Chapter 18

Access to Healthcare and Health Disparities

Chiyo Murata and Katsunori Kondo

1 Introduction

The notion of healthcare access is often considered in discussions of the state of healthcare systems. Arguments concerning the problem of healthcare access usually focus on two main aspects. One refers to access problems caused by physical constraints including availability of healthcare facilities or staff, distance to healthcare facilities, and the existence of means of transportation. The other aspect refers to access problems caused by financial constraints such as the costs of receiving treatment [1]. In addition to these two aspects, psychological barriers such as health illiteracy or distrust of medical systems are also prominent [2]. For there to be equity of access to healthcare, every person in need of healthcare services must make use of them. A major indicator for measuring access to healthcare is “delayed care,” which refers to refraining from visiting a doctor despite the need to do so [2]. This chapter presents Japanese and international research investigating whether healthcare access disparities are caused by socioeconomic status (SES). We also suggest possible measures to eliminate healthcare access inequality based on SES.

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2 Access to Healthcare and SES

Evidence shows that the lower the income of the country, the lower the rate of basic maternal and child health service use [3]. Studies of representative samples of the US population demonstrate high death rates of admitted patients with acute myocardial infarctions in sparsely populated rural areas, especially among people with low income [4, 5]. The reasons cited were medical staff shortages, lack of nearby health-care facilities [4], and financial (cost) barriers [5].

Disparities between the type of medical service received based on the patient's SES also exist in countries with universal healthcare systems. Comparative research between the USA and Canada shows that in both countries, the proportion of people not receiving essential treatment or primary care is greater among low-income and poorly educated groups [6]. However, the research also showed that Canada, which has a universal healthcare system, has less income-related healthcare inequality than the USA, which does not have universal healthcare.

Income or education-based health inequality is also found in the quality of healthcare received. A systematic review [7] of 26 papers covering 12 individual studies and 3 comparative studies, along with a study covering 21 countries with universal healthcare systems from the Organization for Economic Co-operation and Development (OECD), found that primary care service usage equity is assured to a degree, but specialized medical service usage in hospitals is lower among low-income groups.

Japan has maintained a universal healthcare system, built on the German model, for more than 30 years. The insurance component covers most of the population and is financed by premiums paid by insured persons, employers, and government compensation. Japan's National Health Insurance System reimburses by percentage and patients pay co-insurance. The system currently pays 70% of medical charges and patients (with the exception of children and elders) pay the remaining 30%. Healthcare access was previously believed to be broadly guaranteed under Japan's universal national insurance system. However, in recent years, income-based disparities have been noted. The Health Policy Institute's 2008 "Public Survey on Healthcare in Japan" [8] found that low-income groups delay seeking medical care more than twice the rate of high-income groups. The survey also found that within the past 12 months, 39% of sick people in low-income groups did not seek healthcare because of costs versus 18% of those in high-income groups. The proportion of reported low-income people not having a medication prescribed because of costs was 16% versus 2% for high-income people [8]. Another Japanese study (Japanese General Social Survey 2008) using data from a nationally representative sample (2160 people aged 20–89 years), also reported a higher delay rate in seeking medical care within low-income groups [9]. Furthermore, a 2006 study ($N = 15,302$) of older people from the Aichi Gerontological Evaluation Study project [10] found similar associations between delayed care, low income, and limited education.

The Agency for Healthcare Research and Quality (AHRQ), which is part of the US Department of Health and Human Services, reported that lower SES leads to

lower rates of preventative actions, such as the reception of health screenings or vaccinations [4]. Similarly, the proportion of low-income people that underwent cancer-screening procedures, such as fecal occult blood tests, fiber-optic colonoscopies, or sigmoidoscopies, was smaller than the proportion of high-income people [11]. In Japan, the rate of older people without health screenings was linked to low SES [10].

In addition to unhealthy habits such as smoking, unbalanced diet, or sedentary life, an individual's SES, including income, education level, and profession, is related to his or her health. It is reported that people with mental health problems, such as those who are clinically depressed, are more prone to unhealthy behaviors [12]. A US study using data from the Medical Expenditure Panel Survey found a relationship between psychological distress and low reception rates for a variety of health examinations [13]. A study of Japanese elders also found a link between clinical depression and low reception rates for health examinations [1].

