stands at one end of the spectrum. Working-age adults generally depend on private insurance

provided voluntarily by their employer, while the poor and the elderly rely on public coverage. This system leaves 44 million Americans uninsured and creates disparities in cost and access measures.

All of the other survey countries provide public coverage for residents of all ages, but wide variations still exist. In Britain, private health insurance plays a minor role. British patients generally have access to a broad array of medical services without payment at point of service.

The public health systems in Australia and New Zealand, in contrast, are increasingly relying on an array of user fees for services included in the basic public plan. They also depend relatively heavily on private health insurance to supplement public benefits by providing more ready access to private physicians, specialists, consultants, and hospitals. In terms of disparities by income in access to care and cost burdens, the situation in these countries resembles that in the United States more than Britain.

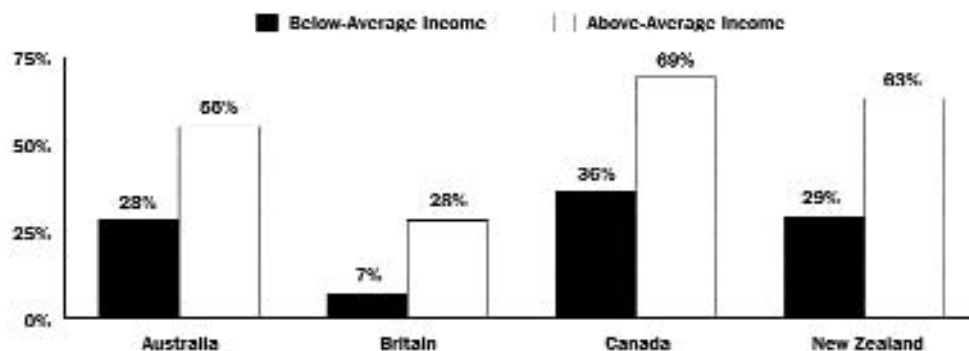
Canada prohibits private health insurers from covering benefits included in the

national plan and, like Britain, generally covers medical costs in full for included benefits. Canada's benefit package, however, is less comprehensive than Britain's. Private insurance in Canada mainly covers benefits left out of the basic public package, notably prescription drugs.

Despite the notion of universal, equal coverage for all, the survey showed that adults with above-average incomes in all four countries with universal coverage were significantly more likely to have private insurance to supplement public coverage (Exhibit 1).

In Australia, Canada, and New Zealand, private supplemental coverage was widespread among adults with above-average incomes. Fifty-five to 69 percent of those surveyed reported having such coverage. Likewise, U.S. adults with above-average incomes are twice as likely as those with below-average incomes to have private health insurance (84% vs. 42%). People with above-average incomes in the universal-coverage countries are able to use private insurance to cover benefits not included in the public plan. They are also able to decrease waiting time

Exhibit 1
Percent of Respondents Who Have Private Insurance in Countries with Universal Coverage



Source: The Commonwealth and IAHN International Health Policy Survey

and gain access to specialists (except in Canada, where this is prohibited).

Access: Problems Getting Needed Care

As noted, sharp disparities in access to health care exist among income groups in the United States. The survey revealed that adults with below-average incomes were twice as likely to report being unable to get needed care (20% vs. 11%) and more than three times as likely to report having difficulty getting care when needed (48% vs. 14%).

Somewhat surprisingly, however, respondents in Australia and New Zealand also indicated perceived inequities in access to care, with significantly higher rates of problems reported by those with below-average incomes. The rate of not getting needed care was two and one-half times higher among below-average income groups in both Australia (12% vs. 5%) and New Zealand (17% vs. 7%). Similarly, adults with below-average incomes in Australia and New Zealand were about twice as likely to say they had difficulty getting care than were those with above-average incomes (20% vs. 11% and 25% vs. 13%, respectively) (Exhibit 2).

