Role of health and care services in improving well-being and economic performance:

Perspectives from the European Quality of Life Survey

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Summary

EU policy documents increasingly refer to the availability of good quality public services. These services contribute not only to meet needs for health and welfare, but also to provide essential support to enable people to participate effectively in society and the labour market.

This background paper highlights the persistent or hidden disparities seen at EU level in health and in health and care services (including disparities in service quality). Such disparities can be seen as evidence of a gap between current economies and the economy of well-being that could be possible; better knowledge of them can help improve focus of the policy measures.

This analysis has found that self-reported health improved after the Great Recession in the EU overall, but the extent of improvement was smaller for people in the lower half of the income scale. In particular, there was lack of improvement for the lowest income quartile on dimensions such as the risk of depression, the average quality ratings of public services, and perceived social exclusion. A number of findings pose particular challenges for policy:

- Well-being among the long-term unemployed is lower post-recession (2016) compared to 2011.
- The proportion of women in the lowest income quartile at risk of depression has remained consistently high – at 36%.
- There are persistent gender disparities in care responsibilities.

In order to improve quality in health and care services to alleviate aforementioned well-being imbalances, the following calls for consideration from the equity as well as economic point of view.

- The 'squeezed middle' in the income spectrum experiences a particular burden of healthcare costs, as well as costs of other care services.
- Some 11% of the EU population reported using emergency care over past year: this points to potential problems with accessibility of regular healthcare.
- Use of e-healthcare is limited in most Member States; by and large, much e-healthcare is used in relation to physical visits to the doctor, rather than as a replacement for such visits.
- There are persistent differences between income groups in the perceived quality of healthcare.
- A relatively high proportion of people do not feel adequately informed and consulted about their care; this proportion is higher among people on low incomes.
- A perceived lack of fairness in health and care services negatively impacts perceptions of the overall quality of these services. Policymakers should note that a lack of equal treatment and perceived corruption in health and care is not confined to solely a few Member States, as is sometimes believed.

Barriers to accessing health and care services, either real or perceived, can result in health inequalities and greater healthcare needs in the future. Improving access and quality of service requires that the aforementioned disparities be addressed, so that the 'well-being effect' can extend across the society. Better access and quality also demand a reflection on current policy concepts of unmet need and prevention, as well as grasping an understanding of fairness from the service users' point of view.

Introduction

EU policy discourse increasingly refers to the importance of good-quality public services to European citizens, especially evident in the case of the European Pillar of Social Rights. These services contribute not only to meeting needs for health and welfare, but also to providing essential support enabling people to participate effectively in society and employment.

This background paper provides some evidence on inequalities in health and healthcare. The World Health Organization (WHO) has recently underlined health equity as a key challenge for the WHO European Region – 'given the relevance of equity for health and well-being, and the relevance of healthy societies for sustainable development' (WHO 2019a, p.2); see also WHO 2019b). In particular, this background paper highlights areas of concern that may be critical for extending well-being across society and creating more opportunities to contribute to growth, which were the policy suggestions outlined in the paper *The Economy of Well-being*, from the Organisation for Economic Co-Operation and Development (OECD 2019).
To move current economies to a desired economy of well-being means addressing, through policy, the disparities in health, and in quality and accessibility of health and care services, that are described in this background paper.

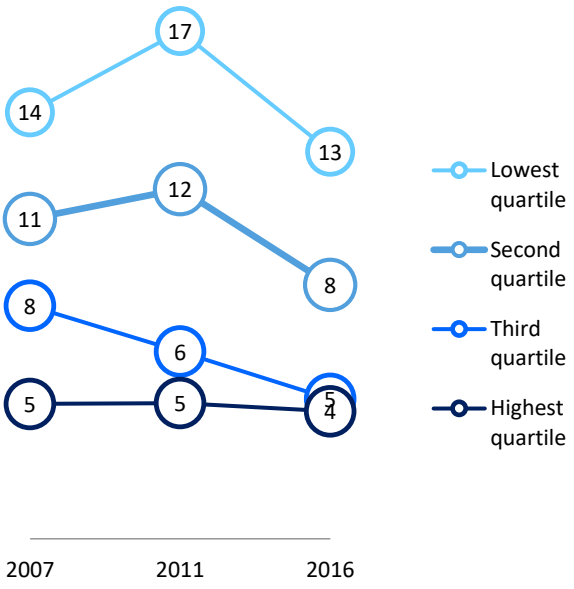
Shaping and implementing policy is inevitably linked to generating and distributing resources; the value-added of focusing on well-being perspective lies in the linking of health and well-being as both outcome and resource for resilience and for socioeconomic development.

