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26 Forgone visits to the doctor due to cost or lengthy waiting time among older adults in Europe

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- ▶ Close to five per cent of older Europeans forwent a visit to the doctor in the previous year due to its cost
 - ▶ More than six per cent did without such visits because of lengthy waiting time
 - ▶ Forgone healthcare is related to one's sociodemographic background, social networks, health and financial situation
 - ▶ Forgone healthcare is related, first and foremost, to having limited financial means
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26.1 The healthcare funding problem

Social exclusion is a process by which individuals or entire communities are systematically blocked from rights, opportunities and resources that are normally available to members of society and which are necessary for their well-being. Healthcare is one of the main pillars of well-being. In international law, healthcare is a basic entitlement that is defined as the right of all individuals and members of their households to a standard of living that suffices to assure their health and welfare, including essential medical care and security in the event of illness. Violation of this entitlement is, in essence, social exclusion. The age-related increase in morbidity and the rising price of available medical care may cause more and more households to relinquish needed healthcare (OECD 2014). The current chapter examines the extent and the correlates of forgone healthcare by older adults, as one example of healthcare-related social exclusion.

The healthcare system is funded by two sources: public and private (out-of-pocket). Public funding is comprised of all sources that originate in the state budget and/or stem from earmarked taxation, including health insurance premiums. Private funding is household expenditure for the purchase of healthcare services, whether covered by public health insurance or not (Bremer 2014). Healthcare systems that are largely publicly funded are central in all welfare states, and the expenditures on them increase with each passing year (Hacker 2004). A healthcare system that is exclusively publicly funded is susceptible to a moral hazard, that is, a situation in which some people take more risks because others bear the burden of those risks. It may also impose an excessive burden on the tax-

payers, as well as constituting a disincentive to family support of elders who need long-term care (Mayhew et al. 2010). In contrast, a healthcare system that relies solely on private funding may marginalise socioeconomically challenged population groups. Such systems tend to widen the disparities in health, in general, and in the access to healthcare services, in particular. They also may erode human capital, an important factor in economic growth (O'Donnell et al. 2007).

According to De Nardi et al. (2010), out-of-pocket (OOP) medical expenses rise in tandem with age. In an analysis based on the American Health and Retirement Study (HRS), McGarry and Schoeni (2005) found that out-of-pocket spending is especially large toward the end of life and claims a particularly large share of income among older persons with low-incomes. According to Goda et al. (2011), the extent of out-of-pocket expenditure increases by 29 per cent, on average, after one is widowed, and much of this outlay accrues to home nursing care.

It should also be noted that morbidity rates rise with age (Kavé 2014). Moreover, elders' consumption of healthcare services is unique in the kinds of illnesses diagnosed and the level of expenditure required due to the frequency of need for prolonged medical and inpatient care. According to Cavanaugh and Blanchard-Fields (2011), the incidence of chronic illnesses rises with age, recovery is uncommon, and the illnesses are often accompanied by functional disabilities.

Forgone care is related to variables in four key areas: sociodemographic background, social network, health and economics. In terms of background, forgone care differs by age, gender and education (Wei et al. 2006). Individuals may also decide whether or not to continue treatments that they should be receiving depending upon their perceptions of the informal support that they may have access to, i.e. their social networks (Diamant et al. 2004). Health is also related; for example, people with multiple morbidities may forgo part of the prescribed treatments (Piette et al. 2004). Finally, the economic burden of OOP medical expenditures may be crucial in the decision as to whether or not to continue making the expenditure (Litwin & Sapir 2009).

Two key reasons for forgone healthcare are cost and waiting time. Difference in OOP payments and the proportion of one's income devoted to OOP payments may lead to cost induced relinquishment of healthcare services. In addition, the increasing demand for medical care that accompanies population aging, along with a lack of growth in the supply of healthcare, may result in longer waiting times for receipt of needed services. Long waiting time may also encourage older adults to relinquish needed care.

26.2 How forgone doctor visits were studied

The research that is at the core of this chapter is based on data from the 5th wave of SHARE among all respondents aged 50+, and focuses on two questions that directly address the issue of forgoing care: “Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?” (HC114) and “Was there a time in the past 12 months when you needed to see a doctor but could not because you had to wait too long?” (HC115).

Independent variables in the analysis reflected the four key groupings that were addressed in the Introduction: sociodemographic background, social networks, health and economics. The sociodemographic variables include age, gender and education. The social network characteristics include marital status, household size, child contact, presence or non-presence of grandchildren, and social network support. We note that the “social network support” variable has two values as follows: (1) “received social network support” reflects if the individual reports having received, in the past twelve months, some form of assistance from a family member/friend/neighbour or a material gift or some form of support from any person in or out of the household; (0) “did not receive social network support” reflects no such assistance.

