Access to Medical Care Depending on the Employment Status and History of Unemployment in different welfare regimes and healthcare systems

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Abstract

Health inequalities between employed and unemployed have been widely studied and found that unemployed have systematically lower health status. Inequalities in access to health care depending on the employment status have not been studied that much. Different welfare regimes and health care systems both play their role as mediators between employment status and access to health care. Using the gradual approach of employment status between employed and unemployed, the group of employed was divided into those with the experience of unemployment and those without it.

In 2014 European Social had the special health inequalities block and it has been utilised in current study. European Social Survey data shows that employed with the experience of unemployment are in several countries more likely not to get medical consultation or treatment in case of need compared to the employed who have never been unemployed, whereas the last group often does not differ from unemployed. The worse access to medical care of the employed with unemployment history is associated with worse working conditions compared to those who have not been unemployed in Estonia, Great Britain, Ireland, Poland and Portugal. These countries have strict access restrictions on the primary level of health care and the Anglo-Saxon and the Eastern-European countries also have more liberal labour markets and that amplifies the differences between mentioned groups on the labour market.

Keywords: access to health care, impact of unemployment, health care systems, welfare state
Introduction

Unequal access to medical care is one of the factors that influence socioeconomic inequality in health. If people who have a disadvantaged position on the labour market, have also worse access to medical care, it leads to multidimensional accumulation of disadvantages. Virtanen et al. (2006) have found that there is rather gradual and not strict difference between employed and unemployed in terms of health care utilization, the marginal groups on the labour market (employees with fixed term contracts) are doing worse than employees with permanent contracts and the health care utilization is the lowest among unemployed. This article compares the access to medical care based on unmet need between different groups according to their unemployment experience (currently unemployed, employed with the experience of unemployment as a more marginal group on the labour market and employed with no previous unemployment experience).

The purpose of this article is to study how the position on the labour market is associated with the access to the medical care in case of need and how health care systems and welfare state types moderate this association.

Unemployment and health

The association between unemployment and worse health outcomes compared to the employed has been well documented. For example Bambra and Eikemo (2008) study the impact of unemployment in different welfare regimes. Unemployment had the most negative effect on women in Anglo-Saxon and Scandinavian regimes. Inequality between employed and unemployed was the greatest in Anglo-Saxon regime, but also for men in Bismarkian and women in Scandinavian regime, the smallest difference between employed and unemployed was among Southern women. In Anglo-Saxon countries there is the greatest income deprivation and stigmatisation (means tested benefits). In Bismarkian familial approach men
are more treated as breadwinners. The authors claim that in Scandinavia many women work part time and do not meet the benefits criteria and therefore there is much income inequality between working and not working women. The small differences in Southern regime can be explained by traditional family model and additional resources by the family. Long term unemployment has become a stronger predictor of healthy life years at the age of 50 in European countries between 2005 and 2010 (Fouweather et al. 2015).

Unemployment and the access to health care

Access to health care be measured based on health care utilisation as it is done very often or based on unmet need, which is individuals’ subjective assessment that they did not receive the needed health care (Allin, Grignon, and Le Grand 2010:465). EU-SILC 2004 data show that of the surveyd countries the highest unmet need was perceived in Sweden (13%), followed by Estonia (11%) and Italy (%) and the lowest proportion of people with unmet need was in Denmark (1%), Belgium and Austria (2% in both) (Koolman 2007:188). The same study shows that in the majority of surveyed countries the cost of the services has been hindrance for access (in Belgium, Greece, Estonia, France, Ireland, Italy and Portugal), waiting list has been the greatest problem in Spain, Finland and Sweden, having no time in Austria and care being too far in Norway (Koolman 2007:188). There is plenty of articles that establish the relationship between unemployment and worse access to health care in US. In US unemployed are often also uninsured and therefore have less access to healthcare (Driscoll and Bernstein 2012). There is only some research that studies the relationship between unemployment and access to healthcare in Europe. In macro
level increase of unemployment is connected to worse health outcomes in European Union
countries and the reasons assumed to be worse access to health care for the unemployed
(Maruthappu et al. 2016). In Greece, in 2013, the unemployed with chronic illness were more
likely to experience the economic, but also waiting lists access barrier to health care
(Kyriopoulos et al. 2014). A Swedish study shows that non-employed (people with no
employment income) have lower access to ACE Inhibitors (that reduce mortality and
morbidity from heart failure), even when other factors, including medical literacy are
controlled for (Ohlsson et al. 2016). The same study found that the impact of non-
employment to the choice of medical treatment is more important than material resources and
ability to access and understand medical information. Different treatment of the non-
employed might be associated with their lower status. It has also been found about underclass
in Canada, that they are stereotyped and treated differently than others in medical system
(Tang et al. 2015).