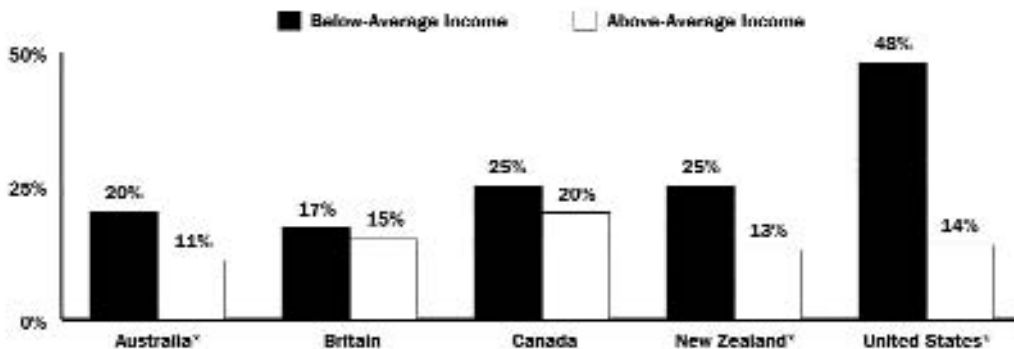
In the United States, cost was the major reason people failed to get necessary medical attention. In Australia and New Zealand, waiting time and scarcity of doctors presented the most formidable barriers to care.

Rates of perceived access problems in Britain and Canada were similar across income groups, in contrast with the experience of Australia, New Zealand, and the United States. British and Canadian adults at all income levels appear to have similar difficulty in getting medical care when needed.

Cost and Financial Burden

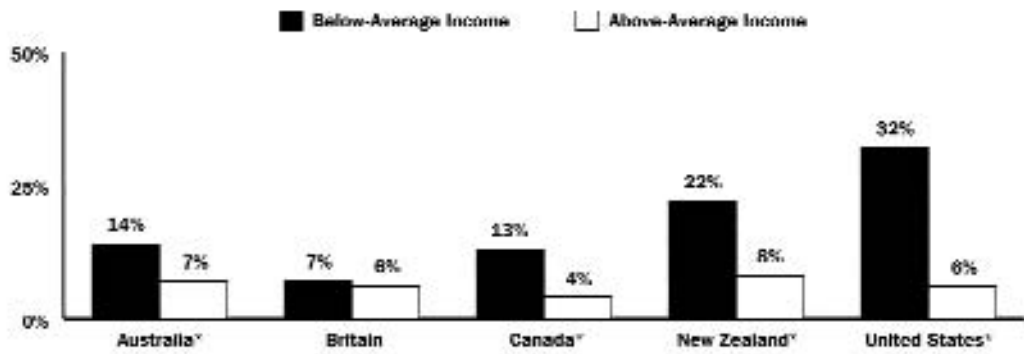
Survey respondents in the United States were generally more likely to report problems paying medical bills than were those in the other four countries. Not surprisingly, cost difficulties were most pronounced among those with lower incomes. Prescription drug costs posed a particular problem. Almost one-third of U.S. respondents with below-average incomes said they failed to fill a prescription in the year prior to the survey because it was too expensive to do so. This was more than five times the rate for those with above-average incomes (Exhibit 3).

Exhibit 2
Percent of Respondents Saying It Is Extremely, Very, or Somewhat Difficult to Get Care



*p < .01
 Source: The Commonwealth Fund 2004 International Health Policy Survey

Exhibit 3
Percent of Respondents Who Did Not Fill a Prescription Due to Cost In the Past Year



*p < .01
 Source: The Commonwealth Fund 2000 International Health Policy Survey

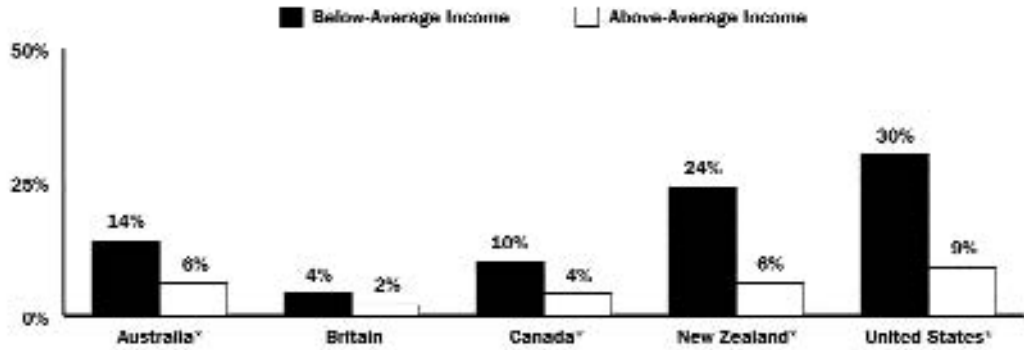
Concern over costs also varied significantly by income in Australia, Canada, and New Zealand. Residents with below-average incomes in these nations were two to three times more likely to report not filling a prescription due to cost than those with above-average incomes. Such disparities likely reflect national benefit policies: prescription drugs are not part of the public insurance benefit package in Canada, and patients in Australia and New Zealand are responsible for a portion of the cost.