The *health* variables include several indicators: difficulties in Activities of Daily Living (ADL), difficulties in Instrumental Activities of Daily Living (IADL), mobility limitations, chronic illnesses, and number of medical symptoms. The variable “supplementary health insurance status”, represents whether the respondent has auxiliary health insurance that pays for services not covered by basic health insurance, for example in-patient services, examination, visits, dental care, other treatments, and/or drugs. Two measures of quality of life were also addressed as health indicators: the CASP index and a global measure of life satisfaction. The *economic* variables addressed were as follows: work status, total household income (on a quartile distribution basis) and the extent of the household’s perceived ability to meet its economic needs (“make ends meet”).

Separate models were estimated for each outcome: forgone care due to cost and forgone care due to waiting time. The country variable was controlled in estimating each set of correlations. The main results of the respective models are shown in Figures 26.2–26.5. Each figure presents the odds ratios of significant variables that are related to the likelihood of postponing meeting with a doctor due to cost or the need to wait.

26.3 What explains forgone doctor visits?

An initial analysis of the observations shows that 4.5 per cent of respondents aged 50+ forwent a visit to the doctor in the twelve months preceding the survey due to its cost. The phenomenon was hardly evident in Denmark, Sweden, the Netherlands, Switzerland, Slovenia and Austria, in which the rate of affirmative responses ranged from 0.4 per cent to 1.5 per cent. In contrast, a relatively higher proportion of those aged 50+ in Israel, Italy and Estonia reported having had to forgo a visit to the doctor due to its cost (Figure 26.1). Furthermore, a gender disparity was found in relation to such forgone doctor visits; women were 50 per cent more inclined to forgo care for this reason than men (5.3 per cent vs. 3.5 per cent, respectively).

As for doctor visits that are forgone because of lengthy waiting time, it was found that 6.4 per cent of those aged 50+ did without such visits for this reason in the year preceding the survey. The phenomenon was rare among older adults in the Netherlands and Switzerland (0.8 % on average) and relatively more frequent among those in Israel, Italy, and Estonia, who reported average rates of 13.1–19.1 per cent, respectively (Figure 26.1). Here too, a gender disparity was found, with women 33 per cent more likely to forgo care than men due to waiting time (7.2 per cent vs. 5.5 per cent, respectively).

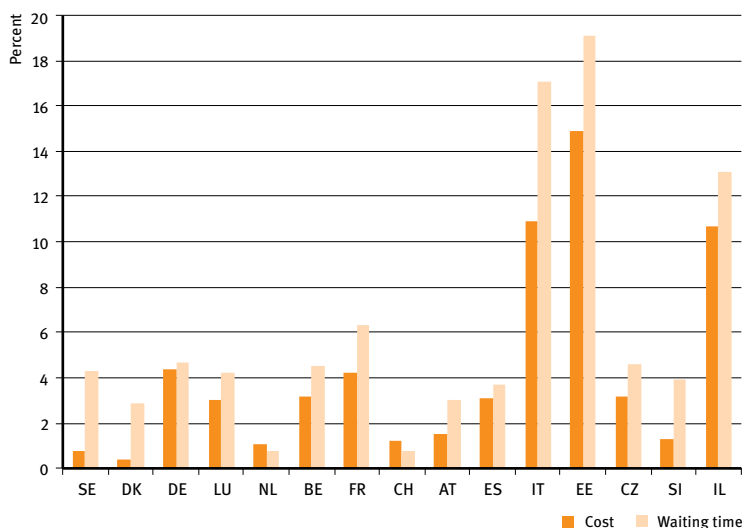


Figure 26.1: Forgone healthcare – postponing meeting with a doctor due to cost or need to wait – by country (per cent)

Notes: n = 46,327 (cost), 46,331 (waiting)

Source: SHARE Wave 5 release 0

In general, among all older Europeans who forwent a visit to the doctor, some 30 per cent did so because of cost, 51 per cent due to waiting time, and the remainder (slightly less than a fifth) for both reasons. These results are consistent with findings from an OECD investigation of the proportion of persons who forwent a medical examination due to cost, waiting time, or travel distance (OECD 2011 & 2014). We note in this regard, however, that the OECD findings relate to the population at large, whereas the current SHARE findings pertain solely to the extent of forgone care among older adults (50+).

