Health and care in an enlarged Europe

Summary

Introduction

Health and lifestyle

Access to health care facilities

Satisfaction with personal health

Satisfaction with the health care system

Responsibility for care across countries

Strength of family support

This summary is available in electronic format only
Introduction

This document summarises the findings of a research report from the European Foundation for the Improvement and Living Conditions on the subject of health and health care. It forms part of a series of reports on quality of life in an enlarging Europe, drawing on the findings of the European Commission’s Eurobarometer surveys carried out in the 15 EU Member States and the 13 acceding and candidate countries (abbreviated here to EU 15 and ACC 13) in Spring 2002, as well as standard EU 15 Eurobarometer studies. Examining quality of life across 28 European countries, the report provides, for the first time, an analysis of the views and experiences of the citizens of the new Europe on their personal health and health care services.

For Europeans, the entitlement to good health care is a basic human right, as enshrined in Article 33 of the European Union’s Charter of Fundamental Rights: ‘everyone has the right of access to preventive health care and the right to benefit from medical treatment’. The major long-term social policy objectives aim to ensure general accessibility, good quality care for all and the financial viability of health care services. The report takes a comparative look at health and health care across 28 countries. It examines how Europeans perceive their own health, whether they lead healthy or unhealthy lifestyles, how easily they can access their national health care system and how satisfied they are with the services. Finally, it examines the provision of care for older people, and points to the strength of family support in many countries for providing care within the family.

Health and lifestyle

The report first looked at current health conditions and the social distribution of stress which is known to be a major factor in mortality. Self-reported long-term illness served as the key indicator for health conditions and was found to be more prevalent in acceding and candidate countries. On average 25% of ACC 13 citizens as compared to 18% within the EU report having a long-standing illness or disability. In the absence of follow-up questions, it is impossible to assess whether this indicates the prevalence of similarly serious health problems among these two groups of countries or country-specific yardsticks in classifying a given health status as a chronic problem. There is some reason to assume that the higher prevalence of long-term illness in former communist countries is related to specific institutional incentives which make the entitlement to some forms of social welfare benefits contingent on the presence of disabled household members.

The research shows that people in acceding and candidate countries are less likely to have a healthy lifestyle than EU citizens. This seems to be related to different opportunities concerning access to good health options and facilities as well as to individual choices. In general, however, the different parts of Europe do not stand apart as clearly distinct blocks of countries with different levels of good or bad health. Instead, there is a considerable overlap in the frequency of health problems or of health-relevant behaviour. The range of a given characteristic within each group of countries - ACC 13 and EU 15 - is usually greater than the gap between the respective group averages.

Examining the patterns of distribution of the health-related variables across social groups tended to reveal similarities between the EU Member States and acceding and candidate countries rather than distinct social profiles. In both groups of countries, health conditions are related to the position in the income distribution, as health impairments are more likely to be concentrated in low income groups. Even when the data were controlled for age, gender and employment status, people with low income have a higher risk of suffering from long-term illness. Obviously, economic problems and health problems overlap to a considerable extent, and this tendency is particularly marked in the acceding and candidate countries. Socio-economic privilege tends to translate into health privileges throughout Europe, but the size of the inequality gap tends to be bigger in acceding and candidate countries.

Gender gaps in the distribution of poor health and health-related lifestyles are usually less marked than income gaps. In both the EU 15 and ACC 13, the research points in the same direction: Women suffer from long-term illness and stress
more frequently than men, who, however, report a higher incidence of unhealthy lifestyles. There is no consistent
tendency for the gender gap to be bigger or smaller in a particular set of countries across various health characteristics,
but the prevalence of long-term illness among women is more common in the ACC than in the EU.

In both parts of Europe, some 40% of respondents report suffering regularly from stress. The experience of stress
deviates from the usual pattern of distribution of health problems to some extent, as it is less clearly associated with
socio-economic inequalities, but rather reflects work overload and time pressures. Unemployed people – whom survey
research frequently finds to be the most unhappy and depressed social category – do not report a particularly high burden
of stress. In both the ACC 13 and the EU 15, those who have a job report to be more stressed than those who are not
working.

Employment is thus seen to function simultaneously as both a socially integrative force and as a stress-inducing factor.
Those with more demanding jobs experience greater levels of stress, while groups who are not economically active
experience less stress. Apart from the many country-specific variations which are usually found in each group of
countries, this basic pattern prevails in the EU Member States and in ACC 13 countries alike, but within the EU the
concentration of stress among more privileged occupational classes is more marked.