The majority of the findings here are drawn from Eurofound reports based on the Agency's European Quality of Life Survey (for more information, see the References section).

Trends in self-reported health post-recession

Generally, there was a positive trend of improvement in self-reported health after the Great Recession and a decrease in the proportion of people reporting bad health across most income groups.

Figure 1. Proportion of people reporting bad health, by income quartile, 2007–2016 (%)



Regarding self-reported health, little changed for the highest income quartile between 2007 and 2016, with about 1 in 20 people reporting bad health. In the third quartile, self-reported health has continued to improve over the past decade, including over the period of the crisis. For the lowest quartile, in particular, developments have been more volatile. The proportion of people reporting bad health increased in 2011, but levels dropped in 2016 to reach levels lower than in 2007. However, a more positive development can be seen in the second quartile, where the proportion of people reporting bad health declined from 11% in 2007 to 8% in 2016.

Notes: EQLS 2016, Q48: In general, how is your health? 1. Very good; 2. Good; 3. Fair; 4. Bad; 5. Very bad'. Based on the responses 'bad' and 'very bad' health. EU28 data.

Inequalities in self-rated health and mental health

Next to income-related differences, other, sometimes subtle but important changes have taken place:

> *While the proportion of people reporting very good health has increased, there has also been a decrease in those reporting good health and an increase in those reporting fair health. This shift towards polarisation is an acute signal underlining the growing policy attention to health inequalities. (Eurofound 2017, p.103)*

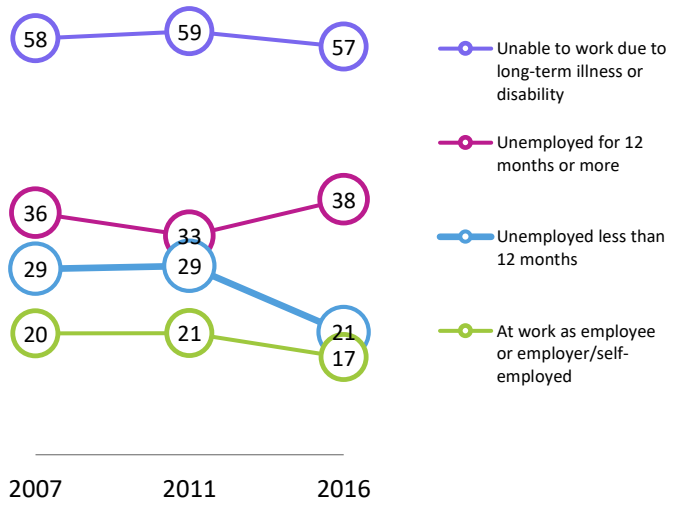
Unfortunately, the rising post-recession tide has not lifted the position of everyone equally:

> *The extent of improvement was either smaller for the two lower income quartiles or was lacking for the lowest income quartile on dimensions such as the risk of depression (for women in the lowest income quartile), the average quality ratings of public services, and the measure of perceived social exclusion. (Eurofound 2017, p.103).*

Negative outcomes of long-term unemployment

The EQLS 2016 revealed a range of negative outcomes from long-term unemployment that go beyond solely economic disadvantage. These include decreased trust in people and increased perception of social exclusion. Also apparent among the long-term unemployed is a deterioration in mental health – one considerably greater than that observed among the short-term unemployed. In addition to the need for systemic solutions in tackling long-term unemployment, these findings suggest the need for essential improvement in policies to assist people more generally if they are experiencing long-term unemployment. For the purposes of policy development, it is essential to carry out detailed analyses of the composition of the long-term unemployed; it is important also to take into account issues regarding 'labour market slack', changes in the inactive population, and the effectiveness of reactivation policies (Eurofound 2017, p.106). It should be acknowledged that the rates of long-term unemployment have effectively decreased since midway during the recession, and the composition of the long-term unemployed population may have changed (some people who were unemployed have since found jobs). However, the problems experienced by those in long-term unemployment are such that it is vital to re-assess how effective public services are in alleviating their situation.