3 Background of Inequalities Based on SES

3.1 *Financial Barriers to Access to Healthcare*

Disparities in seeking medical consultation are related to a country's health insurance system. Commonly cited reasons for delayed healthcare include health insurance type and treatment (co-insurance) costs [4]. A recent 2-month study in the USA compared the medical consultation frequency of uninsured and insured people [14]. The odds ratio of an uninsured person receiving treatment for unintentional injuries was 0.47, which is less than half that of an insured person. Similarly, the odds ratio of an uninsured person receiving treatment for chronic illness was 0.45. Furthermore, uninsured persons were more unlikely to receive recommended follow-up care and remained in poor health 7 months after being injured [14].

Delays in seeking medical consultations do not just occur among uninsured people, but also among those with insurance. In the USA, coverage varies by insurance type, hence the existence of an underinsured or partially covered group. In a study of 2498 patients with acute myocardial infarctions, researchers compared the group not seeking medical consultations because of costs (18.1%) with all of the other groups [15]. Among those not seeking medical consultation because of cost, 68.9% had some type of insurance. After 1 year, patients with cost barriers were 1.3 times more likely to be re-hospitalized for heart disease than those without cost barriers. Therefore, individuals with inadequate health insurance may delay seeking healthcare, which can lead to worsened health and more re-hospitalizations.

An increase in patient cost share is also linked to delays in seeking medical care. According to impact reports on the European healthcare system reform and OECD countries [16, 17], when out-of-pocket expenses increase, treatments decline. According to the National Institute of Population and Social Security Research July

2007 survey [18] on social security in Japan, 17% of households did not visit a healthcare provider when someone was ill. The most common reason was economic, such as “the co-insurance being high” (38.4%). Babazono et al. [19] reported that among Japanese enrolled in health insurance plans, increases in direct treatment costs caused delayed care among low-income people. The study also found that fewer diabetes patients without comorbidities received outpatient treatment because of the rise of co-insurance rates from 20% to 30%. This suggests that delayed care frequently occurs among patients with diseases that develop without initial symptoms.

A comparative study of universal healthcare systems in France, Germany, and Spain reported that as patient cost share increased, outpatient consultations decreased, particularly among people with low income or social status [20]. Similar findings were reported in studies from South Korea [21] and Taiwan [22]. In 2003, a Japanese survey on healthcare usage among elders aged 65 years and over was conducted [1]. At that time, co-insurance for people under 70 years of age was 30% versus 10% for people 70 years of age and older. The survey showed that people under 70 years of age were more likely to refrain from seeking medical consultation because of cost barriers (35.8% of people 65–69 years of age vs. 20.1% of those 70 years of age and older) [1].

3.2 Physical Barriers to Access to Healthcare

Physicality is another barrier to healthcare access. In the aforementioned study of Japanese elders [1], physical access became more problematic with age. Reasons for not receiving needed medical treatment included “no medical facilities nearby” (9.0% for people aged 65–69 years and 15.4% for those aged 70 years and older) and “no means of transportation” (4.7% for people aged 65–69 years and 13.2% for those aged 70 years and older). In the USA, it has been reported that distance from healthcare facilities causes barriers to medical care, particularly among older people [4]. In the UK [23] and Nigeria [24], it was found that residents tend to be healthier as physical access to public health services improves.

3.3 Psychological Barriers to Access to Healthcare

Psychological factors [2] also comprise reasons that low-income groups are less likely to visit medical doctors. A Japanese study showed that people without a happy outlook on the future rated lower rates of receiving health checks than others [25]. In addition, people of low SES, regardless of their health condition, tended to be anxious about not receiving medical care, thus delaying necessary treatment [9]. Furthermore, people of low SES tended to have low trust in healthcare systems [26]. A report from Sweden found that people with minimal trust in healthcare systems

were unlikely to seek medical consultations [27]. In 2004, the East Asian Social Survey compared China, Japan, South Korea, and Taiwan [9]. Results indicated that 50.8% of people that responded “I do not like to see a doctor” were South Korean while 25% were Japanese. In Japan and the USA, communication quality is related to healthcare access [28]. When asked “Did your doctor explain things in a way that is easy to understand?” or “Did your doctor listen to what you have to say?,” those who answered “no” were dissatisfied with their medical care. Such communication problems are more linked to medical care satisfaction than waiting time or medical facility distance [28].