When average tendencies in countries inside and outside the current EU borders are compared, there are considerable
variations around the averages for the different groups of countries. Hardly any health-related results suggested that
various groups of countries form separate clusters that stand clearly apart from each other without any overlap. In terms
of statistical analyses, these patterns suggested affinities and connections rather than divisions between various parts of
Europe.

Access to health care facilities

Proximity to hospitals
The next part of the report focused on the proximity of health care facilities as one dimension of access to health care
services. The yardstick used here was the time of one hour or more to reach a hospital. Countries within the European
Union come very close to realising the goal of universal easy access to hospital care: 96% of EU 15 citizens reported
need less than one hour to get to a hospital, and for more than half of respondents it takes even less than 20 minutes.
The situation is less favourable in acceding and candidate countries, where a sizable proportion of around 15% are not
able to reach a hospital within an hour. Eight of the ACC 13 top the 10% threshold of difficult access, among then five
acceding countries.

Crude comparisons of European averages before and after enlargement do not fully reveal these discrepancies, because
the countries with difficult access tend to be small in population size and hence have little impact on the calculation of
the aggregate averages. For example, the European average proportion of those who need more than one hour to get to
a hospital would merely change from 4% to 7% after enlargement. This would not signal a serious challenge to the goal
of providing universal access to hospital care. A more relevant fact in policy terms is that in the majority of the ACC 13
there is a considerable proportion of citizens (over 10% of the population) who live at a distance from hospital care.
Hence, enlargement should bring about greater challenges to attaining the health policy goal of general quick access to
hospital care.

Analyses of group-specific access patterns confirm this assessment. The structure of privilege in countries inside and
outside the EU is usually the same, but the degree of inequality is higher in the acceding and candidate countries. Within
the current EU 15, for example, 45% of those in the lowest income quartile, and 60% of those in the highest one have
access to a hospital within 20 minutes. Hence a gap of 15 percentage points separates those with higher from those with
lower incomes. In the ACC 13, the income gap is much larger at 26 percentage points on average. Enlargement will thus
bring about some widening of socio-economic inequalities in hospital access in the EU.
The rural-urban gap is just as important as the income gap in the acceding and candidate countries. While only around 5% of citizens living in cities take more than one hour to get to a hospital, about one fifth of the population in the countryside take this time. Retired people usually also have less easy access to hospitals than economically active people, but in this case the gaps are not as large. Once again, however, inequalities are more marked in the ACC 13 than within the EU.

Compared to traditional inequalities between socio-economic categories, the differences between people reporting or not reporting a long-term illness are much smaller, and not very marked in either group of countries. By and large, however, the structure of hospital access appears to run counter to the structure of need, as less privileged groups tend to have more difficulties in getting to a hospital than more privileged groups. This general tendency prevails in Member States and in ACC 13 countries alike, but the research finds that the acceding and candidate countries are much further away from the goal of attaining equal universal access. Hence ensuring the goal of social inclusion in the health care sectors of EU Member States will require extended efforts after enlargement.

**Proximity to general practitioner’s surgery**

Analyses of the proximity to a general practitioner’s office basically repeat these patterns. Judging by the yardstick of quick access within 20 minutes, 85% of EU 15 citizens attain the goal of easy access to primary care, but only 62% of people in the ACC 13. However, great difficulties in reaching a doctor are rare. Across all acceding and candidate countries, more than 90% of citizens can get to a general practitioner’s surgery within less than one hour; even in the countryside, such difficult access to primary care is almost as rare as in big cities. Social inequalities prevailing in access to a general practitioner’s surgery are usually small in EU Member States, but are greater in the acceding and candidate countries, where those who are socio-economically disadvantaged tend to live in less proximity to health care services.

**Satisfaction with personal health**

Differences in the degree of satisfaction with health and the health care system were analysed in the report and the findings partly reflect the differences seen above in the distribution of health conditions. In general, satisfaction with health is found to be distinctly higher in the EU Member States. On average, more than 80% of EU citizens, compared to only about 70% of ACC 10 citizens, say they are ‘fairly satisfied’ with their health. Satisfaction levels tend to be particularly low in the former communist countries. Within each country, respondents with a poor health status report lower health satisfaction scores than those with a better health status. This also suggests that health satisfaction may be considered a valid indicator of actual health conditions.