Figure 2. Proportion of people at risk of depression for selected categories, 2007–2016 (%)



With regard to mental well-being, the EQLS asks several questions that can be used to construct an indicator of mental health, based on the WHO Mental Health Index (WHO-5). On a scale from 0 to 100, people with a WHO-5 score of 50 or lower are considered at risk of depression (Topp et al, 2015). While the WHO-5 assesses whether someone is at risk of depression rather than diagnosing actual depression, it is useful for comparing population groups.

Notes: EQLS 2016; EU28 data. Reproduced from Eurofound 2017, p.19.

Low-income women at persistent risk of poor mental health

Overall in 2016, some 22% of people in the EU were at risk of depression according to their score on the WHO-5 scale (down from 25% in 2011). The proportion of people at risk of depression is lower than in 2007 (when it was 24%), but over one in five of the population is still affected.

As in the case of self-reported health, income level is important. The proportion of people found to be at risk of depression in the top quartile is half of that in the bottom quartile: 16% compared to 32% (2016). There is an improvement across all income quartiles in 2016 compared with 2011, but this is especially the case with the second quartile, where the proportion of those at risk fell from 28% to 24%.

Women seem to be at risk of depression more often than men (20% compared with 18%). However, it has been argued that men systematically tend to under-report symptoms of depression more than women (Hunt et al, 2010). While the impact of the crisis and recovery can be seen in the varying rates among men and women overall, there is one exception: the proportion of women at risk of depression in the lowest quartile was at 36% repeatedly in 2007, 2011 and 2016 – consistently the highest among all groups by income quartile and sex.

Persistent gender disparities in care responsibilities

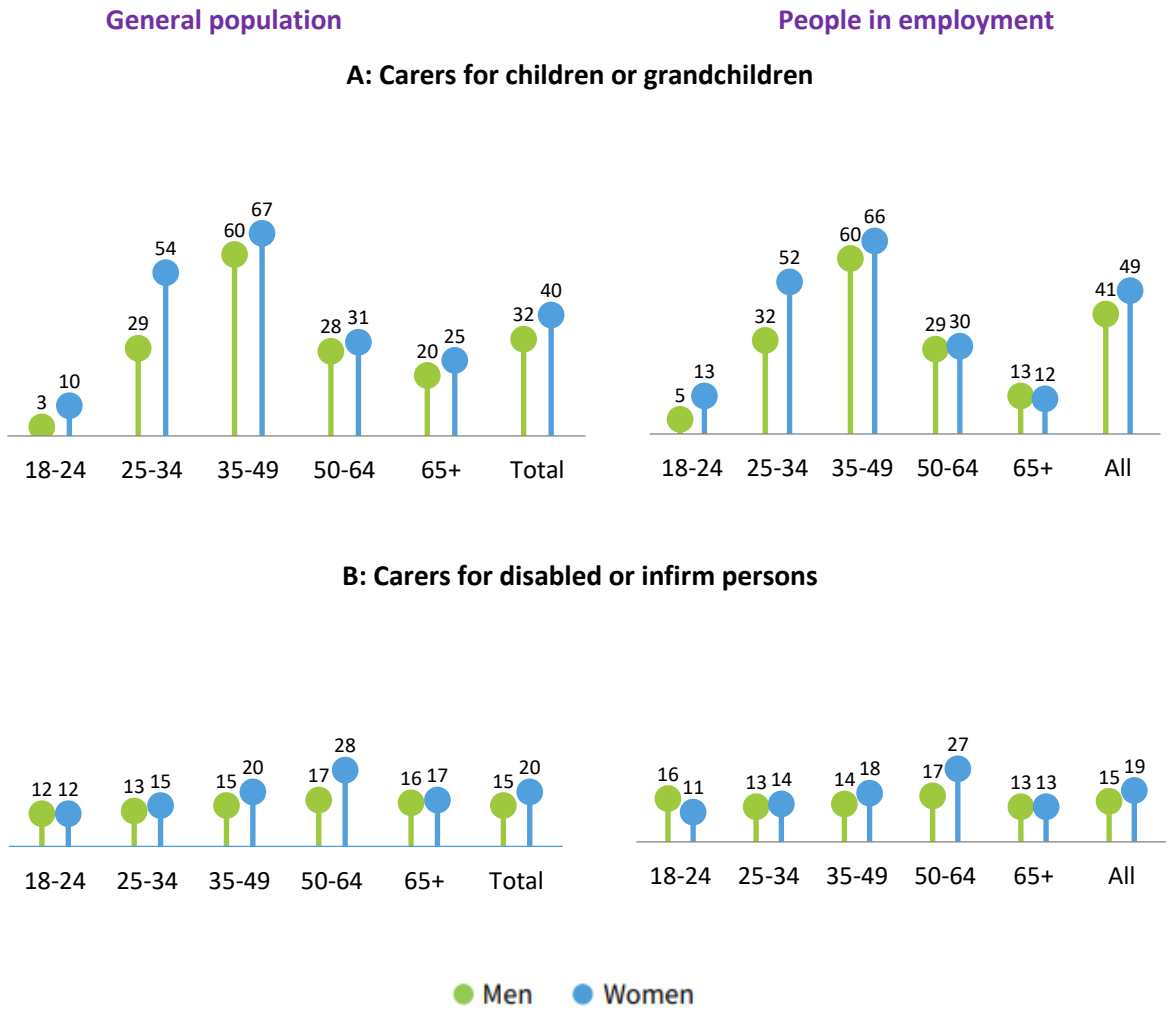
Care responsibilities naturally affect the work–life balance of those in the labour market. However, for some citizens, the burden of care is such that it may prevent them from entering employment or may force to discontinue or end their career. The risk of this is greater for women than for men (see gender disparities in Figure 3).