Health illiteracy is another psychological barrier to healthcare. A 2009 meta-analysis [29] of multiple qualitative studies suggested that health illiteracy (i.e., the inability to analyze and understand issues related to health) was linked to poor communication quality between patients and medical staff. The AHRQ recently reported that low SES begets higher diabetes hospitalization and comorbid condition rates [4]. In Japan, lower education was associated with lower exposure to health-related information [30]. Lack of information may undermine communication between healthcare providers and people with low SES, which leads to delayed or unmet healthcare needs.

4 Measures against Healthcare Access Disparities

As patient cost share increases, not only unnecessary medical procedures but also those that are necessary become less accessible to low-income groups. Although their healthcare needs may increase as their income decreases, low-income groups are often excluded from necessary healthcare. Accessible health insurance systems for low-income earners are vital for elimination of health disparity. Under the slogan “Health for All,” the World Health Organization [3] has called upon governments to “ensure public sector leadership in healthcare systems financing, focusing on tax-/insurance-based funding, ensuring universal coverage of healthcare regardless of ability to pay, and minimizing out-of-pocket health spending.” These inequalities must be resolved via healthcare system revisions.

Out-of-pocket expenses and the dilemma of uninsured people are healthcare access issues that warrant discussion. In the USA, the establishment of the State Children’s Health Insurance Program for low-income children has reduced healthcare access inequalities [31]. In 2009, a revised version of Japan’s National Health Insurance Act went into effect. It issues short-term insurance cards to uninsured young children who have become uninsured following parental payment delinquency.

Healthcare system revisions alone do not address healthcare access problems sufficiently. Mistrust of medicine and miscommunication problems are also related to health inequality [2]. UK initiatives are instructive examples of policies that can be implemented in local areas [32]. In August 2010, a program called “Healthy Homes” emerged in Liverpool (<https://liverpool.gov.uk/healthyhomes>). Using the

slogan “Healthier homes, Healthier lives,” the program designated 40 poverty-affected areas (with high immigrant populations) where “Healthy Homes advocates” visited homes to conduct on-site inspections. If a house posed any health risks, the owner was ordered to make improvements. When visiting, advocates informed residents of healthcare services. The program helped bring early treatment to immigrants who, because of language barriers or low health awareness, may not have sought treatment until their conditions became serious.

Economic factors also contribute to mothers not receiving antenatal care. Infant mortality rates in London’s poorest areas rate 1.3 times higher than the national average. In 2008, local midwives called upon universities and hospitals to act, which led to the formation of a response team. In turn, the team called upon young local mothers to act, which led to the inauguration of the volunteer group called Bump Buddies (<http://www.shoreditchtrust.org.uk/health-and-wellbeing/bump-buddies/>). Young group members that may be of the same ethnicity or have a similar appearance (i.e., same skin color) reach out to local pregnant women. By connecting them with medical services, the Bump Buddies have helped increase antenatal care reception rates by 50% [32]. This is an excellent example of volunteer activities bringing medical care to underserved people.

5 Summary

Socioeconomically based healthcare access inequality must be addressed via healthcare system revisions. In addition, financial, physical, and psychological barriers to healthcare also need to be addressed. Health illiteracy or mistrust in medicine are often seen among people with low SES, and several underlying factors need to be emphasized, such as lack of necessary information provision or poor communication with healthcare providers. Such issues should be addressed when discussing possible countermeasures to healthcare inequalities. To provide disadvantaged groups with the necessary healthcare, community outreach activities (e.g., Bump Buddies) and the resource redistribution mentioned above are important. In Japan, partnerships between social welfare councils, local governments, local residents, and private businesses traditionally conduct a variety of activities to promote local volunteer efforts to support children, mothers, and older people. In other nations, peer support interventions that use the strength of local communities, such as those conducted in the UK [32], will continue to grow in importance.

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