Group-specific comparisons show the members of groups which are known to be susceptible to poor health to be less satisfied with their health. The fraction of respondents who are at least ‘fairly satisfied’ with their own health is lowest in the oldest age group and highest in the youngest age group. The effect of age on health satisfaction is on average much stronger in the acceding and candidate countries than in the EU Member States. Hence the AC 10 display higher degrees of health-related inequality than the EU 15. This is also true with respect to income-related gaps in health satisfaction: in all countries, those with higher incomes have a higher degree of health satisfaction, but the gap separating the highest from the lowest income quartile is smaller in the EU. In both groups of countries, gendered inequalities in health satisfaction are to the disadvantage of women, but they are smaller than the income-related differences. Also in this case, the degree of inequality tends to be higher in acceding and candidate countries.

With regard to indicators of health care provision and health satisfaction, EU 15 countries thus differ from acceding and candidate countries, as they have distinctly higher levels of health-related equality. Enlargement will bring about a greater degree of health-related heterogeneity, both between countries as well as within countries, and extended policy efforts will be needed to attain the level of equality which has characterised the European social model so far.

© European Foundation for the Improvement of Living and Working Conditions, 2004
Satisfaction with the health care system

From a policy perspective, knowing how citizens perceive the health care system, and how united or divided are their views concerning the prevailing provisions, may even be more important than knowing to what extent health conditions and health satisfaction are distributed unequally. Since the health care system and social services are major domains of modern welfare states, their acceptability must be regarded as an important element in the political support of democratic systems. The survey questionnaire provided information on the degree of satisfaction with the health care system and with social services. Judging from a combined index of satisfaction with both, the satisfaction with the health care system is considerably lower in acceding and candidate countries than in the European Union. In the EU, only three countries - from the southern part of the EU - have as low satisfaction scores as the group of ACC, among which only four acceding countries reach similarly high satisfaction scores as most of the EU Member States.

Within single countries, the research analysed how much social inequality there is in the perception of services, what type of inequality is particularly marked and to what extent the majority of people - those who pay most of the taxes and control the bulk of the votes - are satisfied with the prevailing system of care provision. The overall finding is that Europeans are fairly united in their degree of satisfaction with their national health care systems. In EU Member States as well as in acceding and candidate countries, group-specific inequalities in satisfaction tend to be small. Economically active people whose earnings fund the major part of the health bill tend to express a little less satisfaction with the health care system than retired people who are in receipt of medical and other benefits. While the difference between both groups may reach statistical significance, it is in fact small in most countries. The gap separating the two groups is merely half a point on the 10-point satisfaction scale, and it is not higher in the ACC 13 than within the current EU. If economically active persons and retired persons formed two separate or even antagonistic camps in health care politics, reflecting their different status as contributors or beneficiaries, one would certainly expect a larger difference.

With respect to other social categories, there are even smaller differences, and in this sense the European tradition of providing universal access to health care translates into a remarkable equality in health care satisfaction. Age-related differences are small in the ACC 13 and EU 15 alike. In both groups there is even a moderate tendency for health care satisfaction to increase with age. Hence throughout Europe people at various stages in the life cycle are remarkably united in their satisfaction with health care. There are, moreover, no relevant gender-related differences, as Europe’s health care systems are equally satisfying for men and women alike. Income-related differences in health care satisfaction also remain small in most countries, even though respondents with higher incomes tend to be slightly more satisfied than those with less income. Again, there is no significant difference between EU Member States and ACC 13 countries. The ‘middle mass’ of voters and taxpayers – those defined as ranging from 75% to 175% of the mean household equivalent income – are just as or even more satisfied than those below them and practically indistinguishable from those who are above them in income distribution. Hence there are no indications of a relevant degree of disaffection among the ‘middle mass’ in acceding and candidate countries.

Different social groups also display a remarkably similar degree of health care satisfaction. This may be interpreted as an indication that the European tradition of securing universal access to health care for all citizens has a dual positive impact: it unites countries which are inside and outside of current EU borders, and it serves an important integrative function within individual countries.

In recent years, the health care systems of European countries were subject to constant change, as governments tried to contain costs and to control supply and demand. Particular turbulence was experienced during the post-communist transition era among countries which changed from the centralised Soviet model to contribution-financed social insurance schemes. Hence an analysis of changes in satisfaction should indicate to what degree citizens have accepted the recent reforms and cutbacks. The overall result is that satisfaction with health care systems is on the decrease in most European countries. The change is more marked in the former communist countries, where only two countries report a net decrease in satisfaction which remains below the EU average. It is clear that Europeans have become more
discontented with their national health care policies. It would be misleading to attribute the declining average satisfaction to the discontent of a small critical minority in a sea of stability. The growth in discontent is practically just as big in the middle mass as in the population at large, and in this sense we find very widespread dissatisfaction.