While work–life balance has improved for some groups of workers, in general it appears to have declined since 2011. This is especially the case for young and middle-aged women, as well as for workers in blue-collar jobs and those on fixed-term contracts (Eurofound 2017, p.102).
Women in the lowest income quartile present a particular example of a group experiencing a long-term disadvantage in different aspects of well-being:

> *This is a complex challenge that requires gender equality policies to be implemented alongside measures addressing other inequalities and the development of relevant services. This is related to a persistent feature of societies in the EU that a higher burden of unpaid household and care work is carried by women, even if this varies in degree. This set of complex interactions is illustrated by the experience of working age carers outside employment who are disadvantaged in relation to their health, income and social inclusion. (Eurofound 2017, p.103).*

The challenge for policymakers is to find ways to support informal carers and ex-carers, as well as to promote independent living (the basic activities of daily living).

Figure 3. Involvement in care at least once a week, by gender and age (%)



Notes: EQLS 2016; EU28 data. Reproduced from Eurofound 2017, p.43–44

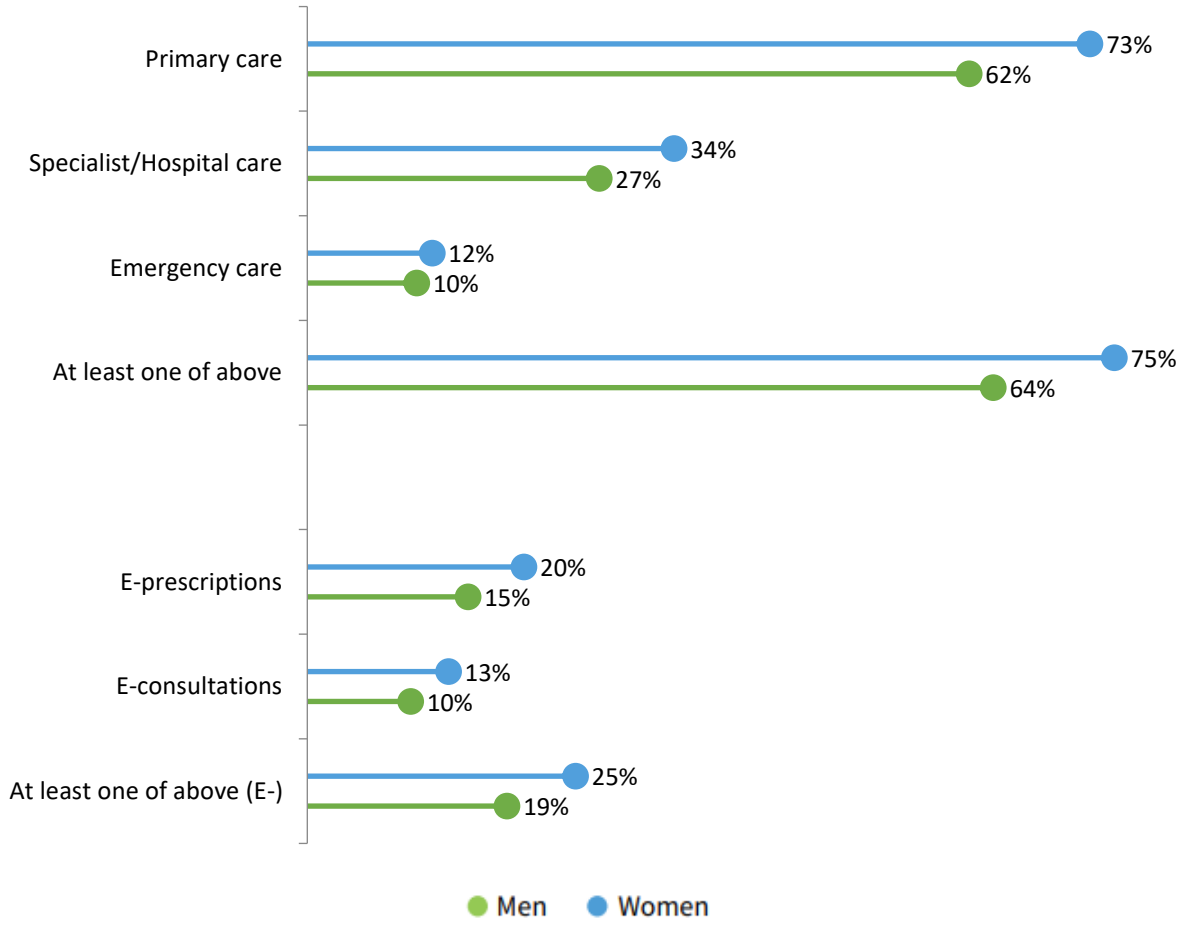
Financial burden of healthcare costs on middle-income citizens

By and large, people in the third-highest income quartile experienced the largest improvements in their quality of life after the recession (Eurofound 2017). However, in the case of health and long-term care services, a substantial proportion of people in the third quartile reported difficulties in accessing services due to cost. An assessment of financial barriers to accessing services should consider not only the groups with the lowest income, but also the 'twilight zones' in which people have incomes that are too high to enable them to benefit from public funding but too low to make services readily affordable.

Emergency care – signal of potential accessibility problems

Using emergency care when regular channels of accessing healthcare are limited was noted during the crisis, but a higher-than-expected usage was registered after the crisis too.

