Access to Health Services

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The twentieth-century growth of government has been the result of government extending public services from the minimal duties of the Night Watchman state preserving public order and promoting industrialization to the promotion of the health, education and income of all its citizens. The modern European state today claims in taxation more than two-fifths of the country's Gross Domestic Product. This money is not spent on employing faceless bureaucrats to shuffle papers at desks in ministries. It finances the payment of pensions and cash benefits for people in need during their working life; it pays for education; and it guarantees everyone the literally vital service of medical care. In the average European country, more than three-quarters of public expenditure today finances welfare state services.

From the perspective of government, welfare state services are public services, because they are delivered by state institutions or by civil society or market institutions financed from public revenue. However, in the jargon of economists these services are private goods, because they are delivered to individuals who could be excluded from receiving them. From the perspective of ordinary individuals, these public services are an integral part of their private lives. A person thinks of my pension, my health care and the education of my children. So taken for granted are the services of the contemporary welfare state that they are often thought of as non-political, even though their existence is the result of political disputes in the past and in the present.

Many social welfare institutions see themselves as part of civil society rather than as under political control. Universities make a special point of operating free of political interference. Not-for-profit charities that run hospitals or schools likewise see themselves as independent of government, even when financed by public revenues. Professional associations of doctors and of teachers stress that they are accountable to professional standards for what they do rather than to political standards. An emphasis on independence of the state is particularly strong among church-related health and educational facilities. Pension contributions which are mandated by law may be managed by private sector institutions with a substantial degree of autonomy from central government.

The rise of the welfare state means that citizens now spend more time receiving the benefits of public policy than they spend trying to influence public policy. Whereas national elections are held only once every few years, social security benefits are paid weekly or monthly and schools provide daily instruction to young people. Citizens do not want to be going to a hospital or a doctor every day, but people do want the assurance that they can receive medical treatment at any time of day or night when it is needed.

Because welfare state services are conventionally regarded as 'good goods', people want to participate in their consumption and benefits are normally made available to all citizens as of right. Citizens have a statutory right to health care as well as a right to vote, and parents have a legal obligation to send their children to school.

Access to national health services

Even though everyone may be formally entitled to a public service, some citizens can nonetheless be excluded and studies of the use of public services show significant differences in the take up of benefits. For example, middle-class youths are more likely to go to university than youths whose parents are manual workers. Access to health services is particularly important. Whereas the need for education is concentrated early in life and the need of a pension in later life, health care is a continuing and vital need throughout the life cycle

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To assess the extent of obstacles to claiming health care, the European Quality of Life Survey asks people about each of four difficulties that can arise in getting health treatment. The replies show the importance of health services. Nine-tenths of adults have relied on treatment recently enough to evaluate how convenient or difficult it is to use the health service, a far higher percentage of the population than could name, let alone evaluate, the work of most Cabinet ministers.

Table 1 Difficulties in participation in health services

Q. On the last occasion you needed to see a doctor or medical specialist, to what extent did each of the following factors make it difficult for you to do so?				
	Very difficult	A little difficult	Not at all difficult	No need to see
	(percent)			
Waiting time to see doctor on day of appointment	13	26	52	9
Delay in getting appointment	12	21	58	9
Cost of seeing the doctor	11	17	59	13
Distance to doctor's office, hospital, medical centre	7	16	70	7

Source: Replies to 2003 European Quality of Life Survey with national results weighted to each country's share of the total population of 28 countries

Waiting for treatment is the biggest difficulty in health services today (Table 1). For every five persons who say that the time they spend in a health centre waiting for treatment is all right, four see it as a little or a big difficulty. Similarly, for every five people who find that there is no delay in getting an appointment for treatment, three see getting an appointment as a little or a big difficulty. A long wait for an appointment or a long queue at a medical centre is a symptom of demand exceeding supply. When this happens in the market place, supply tends to increase so that more goods can be sold. Since the cost of the health services is primarily met from taxation, increasing supply increases public expenditure. The survey evidence indicates that