We turn next to the multivariate analysis of forgone care. In regard to forgone visits to a doctor due to cost, the econometric analysis showed that older-old adults were less likely to have this outcome than their younger-old counterparts (Figure 26.2). Men were less likely than women to forgo a visit to the doctor due to its cost, while education was found to be unrelated. Married people were less likely than those who did not live with a spouse to forgo a visit to the doctor due to its cost (Figure 26.3). Household size and the presence of grandchildren were positively related to forgone doctor visits. Social network support was found to lessen the likelihood of older adults to forgo a visit to the doctor on the grounds of its cost.

As for the effect of the health indicators, the results were uneven (Figure 26.4). The number of chronic illnesses, symptoms and medical constraints strengthened the likelihood to forgo a visit to the doctor while IADL limitations weakened it. In addition, having supplementary health insurance, greater satisfaction with life, and higher CASP scores mitigated the likelihood of avoiding the doctor due to its cost. Participation in the labour force was related to more missed doctor visits, while generally greater income and greater perceived household ability to meet economic needs decreased this tendency (Figure 26.5).

Gender comparison of these same independent variables in relation to forgoing a doctor visit due to its cost yields some additional insights (not shown in figures). The forgone visits rise commensurately with years of education among men, but not among women. Having weekly contact with one's child reduces the likelihood of forgoing among men, while the presence of grandchildren strengthens older women's likelihood to forgo a doctor visit because of cost. IADL limitations weakened the likelihood to forgo a visit among women, while a higher number of medical constraints among women increased their predisposition to forgo. The likelihood of avoiding the doctor was greater among employed men compared to employed women, while greater income dampened men's tendency to forgo a visit to the doctor on account of its cost.

Next we examine the correlates of forgone visits to the doctor because of lengthy waiting time. We found that forgone care for this reason increased along with years of education (Figure 26.2). In addition, older adults with social

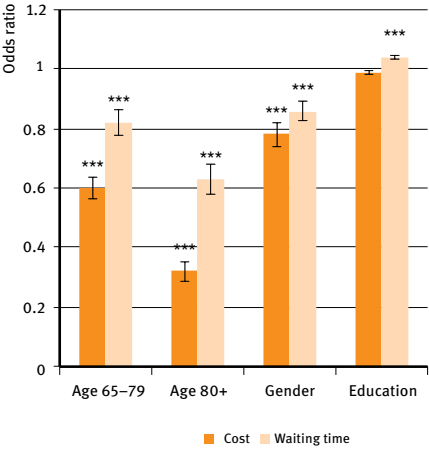


Figure 26.2: Likelihood of postponing meeting with a doctor due to cost or need to wait – by sociodemographic factors

Significance: * = 10 %; ** = 5 %; *** = 1 %

Notes: n = 46,327 (cost), 46,331 (waiting); odds ratios and standard errors; age (reference group: age 50–64); gender (female=0, male=1); education (number of years of education, range 0–25)

Source: SHARE Wave 5 release 0

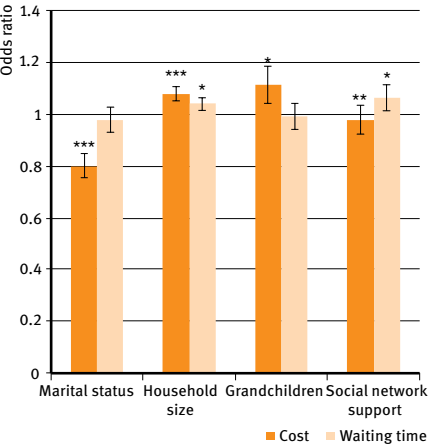


Figure 26.3: Likelihood of postponing meeting with a doctor due to cost or need to wait – by social factors

Significance: * = 10 %; ** = 5 %; *** = 1 %

Notes: n = 46,327 (cost), 46,331 (waiting); odds ratios and standard errors; marital status (0=no spouse, 1=spouse); household size (number of members living at household, range 1–12); grandchildren (0=no grandchildren, 1=having grandchildren); social network support (0= received social network support, 1=not received social network support)

Source: SHARE Wave 5 release 0

network support were more likely to refrain from seeing the doctor due to long waiting time (Figure 26.3). As for the effect of the health indicators, having supplementary health insurance increased the likelihood of avoiding the doctor due to long waiting time (Figure 26.4). Household income had the same effect (Figure 26.5).