There was no significant difference by income in Britain. Prescription drug cover-

age in the public insurance plan apparently protects adults well and gives all Britons, regardless of income, access to necessary prescription medications.

A similar pattern can be seen with regard to problems paying medical bills, another measure of financial burden. The United States stood out among the five nations. Thirty percent of U.S. respondents with below-average incomes reported problems paying medical bills in the past year. In contrast, 9 percent of above-average income respondents reported such problems (Exhibit 4).

Exhibit 4
Percent of Respondents Who Had Problems Paying Medical Bills In the Past Year



*p < .01
 Source: The Commonwealth Fund 2000 International Health Policy Survey

New Zealand followed closely: 24 percent of the below-average income group cited problems, while only 6 percent of the above-average income group did so. Significant differences by income were also seen in Australia and Canada. Britain again remained the only country out of the five in which there were no disparities by income group.

Quality of Care

When asked about their most recent doctor visit, 23 percent of below-average income respondents in the United States rated it as “fair” or “poor,” compared with 11 percent of above-average income respondents (Exhibit 5). The United States was the only country in which there was a significant difference by income. In the other four countries, about 10 to 15 percent of respondents rated their last visit as fair or poor.

Although no significant differences by income exist in Australia, Canada, and New Zealand, a significant portion of the population is dissatisfied with the quality of care and worries that it will decline in the future. When asked whether they thought

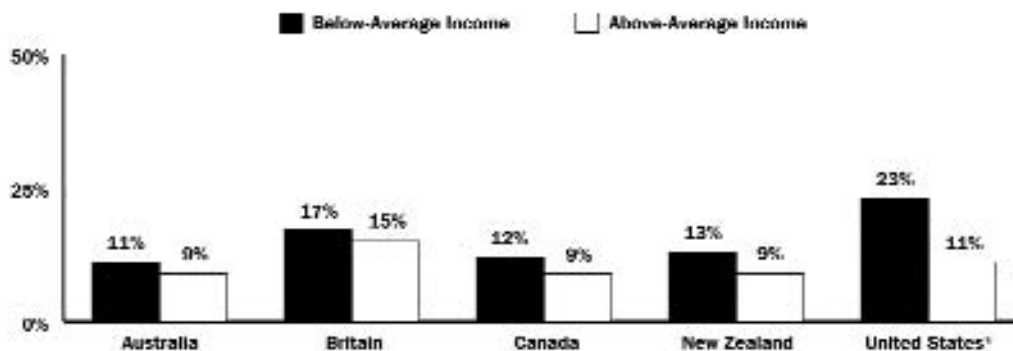
recent policy changes would harm the quality of care, a startling 48 percent of Canadians said yes. Two of five New Zealanders and nearly a third of Australians agreed. Because they have witnessed the impact that cost-cutting measures have had on health care in terms of access and cost, a large percentage of people at all income levels in these countries are concerned that the quality of the care they receive will decline in the near future.

Views of the Health Care System

In the past, the United States stood out in adults’ perception of the health care system, with a third of the population supporting a complete overhaul. Based on 1998 survey responses, the levels of dissatisfaction in Australia and New Zealand are now closer to U.S. levels. Just one-fifth of people in Australia, Canada, and the United States, and only one of 10 New Zealanders, think the system works well and needs only minor changes.

These averages, however, hide sharply divided opinions among income groups in three of the five countries: Australia, New Zealand, and the United States. Adults with below-average incomes in these countries

Exhibit 5
Percent of Respondents Who Rated as Fair or Poor the Care Received at Most Recent Doctor Visit



^a p < .01
 Source: The Commonwealth Fund 2000 International Health Policy Survey

were significantly more likely to vote for redesigning the health system than were adults with above-average incomes. The opinion gap between income groups was widest in the United States and New Zealand (Exhibit 6).

Canadians expressed more dissatisfaction than the British, but they were less sharply divided between higher- and lower-income respondents than were U.S. respondents, Australians, and New Zealanders. Britons are both more satisfied with their system overall and less divided among themselves. Indeed, Britain is the only country surveyed where lower-income families are more likely to support the status quo.

