Reviewer’s report

Title: Socioeconomic patterns in the use of public and private health services and equity in health care

Version: 2 Date: 4 May 2008

Reviewer: Juan Merlo

Reviewer’s report:

I have a essential comment

Assuming similar degree of health care quality (safe, knowledge based, patient centred and timely care) between private and public health care, the choice of a private versus a public facility should not influence equity in health care. Choosing a private care my express sociological preferences (see for example Bourdieu’s concept of “habitus” or the idea of “conspicuous consumption” introduced by Thorstein Veblen) but it is not necessarily a source of inequity. In Sweden private care is public financed. This means that private caregivers have freedom to administrate their activity as they want but patients pay the same fees as in public administrated care. This circumstance offers a natural experiment where the choice of private vs. public care is not condition by the economical component of a different social position but rather by sociological factors.

Previous studies of ours have show that in Sweden private care is more frequent among people with high income


Having said this, the authors found (Table 4) that when public and private services were combined individual in the lowest socioeconomic position visit more GPs but less specialist physician than people with high socioeconomic position. This finding suggests to me a flagrante case of inequity that the authors should discuss more extensively. Why individual in the lowest socioeconomic position have less access to specialized care if it is well known that they have a higher level of needs? Could the gatekeeper function of the GPs, longer waiting times or other factors promote inequity by redirecting people with high social position to private care and leaving people with low social position without care?

Also – assuming residual confounding– the absence of a SE gradient in hospitalisations suggests inequity. One should expect that people with low socioeconomic position having worse health had also a higher rate of hospitalisations than people with high socioeconomic position.
Minor comments

It is classical to discuss terminology when dealing with social disparities in health and health care utilisation…. And I think that the term “Pro-poor inequity” is not appropriate. Rather the term “pro-poor inequality” should be used. Inequity conveys an unfair distribution of health/resources, while inequality only means disparities. The fact that poor people obtain more resources that rich people expresses equity, since poor people have higher needs than rich people (and residual confounding is almost unavoidable in observational epidemiology)

Concerning the imputation method for income. Could you please explain this procedure in more in detail or provide a reference?

In page 19, the head “Data problem”. Could you find another heading? The actual suggest you would discuss about some weaknesses of the database but you don’t handle this aspect in this section.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: Yes, and I have assessed the statistics in my report.

Declaration of competing interests:

'I declare that I have no competing interests'