A closer examination of the social profile of satisfaction changes confirms the rather general nature of discontent and its similarity east and west of the current EU borders. Comparing the net satisfaction change in various income quartiles, those in the lowest and the highest income quartile show very similar degrees of growing dissatisfaction. Only retired people show a tendency to become distinctly more dissatisfied with the health care system than the average respondent, and this tendency is particularly marked in the former communist central and eastern European countries.

The analysis of health care satisfaction and its changes thus produce mixed results. On the one hand, we find high levels of satisfaction with the health care systems in most European countries and a remarkable homogeneity of satisfaction across social groups. Underprivileged groups and those who need health care most tend to be similarly satisfied with the health care system as more privileged groups. In this sense, universal health care unites people in Europe. On the other hand, we find satisfaction with health care to be declining almost everywhere in Europe over the two years preceding the survey. Again, there are no signs that the growing dissatisfaction is socially polarised or concentrated among underprivileged groups or in a particular group of countries. In this sense, Europeans tend to be united even in their growing dissatisfaction. In democratic societies, where the support of the majority of their citizens is indispensable, this general tendency of growing dissatisfaction and the discontent among the middle mass and among retired people should be of concern. Policymakers must make extended efforts to demonstrate that the objective of health care system reform is to meet citizens’ concerns and to make the systems more responsive to the needs of consumers.

Responsibility for care across countries

The research set out to understand what are the needs and concerns of citizens. Looking at both public and private care solutions, it explored to what extent the care preferences of various countries and groups are different. Given concerns that the dual process of welfare state expansion and growing female labour force participation may have eroded the self-help capacities of families and civil society networks, the findings reveal a remarkably high level of informal care giving throughout Europe. One in four respondents in the acceding and candidate countries, and over one in five citizens in the EU report that they are active care givers. There is a high degree of country-specific diversity with respect to the prevalence of care giving, so that the EU 15 and ACC 13 do not stand clearly apart as distinct groups of countries.

Care provided within and outside the home

The research reveals two separate worlds of care in Europe, however, after a distinction is made between care rendered inside and outside one’s own household as well as between care rendered inside and outside the family. Care for co-residents at home is given much more frequently in the acceding and candidate countries, where 17% of the respondents report such activities, as compared to only 10% in the EU. Caring tasks outside the home are similarly performed by 15% of EU citizens and ACC citizens. In both parts of Europe, informal care work is mainly carried out with elderly persons, and throughout Europe informal care is predominantly given to family members. However, family care is six times more prevalent in the acceding and candidate countries than extra-family care, whereas in the EU it is just twice as prevalent. On average, 23% of ACC 13 respondents, as compared to 17% of EU 15 respondents, deliver care to family members. Informal care outside the family is more frequently rendered within the EU. On average, 8% of EU citizens, compared to 4% in the ACC 13 use care services outside their families.

In the absence of more detailed follow-up questions, it is not known whether ACC citizens are more involved in informal care roles because of an adherence to a traditional view of family support, or because the paucity of available services obliges them to do so. The distribution of care activities within current EU member countries contradicts, however, the idea that informal private care and publicly provided community care are opposites which cannot co-exist, but can replace each other. Within the European Union, informal care outside the home is most frequent in countries where
formal community services are most developed, and it is least prevalent in countries where public services are known to be scarce. This suggests that informal care activities are successfully facilitated where their costs are alleviated by forms of public support.

Dual responsibilities
Most of the care work is done by women, but it is just as noteworthy that informal care peaks at prime working age in the middle of the life cycle. Whereas home care for co-residents is frequently rendered by people over 60, the bulk of care outside one’s own household is provided by people of working age who are in the middle of the life cycle. Economically active people are responsible for giving informal care just about as often as non-active people. This means that working people frequently have to shoulder a double burden of formal and informal work. This dual burden is particularly prevalent in the acceding and candidate countries.

Despite being burdened with dual responsibilities, four out of five respondents in ACC 13 countries advocate a strengthening of family responsibilities, when asked whether they consider it a good or a bad thing if working adults would have to look more after their elderly parents in the future. In striking contrast, citizens in EU Member States usually express much more scepticism about taking on extended family responsibilities. On average only 59% of EU citizens advocate more family support in the future. This signals a considerable cleavage between the two country groups concerning adequate care policies. In an enlarged Europe, the views of the acceding countries have more in common with the proponents of family support seen in southern Europe.