Figure 4. Use of healthcare services (last 12 months), EU28, 2016

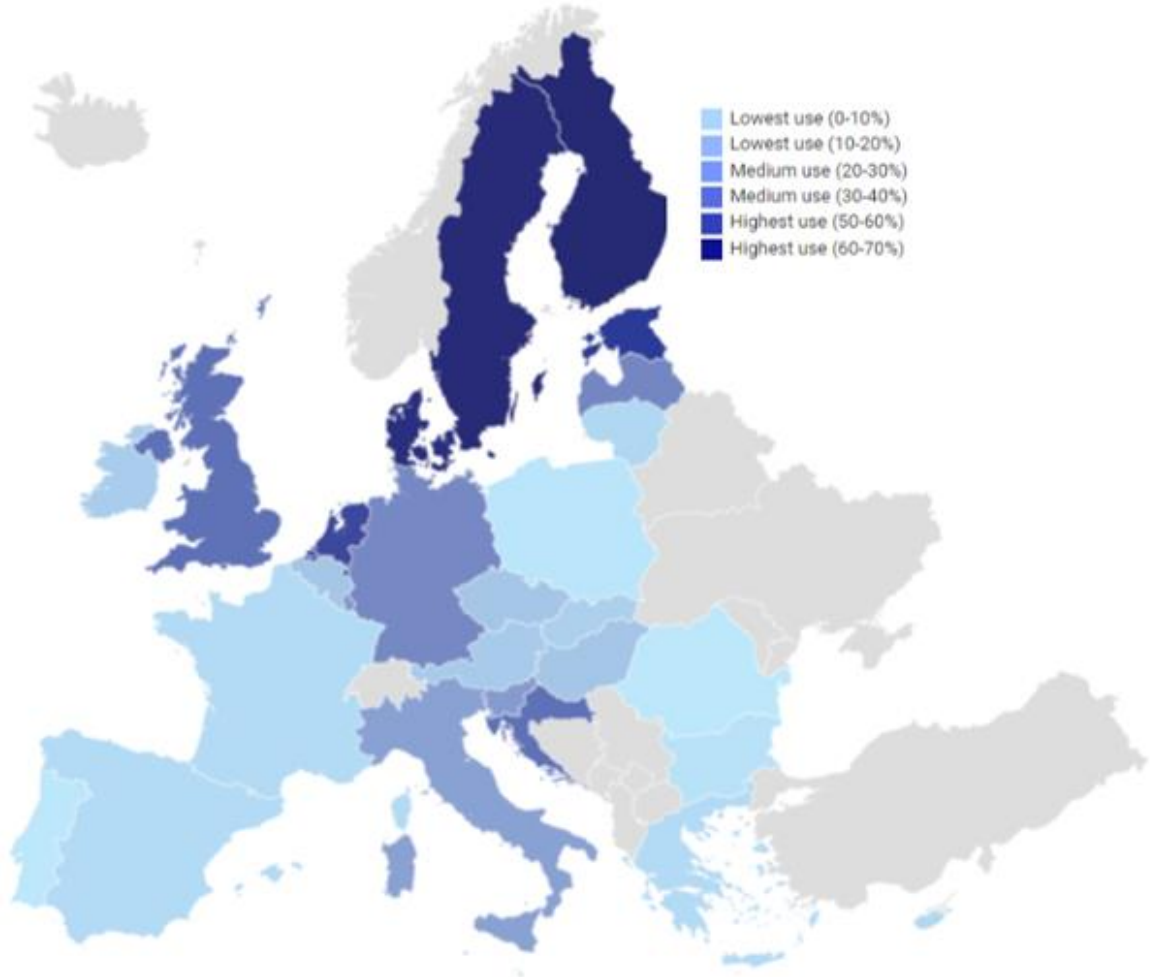


Source: EQLS 2016.

Limited use of e-healthcare among Member States

Regardless of the popular discourse on digitalisation, the use of e-healthcare is limited in the majority of Member States. There is a large gap between countries in terms of the prevalence of e-prescriptions and e-consultations. In particular, in those countries where e-healthcare is uncommon, it seems to be more widely used by higher-income groups and urban populations. Investment in effective e-healthcare is