Gender comparison (also not seen in figures) shows that women aged 65–79 were less likely to forgo a visit to the doctor due to lengthy waiting time than men in the same age bracket. In addition, household size strengthened older male’s likelihood to forgo a visit to the doctor. This same outcome increased with ADL among women (not shown in the figure), while IADL weakened it. In addition, an increase in women’s income mitigated the likelihood of forgone care due to waiting time, while there was no significant effect among older males.

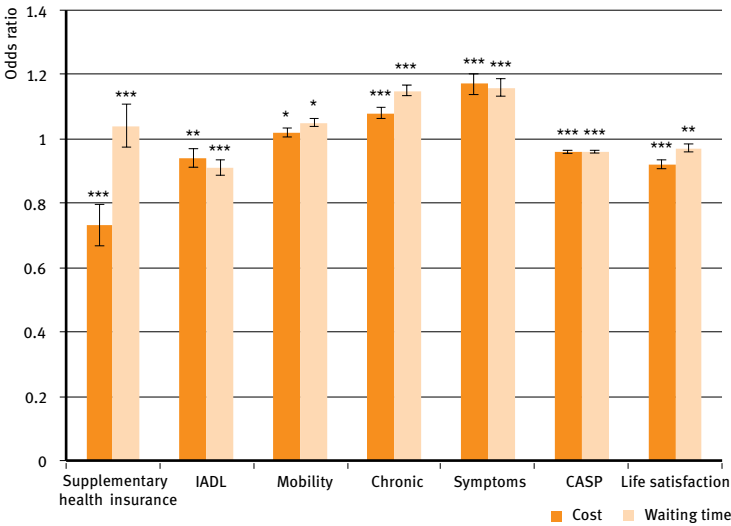


Figure 26.4: Likelihood of postponing meeting with a doctor due to cost or need to wait – by health and quality of life factors

Significance: * = 10 %; ** = 5 %; *** = 1 %

Notes: n = 46,327 (cost), 46,331 (waiting); odds ratios and standard errors; supplementary health insurance (0=not having supplementary health insurance, 1=having supplementary health insurance); IADL (number of difficulties in Instrumental Activities of Daily Living, range 0–7); mobility (number of mobility limitations, range 0–10); chronic (number of chronic diseases, range 0–14); symptoms (number of medical symptoms, range 0–4); CASP (CASP index, range 12–48); life satisfaction (range 0–10)

Source: SHARE Wave 5 release 0

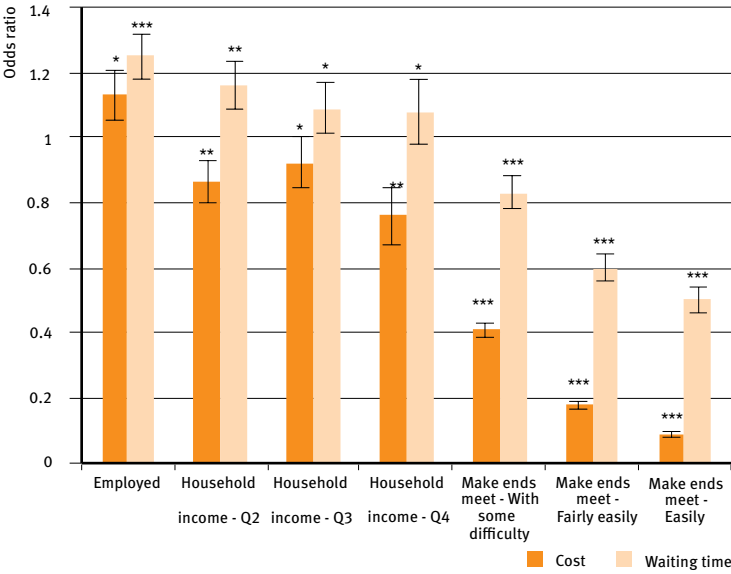


Figure 26.5: Likelihood of postponing meeting with a doctor due to cost or need to wait – by economic factors

Significance: * = 10 %; ** = 5 %; *** = 1 %

Notes: n = 46,327 (cost), 46,331 (waiting); odds ratios and standard errors; employed (0=not employed, 1=employed), house income (reference group: quartile 1); makes ends meet (reference group: with great difficulty)

Source: SHARE Wave 5 release 0

26.4 Forgone doctor visits and exclusion

The importance of medical care for the older adult population is undisputed. Some aspects of healthcare are entrusted to government-budgeted healthcare systems; others rest in the hands of the individual. With the increase in life expectancy and the decline in the proportion of publicly funded types of care, it is important to understand the proportion of the older European population that is currently excluded from receiving a needed health treatment – meeting and consulting with a doctor – and to understand the social and economic correlates of such exclusion.