In terms of the utilisation of the mental care there are different results. Alonso et al. (2007)
and Gouwy, Christiaens, and Bracke (2008) have found that in case of mental health
problems, unemployed seek less often medical care than the employed. However, Buffel, van
de Straat, and Bracke (2015) have found that the unemployed use medical care more than
employed, even regardless of their mental health status.

A Finnish study (Virtanen et al. 2006) shows that the border between employed and
unemployed is not clear-cut. People at margins of the labour market differ from the people at
the core. Permanently employed differ from both, fixed term employed and unemployed in
terms of using dental care and primary care in case of cardiovascular, respiratory and
skeletomuscular disease, permanently employed visit the healthcare specialists most often,
followed by fixed term employed and the least amount of visits are made by unemployed and
the differences between these groups widened after controlling for need (Virtanen et al. 2006).
People have unemployment in their work history are not vulnerable only during that moment of unemployment, but unemployment has a “scarring” effect on their work career later and can have a negative cumulative outcome during their life course (Layte et al. 2000; Vandecasteele 2011). The long term negative effects of unemployment during the working career are lower salaries, more downwards mobility, less upwards mobility compared to the employed who have not experienced unemployment and also reoccurring unemployment episodes (Gangl 2006; Layte et al. 2000; McManus and DiPrete 2000; Vandecasteele 2011).

**Context: welfare state and health care system**

There is a very important mediator between the access to health care and employment status. It is the institutional context of the state. In this study, the 2 concepts have been chosen to explain the mediating role of the institutional context. These concepts are welfare state, labour market type and healthcare system type.

Welfare state has a direct effect to health outcomes but is also a mediator between labour market status, access to healthcare and health outcomes (Beckfield et al. 2015).

Studying social inequalities in health, several authors cluster countries in 5 welfare regime types: Scandinavian (Denmark, Finland, Norway, Sweden), Anglo-Saxon (UK and Ireland), Bismarckian (Germany, France, Austria, Belgium, the Netherlands), Southern (Greece, Italy, Portugal, Spain) and Eastern-European (Czech Republic, Estonia, Hungary, Poland, Slovenia, Slovakkia) (Bambra 2009; Bambra and Eikemo 2008; Bambra, Netuveli, and Eikemo 2010; Eikemo, Bambra, Joyce, et al. 2008; Eikemo, Bambra, Judge, et al. 2008; Eikemo, Huisman, et al. 2008). Scandinavian regime can be described by universalism, generous transfers, strong interventionist state and promotion of social equality through social security system; Anglo-
Saxon regime has modest social transfers and minimal level of provision and dominance of the market; Bismarckian regime is characterized by often earnings related benefits, administration through employer, the role of the family is emphasized and the role of the market marginalized; Southern welfare regime has strong reliance on family and only fragmented provision, health care system provides only limited and partial coverage; Eastern-European system includes post-socialist countries where there have been great reforms with direction of decentralization and liberalization since the beginning of 90s (Eikemo, Bamba, Joyce, et al. 2008).