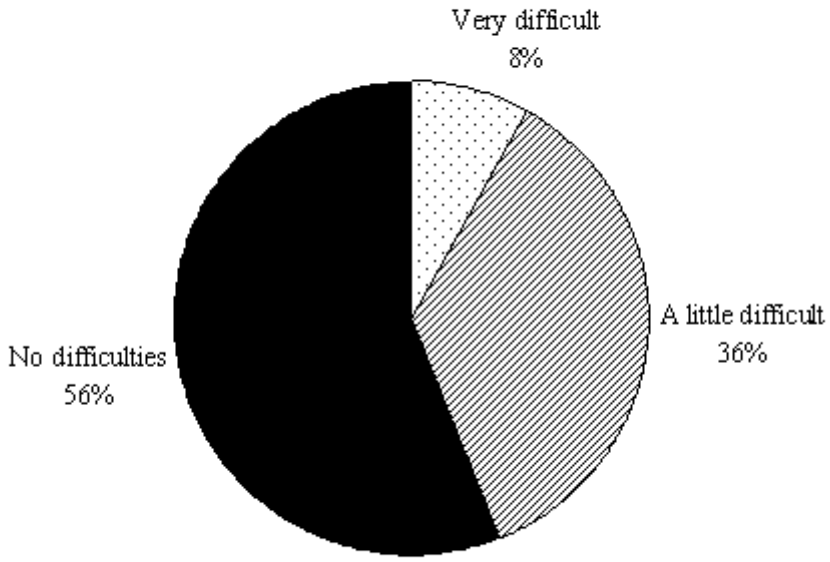
national governments are not responding to increased demand by spending enough to reduce waiting times; instead, they are rationing services, and delays in treatment can have deleterious consequences for many in need of treatment.

Although the bulk of health expenditure is met from public finance, every national health service imposes charges on some people for some services, for example, prescriptions or eyeglasses, and it may ask users of the health service to pay a limited fee for each medical consultation or treatment. Even if there is a low ceiling on these charges and means tests allow some users to be exempt from any payment, costs of health treatment are seen as making it very difficult to use the health service by 11 percent, and as creating a little difficulty by 17 percent. For almost three-quarters of health service users, the cost of use presents no difficulty.

The public provision of health services is truly nationwide, for only 7 percent say that distance from a doctor's office or health centre is a big difficulty and three-quarters do not see any difficulty in getting to a medical facility for treatment. Accessibility reflects both the government's obligation to deliver services to remote regions and the growing prosperity of Europeans, since most households now have a car and those that do not often have friends who will drive them to a doctor.

Figure 1 Index of Health Service Participation

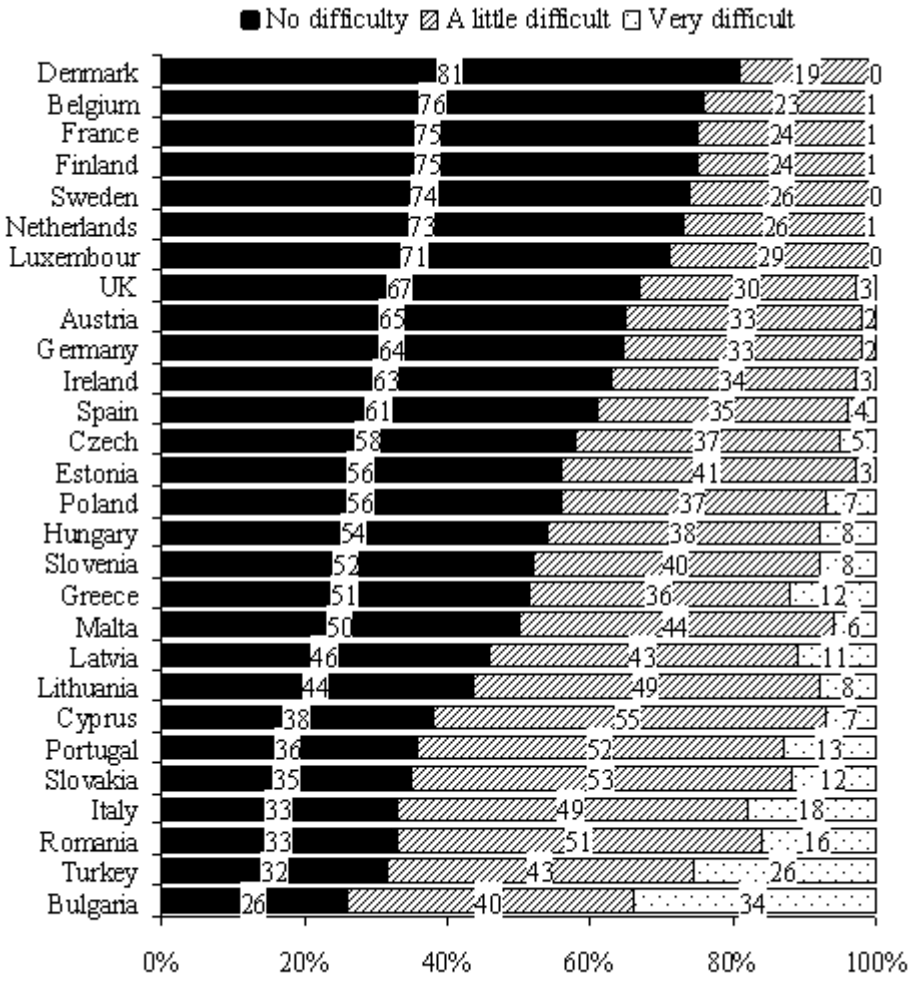
Average of replies to four questions about access: Table 1