needed if Member States are to reap its potential benefits. E-consultations are rarer than e-prescriptions, and much e-healthcare seems to be related to physical visits to the doctor, rather than replacing such visits.

Figure 5. Use of e-healthcare in EU28, country, 2016

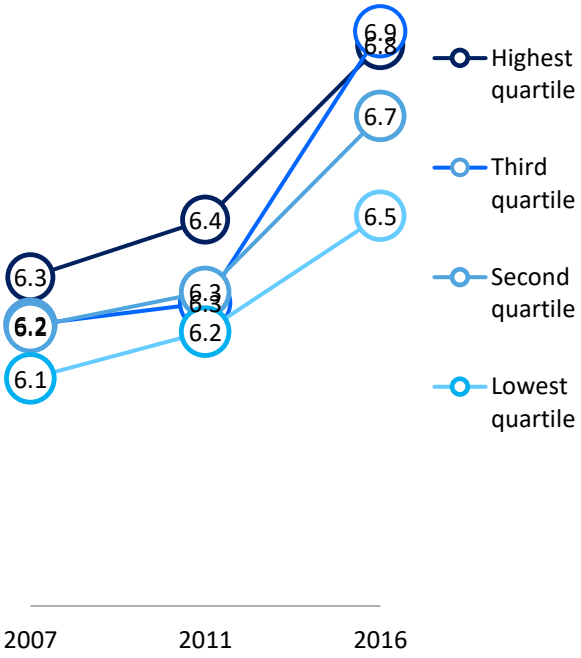


Notes: *Includes those who responded that they have used any or both these services themselves in last 12 months: Q60d 'Ordering prescriptions online or by telephone' and Q60e 'Medical consultation online or by telephone'.*

Source: EQLS 2016. Reproduced from Eurofound 2019a, p.26.