Wendt (2014) divides European countries between 4 main types of healthcare systems. First type is described by high share of public financing, moderate level of out-of-pocket payments and very high access regulation. Australia, Denmark, Ireland, Italy, the UK, Czech Republic, Estonia, Hungary, Poland, the Slovak Republic, Slovenia and the Netherlands can be described by this type. The second type of healthcare systems have high share of public financing as well as out-of-pocket payments and high access regulation. The countries in this type are Finland, Iceland, Portugal, Spain and Sweden. The third type with Greece, Israel and Turkey can be described by low level of public financing and no control over patients access to medical care. The medical systems in the last group, Austria, Belgium, France, Germany, Luxembourg, have the highest share of public financing, the lowest share of out-of-pocket payments and free choice of medical doctors.

Based on this context, it can be hypothesised that first unemployment as a status might play a greater role in a system with strict gate keeping (like healthcare system types 1 and 2 by Wendt 2014), because might make their decisions based on the status of the patient and labour market status makes a contribution in general status. Second, it can be hypothesized, that unemployment in the past which leads to cumulative disadvantage on the labour market, plays a greater role in the Anglosaxon and Eastern-European welfare regimes, because less state
intervention leads to greater inequality on the labour market (for example less flexible working conditions, more job insecurity, working contract with no entitlement to health insurance coverage), which can be a hindrance accessing health care.

**Data and methods**

European Social Survey (ESS) where the sample are non-institutionalized persons 15 years old and older. In current study there is only active population (working and unemployed) and in the regression analysis only those who had need for medical treatment or consultation during last 12 months. In 2014 there was the special block on health inequalities in ESS. There was all together 15054 individuals in the analysis. The countries in the analysis were Austria (781 individuals), Belgium (728), Switzerland (671), Czech Republic (664), Germany (1429), Denmark (625), Estonia (785), Spain (855), Finland (851), France (840), Great Britain (829), Hungary (420), Ireland (617), Lithuania (696), The Netherlands (662), Norway (627), Poland (571), Portugal (517), Sweden (616), Slovenia (405).

The dependent variable in the regression analysis measures whether the respondent was able to get or was not able to get medical consultation or treatment in case of need. The central independent variable of interest was labour market status connected to unemployment (unemployed, currently employed, who have been unemployed and as a reference category, employed who have never been unemployed).

To further study the wider relationship with labour market, there are some characteristics of the working conditions in the analysis: the type of the contract (permanent as reference, compared to fixed and no contract), total working hours normally per week and work autonomy (to what extent allowed to decide, how daily work is organized, on the scale 0-10).
The control variables on the regression models were age, gender, marital status, children at home, place of residence, ethnic minority, migration background, citizen of country (except in Czech Republic, Hungary and Poland due to lack of variation), life satisfaction, subjective health, hampered in daily life, assessment of current household income.

**Results**

The proportion of the respondents with met and unmet need varies country by country as can be seen in Graph 1. Only 5% of respondents in the Netherlands felt that they needed medical consultation or treatment, but did not get it, followed by 5% in Austria and Hungary. At the same time almost a fourth of the respondents in Poland and around a fifth of the respondents in Finland, France, Portugal and Estonia perceived the need for medical consultation or treatment, but did not receive it.

![Graph 1. Met and unmet needs by country](image-url)
The proportion of respondents with unmet need is broken down by the position on the labour market on the graph 2.

In France clearly unemployed are the most disadvantaged in terms of getting medical consultation or treatment, when needed, half of them did not receive it. Also in Finland, like in France, the unemployed are the most disadvantaged. However in several countries (like Great Britain, Portugal, Poland, Norway, Lithuania etc) working people with the history of unemployment are the most disadvantaged one in terms of the access to the health care.

Table 1 presents the results of the regression analysis.
Table 1. Logistic regression predicting not getting medical consultation or treatment in case of need.