Source: Percentages based on replies to 2003 European Quality of Life Survey with national results weighted to each country's share of the total population of 28 countries

Since the four difficulties are statistically highly correlated, the replies can be combined into a single *Index of Health Care participation*. The index reflects the extent to which an individual finds it not at all difficult, a little difficult or very difficult to get health care when needed. The Index shows that a majority of Europeans have no difficulty in getting access to health (Figure 1). When they need it there is a health centre near at hand, the waiting time is reasonable and any charges can be paid without difficulty. On the other hand, 36 percent tend to experience a little difficulty in participating in health care. An additional 8 percent say it is very difficult to participate in the use of a public service that is in their vital interest.

Figure 2 Participation in Health Services by Country



Source: Percentages based on replies to 2003 European Quality of Life Survey with national results weighted to each country's share of the total population of 28 countries

The extent to which participation in the health service is easily achieved varies substantially between European countries (Figure 2). In two-thirds of European countries an absolute majority say they have no difficulty in participating in the health service. In Denmark 81 percent report no difficulty in getting health care and in four more countries at least three-quarters can get health care without difficulty. However, in four countries two-thirds of citizens say that they have at least a little difficulty

receiving health treatment. The difficulties are high not only in low-income countries such as Bulgaria, Turkey and Romania, but also in Italy. Where difficulties are most often found, they tend to be small rather than great, except in Bulgaria and Turkey, where more than one-quarter of citizens usually find that it is very difficult to participate in the health service.

Influences on access to health services

The take up of health care is problematic, since there is no compulsion to go to a doctor regularly, as there is compulsion to go to school. Nor is there a cash incentive to claim treatment, as in the case of a pension or unemployment benefit. Given a choice, people would prefer to be in good health and not need to see a doctor or go into hospital from one year to the next. However, when health problems arise, there is a desire for prompt treatment and in the great majority of households at least one person will need to see a doctor or go to a clinic or hospital at some time during the year.

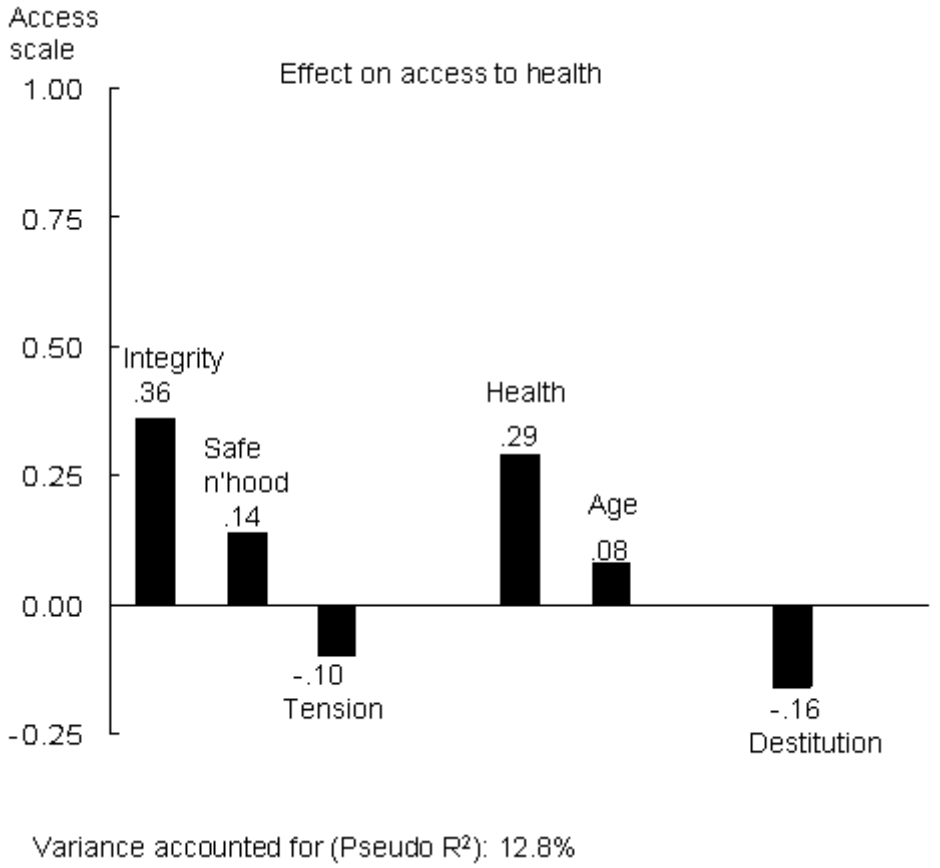
There is a multiplicity of difficulties that can effectively exclude people from health care. People who live in rural areas may be put off by the distance to a doctor's office or to a hospital. If a health service supplies insufficient clinics or hospital beds, this will cause delays in getting an appointment and once an appointment is obtained there may be long waits in a doctor's office, resulting in frustration, anxiety or lost wages. In countries where some cash payment is required, people may regard the cost of treatment as too high, even if they could have it subsequently reimbursed through a public agency or insurance company. Although the majority of Europeans say that they have no difficulty in claiming health care, nonetheless 36 percent report at least a little difficulty and an additional 8 percent find very great difficulty in getting health care to which they are entitled. (see Table 1; Figure 1).