Growing differences between income groups in perceived quality of healthcare

Figure 6: Quality ratings of health services, by income quartile



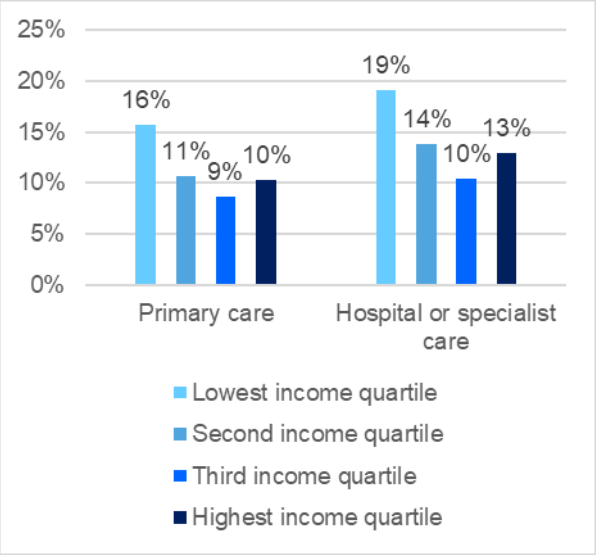
Notes: EQLS, Q58a: In general, how could you rate the quality of each of the following public services in [country]? - Health services. Please tell me on a scale of one to 10, where one means very poor quality and 10 means very high quality. EU28 data.

Of the four income quartiles, people in the lowest quartile consistently gave the quality of health services the lowest rating. Ratings increased in every edition of the EQLS for the lowest quartile – in 2007, 2011 and 2016 for lowest quartile; however 'it did so at a slower pace than for the other income quartiles. In 2007–2016, the bottom income quartile ratings of health services increased by 0.4 from 6.1 to 6.5, while other income groups increased by 0.5 (second and top income quartiles) or 0.6 (third income quartile). In 2016, the ratings had become highest for the third income group (6.9) with the top income group close behind (6.8).' (Eurofound 2019b, p.15)

Role of attention for clients in raising perceived quality of care

Giving clients time and attention, as well as keeping them informed about the care are important for the perception of quality in health and care. Giving such time and attention can be challenging in sectors already known to have high work intensity. However, if these 'softer' aspects of care are not addressed, quality in terms of the professionalism of staff is also perceived as lower.

Figure 7: Dissatisfaction with being informed or consulted about care: users of primary and hospital/specialist care, by income quartile, EU28, 2016



Notes: 'Dissatisfied' refers to people who rated their satisfaction with 5 or below in response to Q62: 'You mentioned that you used GP, family doctor or health centre services.' Q64: 'You mentioned that you used hospital or medical specialist services.' Both questions then read: 'On a scale of 1 to 10 where 1 means very dissatisfied and 10 means very satisfied, tell me how satisfied or dissatisfied you were with each of the following aspects the last time that you used the service'; 'd. Being informed or consulted about your care'.

Source: EQLS 2016. Reproduced from Eurofound 2019a, p.24.

Perceived lack of fairness negatively impacts overall perception of service quality

Policymakers should take into account that a perceived lack of equal treatment, and of corruption, is not limited to solely a few Member States.

The EU's policy priorities – both general (European Commission, 2013b) and more specific (European Commission, 2017c) – underline the importance of ensuring equality of opportunity and fairness in outcomes. Improved equality of access to key public services is fundamental to achieving the EU's highest policy goals. However, there are widespread concerns, since unequal practices and corruption have been documented in some EU Member States, as indicated by Transparency International (2017).