Implications of Cost-Control Measures

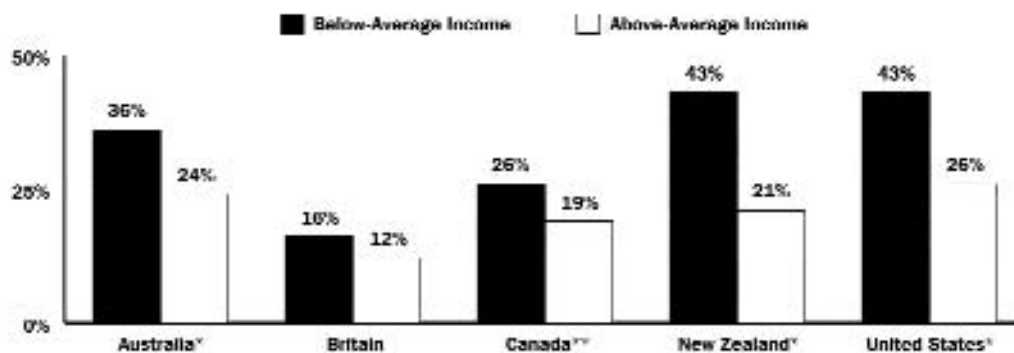
The survey findings indicate that universal health coverage does not necessarily ensure equitable access to health care for lower-income populations. Policies regarding the roles of private health insurance and patient cost-sharing requirements have an impact. To the extent that people with private insurance can avoid waiting lists and user fees and have easier access to

hospitals and specialists, lower-income families appear more likely than higher-income ones to bear the burden of constraints on resources.

Within countries, variations according to income group in access to specialists and in waiting times for nonemergency surgery appeared to be particularly sensitive to national health policies. For example, waiting times for surgery vary widely by income in Australia and New Zealand, where private coverage can be used for differential access to hospitals or specialists. Differential access appears to be of less concern in Britain, where perceived access to specialists and reported waiting times for elective surgery were similar across income groups—most likely a reflection of relatively low rates of private insurance.

The findings further indicate that cost-sharing, even at relatively low levels, can result in perceived financial burdens and access problems for lower-income families. The difficulties associated with cost-sharing are illustrated by the comparatively high percentage of the below-average income group in Australia and New Zealand who

Exhibit 6
Percent of Respondents Who Believe the Health System Needs to Be Completely Rebuilt



Source: The Commonwealth Fund 1998 International Health Policy Survey.

report having problems paying medical bills. These rates contrast with those in Britain, where limited use of patient copayments provides financial protection. Gaps in public systems' coverage of essential services, such as prescription drugs, also increase the risk that low-income families will forgo important treatment or medicines.

Public opinion regarding the need for major health system reform tracks care experiences. Opinion tends to be more divided in countries whose residents report more unequal care experiences, and more united in countries where there is little difference in reported rates of access difficulties across income groups. Reliance on market competition based on patient out-of-pocket costs and a major role for private health insurance appear to incur social costs.

These strategies can raise access barriers for those with the greatest health care needs and divide communities around reform policies. Even small levels of copayment and use charges can drive a wedge in social solidarity. To the extent that lower and higher income groups have different access experiences, they are likely to view their nation's health system differently.

Methodology

Data are from *The Commonwealth Fund 1998 International Health Policy Survey*, a five-nation survey consisting of interviews with approximately 1,000 adults age 18 and older in each of five countries: Australia (1,001), Canada (1,006), Great Britain (1,043), New Zealand (999), and the United States (1,010). Interviews were conducted by Louis Harris and Associates, Inc., and country subcontractors from April through June 1998 by telephone, except in Great Britain, where interviews were conducted in person. The survey randomly selected an adult in each household and asked him or her a series of questions about recent personal health care experiences, recent use of services, health status, socioeconomic status, and views or concerns about the national health care system.

Survey respondents were given the national, median household income in their country in 1998 and asked to self-classify their annual household income as "much above," "somewhat above," "average," "somewhat below," or "much below" the cited median income. In the analysis, those classifying their incomes as "much above" or "somewhat above" were grouped as "above average," and those classifying their income as "much below" or "somewhat below" were grouped as "below average." Self-classification resulted in a below-average group consisting of about 27 percent to 40 percent of respondents and an above-average group of 32 percent to 40 percent of respondents across the five countries.

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