Views of young and old persons
A group-specific analysis of attitudes to care shows very little potential for a divide between the generations or between the providers and recipients of care. Throughout Europe, generation gaps in care preferences remain small, particularly in acceding and candidate countries. Older people who are likely to see themselves as potential recipients of care are somewhat more in favour of extended family support than younger persons who are likely to see themselves as potential providers, but the differences between the generations are not very big. Even in the EU, where the differences between the generations tend to be more sizable, the proponents of extended family solidarity outnumber its opponents by large margins also in the youngest generation. This is an interesting finding because the younger generation is likely to be the future supplier of informal care. In a turn away from narrow self-interest, younger respondents profess a preference for family care. In a similar vein, women express a preference for family care more frequently than men, even though they do most of the care work. This reveals a remarkable degree of altruism in European attitudes to care. A more specific analysis for the ACC 13 confirms that giving care to elderly persons tends to foster positive rather than negative thoughts about extended family responsibilities in the future. Those who are engaged in care work in the acceding and candidate countries seem not to want to liberate families from this task, and indeed wish to strengthen further the caring relationship within families.

European citizens from both country groups are fairly united when it comes to considering the adequate form of formal help for elderly people who need care. Sending elderly people to residential care facilities is a highly unpopular solution. In 12 of the 13 acceding and candidate countries more than 80% of the respondents say they would prefer to avail of social services which allow elderly persons to remain in their own homes. The citizens of EU Member States in general opt for domestic care over residential care to an almost identical degree.

Strength of family support
When respondents were asked to think about the best care solution for their own parents when they become dependent, the preference for domestic care over residential care and for family support models over formal help becomes even stronger. The vast majority of respondents in acceding and candidate countries opt for family support when they are given a choice between five alternatives. The citizens of the EU Member States are much more divided in their views on desirable forms of care. In southern Europe they tend to favour family support; in the northern countries they advocate
state-provided formal care; and in the central, ‘continental’ countries they tend to fall between these poles. As there is a high degree of diversity within the current EU, enlargement will only add a little further diversity. The data leave little doubt, however, that enlargement will strengthen the family support model. The concept of ‘intimacy at a distance’, which has gained some following in EU Member States, can only become attractive in the acceding countries when a sufficient supply of adequate housing allows multi-generational households to split up at a reasonable cost.

The vitality of family support in the acceding and candidate countries is a double-edged sword. It can help to unburden the welfare state, but it also puts a heavy dual burden on working people who already have to struggle to make ends meet, and are facing a growing challenge to combine formal and informal work. However, the strength of family support helps to span inter-generational divides in Europe’s ageing societies. This becomes particularly evident when the research analyses peoples’ views on responsibility for paying for care. When asked who should pay for the care of elderly parents, citizens of acceding and candidate countries are divided between favouring state funding and private funding (children should pay the cost). By far the least popular idea is to have the elderly people themselves foot the bill. The idea of sustainable social policies which take the interests of future generations into account has obviously not yet gained much support in these countries. While EU 15 citizens tend to be more frequently in favour of state financing, they are much more reluctant to have the children pay, and they tend to be less reluctant to advocate that the elderly bear the cost themselves.

Further analysis reveals a remarkable degree of inter-generational empathy and surprisingly little self-interest among Europeans when it comes to reflecting on the best ways of paying for care. In the ACC 13 and EU 15 alike, older citizens are more in favour of shifting the burden of financing to the elderly than those in the youngest generation. In 27 of the 28 European countries, shifting the cost of care to the elderly is more popular among the older than among the younger generation. These results lend little support to the idea championed by some political economists that the growing age of the average voter will automatically translate into a package of reforms aimed at more sustainable policies. The research shows that older citizens in Europe are willing to shoulder their part of the cost of care, and they are reasonable and compassionate enough not to advocate externalising the cost to others more frequently than younger voters. This suggests that older voters are quite amenable to arguments which highlight the importance of sustainable policies in aging societies. It is up to policymakers to utilise this considerable potential for a reasonable political debate.

The report, *Health and care in an enlarged Europe*, is available online at [www.eurofound.eu.int/publications/EF03107.htm](http://www.eurofound.eu.int/publications/EF03107.htm)

The other reports in the Foundation’s ‘Quality of life’ series and accompanying summaries are available on the Foundation website at [www.eurofound.eu.int/living/qual_life/index.htm](http://www.eurofound.eu.int/living/qual_life/index.htm)

J. Alber and U. Köhler, Social Science Research Center (WZB), Berlin

© European Foundation for the Improvement of Living and Working Conditions, 2004