Table 1: Perceptions of fairness and corruption in healthcare, long-term care and childcare/school services, EU28

Fairness ('All people are treated equally in these services in my area')			Corruption ('Corruption is common in these services in my area')		
Highest	**EU28**	**Lowest**	**Highest**	**EU28**	**Lowest**
GP services					
Denmark **Austria** **Malta**	7.6	Cyprus Greece Slovakia	Romania Cyprus Greece	2.9	Denmark Sweden Netherlands
Hospital services					
Denmark Sweden Malta	7.3	Cyprus Greece Croatia	Greece Cyprus Romania	3.2	Denmark Sweden Finland
Long-term care					
Denmark Malta Sweden	7.1	Cyprus Greece Croatia	Romania Lithuania Hungary	3.2	Denmark Sweden Finland
Childcare					
Denmark Sweden Malta	7.7	Croatia Greece Italy	Romania Croatia Hungary	2.8	Sweden Denmark Finland
Schools					
Denmark Bulgaria Malta	7.6	Cyprus Croatia Italy	Romania Croatia Hungary	2.7	Sweden Denmark Finland

Notes: EQLS 2016, Q66, Q75, Q83, Q86: 'To what extent do you agree or disagree with the following statements about hospital or medical specialist [Q66]/ long-term care [Q75] / childcare [Q83]/ school [Q86] services in your area? Please tell me on a scale of 1 to 10, where 1 means "completely disagree" and 10 means "completely agree"'. Table 1 lists the countries with the three highest and the three lowest ratings. EU28 data.

The EQLS 2016 contained two questions to elicit perceptions regarding fairness in treatment and corruption, with regard to specific public services. The results demonstrate at least that the questions relate to opposing attitudes and that views are relatively consistent across the different services (Table 1).

On average, the perception that corruption is present in the respondents' area is greater for hospital services (a score of 3.2) than for GP services (2.9). It is higher among people in urban than in rural areas for both hospital services (3.3 compared with 3.0) and GP services (3.0 compared with 2.7). This pattern is relatively consistent across countries, except for Ireland, where it was higher in rural areas.

Pointers for reflection and action

1. Healthcare systems in the EU are often described as 'universal'. However, many people face barriers in accessing healthcare. By addressing them, policymakers can prevent care being postponed and hence unmet needs (which can result in health inequalities and greater healthcare needs in the future).
2. Some differences in service use seem related to certain services being easier to access rather than by being the most appropriate point of access. For instance, in some countries, emergency services are used more often by people in the bottom income quartile; this is possibly because such services are easier to access after-hours or at weekends, or because they do not charge or implement co-payments. Policymakers should seek to steer people to the most appropriate type of care and prevent the possible overuse of relatively expensive services – for instance, by further improving access to primary care on all dimensions.
3. It is important for policymakers not to underestimate the perceptions of unequal treatment and corruption in healthcare, which are clearly not confined to a small number of Member States. With their country-specific forms and causes, such perceptions do negatively impact on the perceived quality of primary care and specialist or hospital care.
4. Perceptions of unfairness, of unequal treatment and of corruption are prevalent in particular in urban areas and among people in the bottom half of the income scale. Policymakers should explore how these perceptions can be explained and seek to address their causes.
5. To improve user satisfaction, there is scope to pay more attention to better informing and consulting users about the care they receive. This particularly applies to hospital and specialist care, and to people in the bottom income quartile. Training of healthcare providers, and staff-guided use of information and communications technology to inform users accurately and efficiently, can contribute.
6. There is a large gap between Member States in the use of e-healthcare (the use of e-prescriptions and e-consultations). In particular, in those Member States where e-healthcare is uncommon, it is used more by higher-income groups and in urban areas. E-healthcare can make healthcare services more sustainable and can improve quality and access. For this to happen, its use needs to be stimulated in all but the few Member States where it is prevalent. Apart from the required information and communications technology infrastructure, also of central importance is the training and remuneration of the staff providing services, so that staff are encouraged to provide e-healthcare. These solutions to spanning distances have particular relevance for remote and rapidly ageing regions (as well as for the older population in general). They are also applicable for young people with both health and mental health challenges who are hard to reach, especially if they are in rural areas or are not in education, employment or training (Eurofound 2019c).
7. The potential for preventing of health and care problems is under-recognised. Prompt access to primary health care, social care and long-term care can stimulate early intervention, boost monitoring of ongoing needs and prevent a disproportionate concentration of problems in particular locations. Policymakers should look beyond the health(care) sector and its associated budget. For instance, more attention needs to be paid to the world of work, to more broadly sustain health and facilitate care needs and responsibilities. To promote health directly, a broad approach to prevention should cover the local areas where people live and work – from good-quality housing that can contribute to preventing mental and physical healthcare needs to healthy environments and healthy behaviours (Eurofound 2018).

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