Insofar as individual resources affect access to health care and health itself, the causes may be perverse: people most in need of access because they are unhealthy will have most difficulty in accessing health care. However, as obstacles are due to contextual influences, there are measures that national governments could take so that everyone entitled to health care can access it without difficulty as and when they need to do so.

The provision of health care is a collective resource: an individual cannot afford to maintain a hospital just for their family, and a doctor treats many patients rather than a single individual in the course of a month. This explains why where you live has a bigger influence on individual access to health care than who you are.

The integrity of government has the biggest effect on access to health: the greater the honesty of government, as shown by the Transparency International Perception of Corruption Index, the fewer the difficulties that its citizens have in getting appointments on time, getting treatment without having to wait hours after arriving at a clinic and the less costly is health care (Figure 3). By contrast, where government is perceived as corrupt, then access to health care tends to involve at least a little difficulty. The finding is particularly striking since many surveys show that doctors are much more trusted than the media, the police, or Members of Parliament.

Figure 3 Major Influences on Access to Health Services



Source: Calculated from Multi-level Hierarchical Model analysis reported in Appendix Table 2, which contain full details including minor and not significant influences

In the modern world getting medical care is a complex process, and an individual has to get by many gatekeepers. Whereas going to the cinema or a shop involves a single payment to a cashier, getting an appointment to see a doctor and, even more, getting an appointment for an operation, requires going through a multiplicity of gatekeepers from a doctor's secretary to a hospital admissions officer. In countries where government integrity is high, people report that these multiple steps do not cause difficulties. However, in countries where corruption is relatively high, public officials can tolerate or even create difficulties in order to extract payments as the price of giving individuals access to the health care that they are entitled to as citizens.

While people living in a rural area will be much further from a hospital than urban residents, this has no significant effect on whether a person has difficulty in getting health treatment. Within a country, variations in difficulty reflect the extent to which people feel they live in a safe neighbourhood. The safer is the neighbourhood the less are the difficulty. However, the greater the fear people have of being mugged on the street if they go out at night, the more difficult it is to go a hospital, even if the distance is not great in terms of kilometres.

A third collective obstacle to health care is tension in society. This is prior to the temporary anxieties that are induced by a sudden need for medical treatment. People who think that there is tension in society between rich and poor and employers and managers are more likely to face difficulties in gaining access to health care.

The depressing effects of context on access to health are cumulative. Thus, people who live in a country where corruption is high, streets are unsafe and economic tensions are high are six-tenths of a point more likely to face difficulties in getting health care, regardless of their education or the income quartile that they are in. While the integrity of governments in Europe is much higher than on some other continents, fear of crime can be found within some neighbourhoods in all countries of Europe, and the same is true of a degree of economic tension.