The findings in this chapter show that four key grouping of indicators are related to the propensity to forgo a visit to the doctor due to cost or waiting time – sociodemographic background, social networks, health and economics. Each indicator has a marginal effect on the individual's predisposition; together,

however, they create a complex and detailed web of considerations that motivate people over time. As this chapter shows, the tendency to forgo doctor visits is related to a variety of factors.

The main finding showed that generally greater income lessened the likelihood of avoiding a doctor visit due to its cost. In addition, greater perceived household ability to meet economic needs lessened forgone doctor visits due to both cost and waiting time. These outcomes reinforce the proposition that wealthier individuals tend to be risk-averse and more willing to broaden the span of healthcare services that they access in order to optimise their health security. Moreover, the objective income variable (household income) had almost twice the effect on the likelihood of forgoing a physician visit than that attributed to the subjective income variable, that is, the perceived ability of the household ability to make ends meet. It seems, therefore, that forgone healthcare is indeed related to having limited financial means.

If the goal of public policy is to promote the social inclusion of all older adults within the fabric of society, efforts should be made to prevent their need to forgo healthcare, an act that essentially augments their exclusion from social life. This is because good physical and mental health facilitate active aging and social inclusion. In contrast, failure to maintain good physical and mental health in older age challenges the ability of older people to take part in the larger social sphere. A key means by which to prevent forgone care, as this chapter illustrates, is to promote better income security among the older population.

References

- Bremer, Patrick (2014): "Forgone care and financial burden due to out-of-pocket payments within the German health care system". In: *Health Economics Review* 4. No.36, p. 36–44.
- Cavanaugh, John, Blanchard-Fields, Freda (2011): *Adult development and aging*. 6th edition, Belmont, CA: Wadsworth.
- De Nardi, Mariacristina, French, Eric, Jones, John Bailey (2010): "Why do the elderly save? The role of medical expenses". In: *Journal of Political Economy* 118. No.1, p. 39–75.
- Diamant, Allison, Hays, Ron, Morales, Leo, Ford, Wesley, Calmes, Daphne, Asch, Steven, Gelberg, Lillian (2004): "Delays and unmet need for health care among adult primary care patients in a restructured urban public health system". In: *Journal Information* 94. No.5, p. 783–789.
- Goda, Gopi Shah, Shoven, John, Slavov, Sita Nataraj (2011): "Does widowhood explain gender differences in out-of-pocket medical spending among the elderly?". In: *NBER Working Paper* 17440. Cambridge, MA: National Bureau of Economic Research.
- Hacker, Jacob (2004): "Review article: dismantling the health care state? Political institutions, public policies and the comparative politics of health reform". In: *British Journal of Political Science* 34. No.4, p. 693–724.

- Kavé, Gitit (2014): *Psychology of aging and old age: a textbook and study guide*. Raanana, Israel: The Open University (in Hebrew).
- Litwin, Howard, Sapir, Eliyahu (2009): "Forgone health care due to cost among older adults in European countries and in Israel". In: *European Journal of Ageing* 6. No.3, p. 167–176.
- Mayhew, Les, Karlsson, Martin, Rickayzen, Ben (2010): "The role of private finance in paying for long term care". In: *Economic Journal* 120. No.548, p. 478–504.
- McGarry, Kathleen, Schoeni, Robert (2005): "Widow(er) poverty and out-of-pocket medical expenditures near the end of life". In: *Journal of Gerontology* 60. No.3, p. 160–168.
- OECD (2011): *Health at a Glance 2011 – OECD Indicators*. OECD Publishing.
- OECD (2014): *Health at a Glance 2014: Europe 2014*. OECD Publishing.
- O'Donnell, Owen, Van Doorslaer, Eddy, Zhao, Yuxin (2007): "The incidence of public spending on healthcare: comparative evidence from Asia". In: *The World Bank Economic Review* 21. No.1, p. 93–123.
- Piette, John, Heisler, Michele, Wagner, Todd (2004): "Cost-related medication underuse among chronically ill adults: the treatments people forgo, how often, and who is at risk". In: *American Journal of Public Health* 94. No.10, p. 1782–1787.
- Wei, Wenhui, Akincigil, Ayse, Crystal, Stephen, Sambamoorthi, Usha (2006): "Gender differences in out of-pocket prescription drug expenditures among the elderly". In: *Research on Aging* 28, p. 427–453.