EDITORIAL

Disparities in Healthcare Access and Use: Yackety-yack, Yackety-yack

Despite change, uncertainty and disarray in Canada's healthcare system(s), some observations about Canadian medicare still seem beyond challenge:

- access to healthcare based solely on need is the core value that gave rise to and sustains medicare;
- the advent, through medicare, of universal, publicly funded physician and hospital services substantially reduced disparities in access to, and outcomes of, healthcare based on socio-economic status (Enterline et al. 1973; James et al. 2007);
- despite those gains, disparities remain – factors other than need continue to influence access to and use of services.

The last point deserves elaboration. A growing body of research evidence indicates that use of hospital services in Canada is generally consistent with relative need across income groups (e.g., Manga et al. 1987; van Doorslaer and Masseria 2004; Allin 2006). Some studies (van Doorslaer and Masseria 2004; Allin 2006) show greater use of hospital services by those with lower income after controlling for healthcare need – perhaps calling into question the adequacy of existing measures of need. On the other hand, studies of specialist services have demonstrated a direct relationship between use and income, education or both (McIsaac et al. 1993, 1997; Roos and Mustard 1997; Dunlop et al. 2000; Finkelstein 2001; van Doorslaer et al. 2006; Allin 2006) – wealthier and better-educated Canadians use more specialist services independent of need.

The picture with respect to primary care physicians' services is less clear. Some studies show an equitable (i.e., needs-based) distribution across education and income groups (McIsaac et al. 1993, 1997; Roos and Mustard 1997; Dunlop et al. 2000), while others do not. For example, Birch et al. (1993) found the use of family physician services to be positively associated with level of education (and extent of contact with friends and relatives). Based on data from the 2001 Canadian Community Health Survey (CCHS), van Doorslaer et al. (2006) found that, after standardizing

for healthcare need, higher income was associated with a greater likelihood of seeing a primary care physician but a lower number of visits. Using 2003 CCHS data and a similar methodology, Allin (2006) observed a pro-rich inequity in the probability of visiting a family physician, a finding that was inconsistent among the provinces and territories. In the 2002/03 Joint Canada/US Survey of Health, Canadians with low income were less likely to have a regular doctor and more likely to report unmet healthcare needs than those with high income (Lasser et al. 2006). In an earlier international population survey, Canadian respondents with below-average income were more likely than those with above-average income to report having difficulty getting needed care (Shoen et al. 2000).

Data from the 1994/95 National Population Health Survey showed that the likelihood of women in the appropriate age groups having either a Pap smear or a mammogram was associated with higher education level and being born in Canada (Gentleman and Lee 1997; Lee et al. 1998). Income level was also independently associated with having a Pap test (Lee et al. 1998). In the 2005 CCHS, respondents in the highest two (of four) income categories were more likely than those in the lowest income category to report having a flu shot in the previous 12 months (Kwong et al. 2007).

Ontario-based studies have shown a positive association between income and access to coronary angiography and revascularization (Alter et al. 1999) and to in-hospital occupational therapy, physiotherapy and speech pathology following a stroke (Kapral et al. 2002). Patients from the lowest-income neighbourhoods waited much longer for coronary angiography (Alter et al. 1999) and carotid artery surgery (Kapral et al. 2002) than those from the highest-income neighbourhoods. Recently published studies in *Healthcare Policy/Politiques de Santé* point to inequities in access to radiation therapy for breast cancer based on income level (Fortin et al. 2006) and to mental health services for anxiety or depression provided by both family physicians and psychiatrists based on education level (Steele et al. 2007).

This summary, reflecting a brief and unsystematic scan of the literature, describes only the tip of a much larger evidence iceberg. Clearly, Canadian medicare has failed to achieve healthcare access (and use) based on need, even for those services within the purview of the *Canada Health Act*: hospital and physicians' services. Being poor, poorly educated or both impairs access to specialist and (probably) family physician services, to preventive care (e.g., Pap tests, mammograms and flu shots) and to services for specific health problems (e.g., cardiovascular and mental health).

But income and education are not only associated with access to services; they are themselves determinants of health, and often cluster together with other determinants such as Aboriginal status, early life experiences, employment and working conditions, food security, housing, social exclusion, social safety net, unemployment and employment security (Raphael 2004). The very people who need care the most are the least likely to get the care they need.

Evidence of the continuing relationship between socio-economic characteristics and access to health services under medicare is abundant, long-standing and persistent. This evidence is without doubt well known (at least in part) to health system decision-makers.

Why, then, is there so little sign of concerted heath policy or health system design and management initiatives at the federal or provincial/territorial levels to address this violation of the fundamental rationale for Canadian medicare? It may be more than coincidence that those on the receiving end of inequitable access are among the least politically and economically powerful members of Canadian society. Although many Canadians are passionately committed to the principle that access to essential health services should be based only on need, they may, given a lack of media and political attention to the issue, assume that the elimination through medicare of (most) financial barriers to obtaining hospital and physicians' services has solved the access problem. Under these circumstances, politicians and governments at the federal and provincial/territorial levels are under little or no pressure to mount a response. As a result, current policy complacency seems likely to continue unless equity of access emerges as a public issue that resonates with Canadians who support the core principles of medicare and mobilizes civil society. Now, *there's* a challenge for knowledge translation. Meanwhile, there will undoubtedly be lots of talk (research on access inequities and acknowledgment – out of public view – of their existence), but little policy action.

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