Individual resources have a secondary influence on access to health care. As would be expected, the healthier an individual is, even though it is not needed it is easier for a person to access treatment. This is supported by the fact that older people find it slightly easier to get health treatment. Even though older people are likely to be less mobile and less educated than the average citizen, they are also likely to be more experienced in making use of health services.

The importance of learning by doing (that is, making use of the health service) as against learning in school is borne out by the fact that having more education does not make it significantly easier for people to use health services. Women have more experience than men in accessing health care during periods of maternity men and, during a longer life expectancy, for problems of advanced old age. After controlling for all other potential influences, there is no significant gender difference in the capacity of women and men to access health care (Appendix Table 2).

The chief economic obstacle to accessing health care is absolute deprivation rather than relative inequality in income. The minority who sometimes have difficulty in meeting their food, electricity or rent bills also find it substantially more difficult to take up health services to which they are entitled. By contrast, while people who are below average in income may be considered relatively poor, if they are not threatened with destitution this has very little effect on their access to health care.

Whereas group involvement in the world of work or attendance at church has a positive effect on conventional political participation, it is without significant influence on access to health care. Likewise, trust in other people has no significant influence on health care. Conventional participation is necessarily collective, because it involves working with others in a group such as a political party or a trade union. By contrast, health care is a private good of individuals. To obtain treatment for health problems it does not help to be a joiner of organizations; it is more important to live in a neighbourhood that is safe and in a society that is free of tension and corruption.

Implications for policy

In 18 of the 28 countries covered in the European Quality of Life Survey, a majority of citizens report no delays in getting treatment at a reasonable distance from their home and there are no problems with cost (see Figure 2). In those countries in which a majority experience difficulties, difficulties tend to be less rather than greater. While the incidence of difficulty varies between and within countries, some citizens in every European country have problems arising from health aggravated by facing difficulties in getting access to treatment to which they are entitled.

The rising cost of health services, a principal worry of most governments, is not the prime obstacle to access highlighted by analysis of the European Quality of Life Survey. The closure of smaller hospitals in less populous areas has not made distance from a hospital a great problem, probably due to widespread automobile ownership. Any shortages of doctors have not made long waits in a doctor's office or for an appointment a major difficulty. Nor do the cost of any fees that may be associated with claiming health benefits created a problem. The indications that people more likely to use health services, such as older people and women, have equal or even improved access independent of their education or income status, implies that with experience frequent patients learn how to deal with health professionals to the satisfaction of both.

The major obstacles to health care go beyond the health sector and are indications of broader shortcomings of governance. A lack of integrity in public services is likely to involve corruption in money spent on roads and schools and ineffective or corrupt policing as well as the extraction of small payments or ‘gratitude money’ for health care. The very high correlation at the aggregate level between a country's integrity and its Gross Domestic Product per capita (r 0.87) is actually a caution against regarding greater inputs of public expenditure as the best way to remove obstacles to health care. Pouring more money into a system where integrity is low is likely to result in public officials skimming off a share for their own private benefit and inefficient use of other resources. By contrast, reducing corruption makes more effective and fairer use of existing resources. It also creates conditions attractive to increasing expenditure from domestic taxation or the growth in the national economy that is likely to accrue when pervasive corruption is reduced.

The means required to make government honest are well publicized by national reformers, by intergovernmental organizations such as the World Bank, and by international NGOs such as Transparency International (2005). The difficulties of doing so can be exaggerated. For example, Estonia has a far lower Gross Domestic Product per capita than Italy and Greece but it has a higher ranking on the Transparency International Perception of Corruption Index. It has shown that major effects of the Communist legacy on corruption can be overcome more quickly than living standards can be raised to that of the most prosperous European societies. Insofar as corruption and difficulties in accessing health service reflect mal-administration that is, slowness or negligence in responding to requests, unexplained cancellations of appointments, etc. then employee training in standards of courtesy, helpfulness and fairness are relevant (Galbreath and Rose, forthcoming).

Unsafe neighbourhoods also create difficulties in claiming health services as increasingly specialized and costly hospital care is being concentrated in larger urban centres. While American problems of urban decay leaving good hospitals isolated in unsafe neighbourhoods are not so pressing in Europe, there is a perception of rising crime, as shown by the fact that a substantial proportion of Europeans thinks their neighbourhood is fairly or very unsafe. If the Ministry of the Interior does a good job in making neighbourhoods safe, this reduces the access problems of the Ministry of Health.

