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An analysis of perceived access to health care in Europe: How universal is universal coverage?☆

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ABSTRACT

The objective of this paper is to examine variations in perceptions of access to health care across and within 29 European countries. Using data from the 2008 round of the European Social Survey, we investigate the likelihood of an individual perceiving that they will experience difficulties accessing health care in the next 12 months, should they need it ($N = 51{,}835$). We find that despite most European countries having mandates for universal health coverage, individuals who are low income, in poor health, lack citizenship in the country where they reside, 20–30 years old, unemployed and/or female have systematically greater odds of feeling unable to access care. Focusing on the role of income, we find that while there is a strong association between low income and perceived access barriers across countries, within many countries, perceptions of difficulties accessing care are not concentrated uniquely among low-income groups. This implies that factors that affect all income groups, such as poor quality care and long waiting times may serve as important barriers to access in these countries. Despite commitments to move towards universal health coverage in Europe, our results suggest that there is still significant heterogeneity among individuals' perceptions of access and important barriers to accessing health care.
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1. Introduction

Universal health coverage refers to the movement towards two objectives–access to high quality services and financial protection [1,2]. Europe has shown a strong commitment to this goal, with most countries in the region having legal mandates for universal health coverage [3]. However, evidence suggests that some Europeans still feel as though they are unable to access care [4]. In certain European countries, such as Bulgaria, Croatia, Latvia, Poland, Romania and Sweden, those without access to care comprise over 10% of the population [5]. Levels of horizontal equity–or equal access for equal need—vary within developed countries for many types of care [6], with structural or design features of systems being key factors that determine which groups have access to care and which groups do not [7,8].

While a number of studies use levels of coverage [9,10] and equity in utilization of health care services [11–13] as proxy measures for access, it is difficult to accurately identify the individuals who are unable to access care, precisely because their lack of utilization is, by definition, unobserved. Likewise, it can be difficult to pinpoint the reasons people do not access health care services, particularly if they are legally entitled to health care services. Gaps in access to health care in countries with mandates for

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universal coverage may occur due to a number of reasons, such as financial barriers like user charges or informal payments, or non-financial barriers such as waiting times, service exclusions, or poor quality care.

In order to identify access barriers among non-users of health care, indicators of 'unmet need' have been introduced [4,5]. These self-reported measures identify individuals who have encountered barriers that prevent access, and in some cases, include the reasons for lack of access. Most of these indicators capture past attempts to access care, but a few indicators assess the uncertainty health care users may feel regarding their ability to access care should they need it in the future. However as Saksena et al. [14] note, financial protection in health implicitly involves some notion of minimizing the uncertainty associated with future need for health services and the ability to pay for them. The goal of financial protection as a component of universal health coverage thus serves a dual role: (1) minimizing the level of uncertainty in access to health care—which can reduce wellbeing in its own right; and (2) ensuring that no member of the population faces the uncertainty of having to choose between saving for a future health care event and other necessities.

Our study seeks to better understand individual's perceptions of their ability to access health care in European countries. Using data on self-reported perceptions of access (within the next 12 months) we estimate how perceptions of access barriers differ across 29 European countries, and identify individual characteristics that are systematically associated with perceived access barriers. To explore disparities within-countries, we focus on variation in access perceptions among high and low-income groups in each country. In an effort to contextualize the results, we calculate country-specific probabilities of perceived inability to access care based on our model results. We then discuss potential linkages between our empirical findings and selected country-specific features of health systems. While the results are intended to be illustrative given the subjective nature of the data, our study allows policymakers to better understand which of their constituents feel there are barriers to accessing care, and provides some indication of the factors that may prohibit those individuals from benefiting from progress towards universal health coverage.

2. Methods

2.1. Data

Data used for this analysis come from the 2008 round of the European Social Survey (ESS). The ESS is a cross-sectional multi-country survey designed to capture the attitudes, beliefs, and behaviors of Europeans in 29 countries: Belgium, Bulgaria, Switzerland, Cyprus, Czech Republic, Germany, Denmark, Estonia, Spain, Finland, France, United Kingdom, Greece, Croatia, Hungary, Ireland, Israel, Latvia, Netherlands, Norway, Poland, Portugal, Romania, Russian Federation, Sweden, Slovenia, Slovakia, Turkey, and Ukraine. All but two of these countries (Cyprus and Turkey) had legislation in place to ensure universal health coverage in 2008. Both Cyprus and Turkey, however, had legislation to move towards universal coverage in the near future [15,16]. Reports from a number of countries with mandates for universal health coverage, such as Greece [17], Ukraine [18] and the Russian Federation [19] acknowledge that there exists less than universal coverage in practice as particular groups of the population find it difficult to access services due to barriers such as waiting times, lack of service availability, quality concerns and costs (which often take the form of hidden or informal payments).

ESS data is collected via hour-long face-to-face interviews with randomly selected respondents ($N = 51{,}835$). The 2008 version is the 4th round of the survey and the only round that includes a question on access to health care. The perceived health care accessibility question asks respondents to report their likelihood of accessing health care should they need it in the next 12 months (i.e. not at all likely, not likely, likely and very likely of being able to access care). This indicator allows us to capture the uncertainty individuals may feel regarding their ability to access health care in the future. Moreover, we feel that this may also be a good predictor of true access, since individual perceptions play an important role in how people construct their own social realities [20]. Thus, we assume that individuals who perceive that they are not able to access care in the next 12 months will be less likely to access care in the future—regardless of true accessibility or availability of health services. Other relevant individual level data in the ESS which we hypothesize may be associated with variations in access perceptions includes information on age, gender, education, marital status, employment status, citizenship, household size, self-reported health, income perceptions and income deciles.

2.2. Empirical analysis

We use logistic regressions with country fixed-effects to estimate the odds that an individual perceives that they will be unable to access health care services in the next 12 months, conditional on a wide-spectrum of individual socio-demographic characteristics. The Model 1 logistic regression specification is:

$$\begin{aligned}\text{prob}(\text{unable to access care} = 1) &= \alpha + \sum \beta_1 \text{hlth}_i + \sum \beta_2 \text{inc}_i + \beta_3 \text{educ}_i + \sum \beta_4 \text{age}_i \\ &+ \beta_5 \text{emp}_i + \beta_6 \text{gndr}_i + \beta_7 \text{mar}_i + \beta_8 \text{hhsize}_i \\ &+ \beta_9 \text{citizen}_i + \sum \beta_{10} \text{curract}_i + \text{country}_i\end{aligned}$$

where the dependent variable is a binary indicator of whether an individual feels it is not at all likely or not likely that they would be able to access care. For each individual i, hlth is a categorical variable of self-reported health (very good, good, fair, bad, very bad), inc is a categorical level of income perceptions (living comfortably, coping, difficult to get by, very difficult to get by), educ is the number of full-time equivalent years of education, age is the respondent's age category (below 20, 20–29, 30–39, 40–49, 50–59, 60–69, 70–79, 80+), emp reflects employment volatility (a dummy variable signifying that the respondent has

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