<table>
<thead>
<tr>
<th>Country</th>
<th>Employment status</th>
<th>Working conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unemployed</td>
<td>Employed,</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Sig</td>
</tr>
<tr>
<td>Austria</td>
<td>-0.02</td>
<td>0.28</td>
</tr>
<tr>
<td>Belgium</td>
<td>0.29</td>
<td>0.57 *</td>
</tr>
<tr>
<td>Switzerland</td>
<td>0.35</td>
<td>1.37 ***</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>-0.33</td>
<td>0.42</td>
</tr>
<tr>
<td>Germany</td>
<td>-0.48</td>
<td>0.08</td>
</tr>
<tr>
<td>Denmark</td>
<td>-0.42</td>
<td>0.24</td>
</tr>
<tr>
<td>Estonia</td>
<td>0.32</td>
<td>0.39 *</td>
</tr>
<tr>
<td>Spain</td>
<td>-0.21</td>
<td>0.04</td>
</tr>
<tr>
<td>Finland</td>
<td>0.14</td>
<td>0.05</td>
</tr>
<tr>
<td>France</td>
<td>0.79 **</td>
<td>-0.03</td>
</tr>
<tr>
<td>Great Britain</td>
<td>-0.95 *</td>
<td>0.47 *</td>
</tr>
<tr>
<td>Hungary</td>
<td>0.28</td>
<td>0.26</td>
</tr>
<tr>
<td>Ireland</td>
<td>-0.34</td>
<td>0.64</td>
</tr>
<tr>
<td>Lithuania</td>
<td>-1.40 *</td>
<td>0.00</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>-0.78</td>
<td>0.52</td>
</tr>
<tr>
<td>Norway</td>
<td>-0.6</td>
<td>0.39</td>
</tr>
<tr>
<td>Poland</td>
<td>-0.04</td>
<td>0.39 *</td>
</tr>
<tr>
<td>Portugal</td>
<td>0.65 *</td>
<td>1.23 ***</td>
</tr>
</tbody>
</table>
Table 1 shows that in France and Portugal, unemployed have better access to medical care than employed who have never been unemployed, but in Lithuania unemployed are disadvantaged in terms of access to the health care. In Belgium, Estonia, Great Britain, Ireland, Poland and Portugal, employed with unemployment history were more likely not getting medical consultation or treatment in case of need, but this association looses statistical significance after adding working conditions to the model. In case of Portugal having been unemployed still significantly predicts no access to medical care in case of need, but the coefficient is somewhat reduced. Adding working conditions to the model does not influence the association between unmet need and unemployment background in Switzerland. The concrete working conditions seem to have different influence on the relationship between access and employment status in different countries.

**Discussion and conclusions**

Although in the Bismarkian system, the labour market based entitlement to heal care insurance is more expected, the analysis shows that of the Bismarkian countries, only in France the unemployed are much more likely to get no medical consultation or treatment in case of need.
Following Virtanen et al. (2006) and dividing the employed into groups, has showed some important differences between the employed with and without the experience of unemployment. The employed with the history of unemployment differed in terms of access to the health care from the employed who had never been unemployed in Belgium, Switzerland, Estonia, Great Britain, Ireland, Poland and Portugal. In all of these countries other than Switzerland, difference in working conditions was behind the difference between employed with and without the experience of unemployment. Going back to the healthcare system types described by Wendt (2014), all these countries other than Belgium are in types 1 (Estonia, Great Britain, Ireland, Portugal, Poland) and 2 (Portugal) according to Wendt 2014 in both of these clusters there is high access regulation.

Gatekeepers can play a role in two ways. First they can be influenced by the unemployment as a status. The research of Ohlsson et al. (2016) and Buffel et al. (2015) has shown that unemployment works in medical system as low status compared to employed. Second, people with the history of unemployment might also possess different characteristics than people without that experience and these characteristics might play an important role getting through and around the gatekeepers.

Working conditions play also a role in enabling or disabling access to needed medical care. First people with less autonomy, higher work strain and longer working hours may encounter more difficulties to get time off for doctor’s appointment. Also people with the history of unemployment and temporary or no contract might feel less job security and therefore are more hesitant to take time off of work for the doctor’s appointment and they also might be more reluctant to indicate their health problems, not to be seen as less productive due to health issues. The more liberal and less regulated labour markets in Eastern European and Anglo-Saxon countries is likely to amplify the inequality of working conditions between the workers with and without the experience of unemployment.
References


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