Destitution can cause ill health, because people who have difficulty in buying food are likely to have unhealthy diets and difficulty in meeting utility bills and rent is likely to

correlate with unhealthy housing. Because destitution also reduces the likelihood of a person receiving treatment for ill health, its consequences compound an individual's disadvantages. Moreover, destitution appears to be the significant economic problem of health care, since the MLHM analysis found, after controlling for other conditions, that income quartile, being a manual worker or not participating in the labour force had no significant influence on access to health.

The importance of contextual influences is a reminder that programmes of a Ministry of Health are not the only way in which public policy affects a country's health. Corrupt government, unsafe neighbourhoods, tensions between rich and poor and people becoming destitute are undesirable in themselves and have a bad effect on health. These collective pathologies can bring stress to individuals, and stress is itself a significant cause of ill health (Marmot, 2004).

References

Galbreath, David and Rose, Richar, 2008. 'Fair Treatment in a Divided Society: A Bottom Up Assessment of Bureaucratic Encounters in Latvia', *Governance*, vol. 21, in press

Marmot, M., *Status Syndrome: How Your Social Standing Directly Affects Your Health and Life Expectancy*, London, Bloomsbury, 2004.

Transparency International, *Perception of Corruption Index*, Berlin, 2005, www.transparency.org

Appendix

Appendix Table 1. Descriptive Statistics for Variables Used in Analysis

VARIABLE NAME	Quest. N	MEAN	SD	MINIMUM	MAXIMUM
DEPENDENT VARIABLES					
Access to health	45abcd	2.53	.51	1 Very difficult	3 Not at all
CONTEXT VARIABLES					
Integrity/corruption[1]	Corrupt	6.17	2.05	2.8	9.9
Population (millions)	Popsize2	19.64	24.02	.40	82.44
GDP/capita thousands $PPS	Gdppcap2	18.99	9.12	5.92	45.43
English national language		.11	.31	0 No	1 Yes
INDIVIDUAL VARIABLES					
Female	hh2a	.52	.50	0 No	1 Yes
Education (age finished)	Teacat1	2.11	.72	1 15 or less	3 20+
Age	hh2b	45.73	17.61	18	83
Health self-assessed	43	3.06	1.14	1 Very poor	5 Excellent
Destitute: rent, food, utilities	59ab, 60	.31	.63	0 Pay all	2 Pay 1 or 0
Income quartile	hhincqu2	2.50	.99	1 Lowest	4 Highest
Employed[2]	2	.50	.50	0 No	1 Yes
Manual worker[3]	2, 3	.29	.45	0 No	1 Yes
Safe neighbourhood	57	2.96	.87	1 Very unsafe	4 Very safe
Tension in society[4]	29ab	2.22	.58	1 None	3 A lot
Urban area	region	.56	.50	0 No	1 Yes
Trusts people	28	5.39	2.30	1 Least	10 Most
Attends church	26	2.13	1.93	0 Never	5 >oncewk
Weight (equal by country)	wcountry	.15	12.04	1.07	.46
Weight by population	Wtot28	0	5	1.00	1.15
Notes:					
(1) Transparency International scores for 2001, except used 2003 score for Cyprus and 2004 score for Malta.					
(2) Includes all respondents who are working (Q2)					
(3) Includes those who were formerly manual workers but are no longer working.					
(4) Mean of replies to questions on tension between rich and poor and between workers and management.					

Source: Replies to 2003 European Quality of Life Survey. Means and standard deviations computed with national results weighted equally

Appendix Table 2. Access To Health Services: Multi-Level Hierarchical Model

Variance accounted for (Pseudo R2): 12.8%				
		Standard		
	Coefficient	Error	T-ratio	Effect
Integrity/corruption	0.05	0.01	5.46	0.36
Safe neighbourhood	0.05	0.01	9.54	0.14
Tension in society	-0.05	0.01	-7.24	-0.10
Urban area	0.02	0.01	1.43	not sig
Population	0.00	0.00	0.03	not sig
Destitute: rent, food, utilities	-0.08	0.01	-6.77	-0.16
Income quartile	0.02	0.01	2.53	not sig
Employed	0.00	0.01	0.13	not sig
Manual worker	-0.01	0.01	-1.12	not sig
Health	0.07	0.01	12.13	0.29
Age	0.00	0.00	3.92	0.08
Trusts people	0.01	0.00	2.04	not sig
Education	0.01	0.01	1.94	not sig
Attends church	0.00	0.00	-0.68	not sig
Female	-0.02	0.01	-2.13	not sig

Source: Replies to 2003 European Quality of Life Survey with national results weighted equally