

European Social Survey Round 2 module proposal.

Health and Care Seeking in a changing Europe.

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An important feature of all European societies is that governments provide for the health care of their citizens. Europe is very different from the US in this respect. The level of provision however varies widely between European countries. On the one hand there are systems like in the UK that operate at low cost, but result in long waiting lists. On the other hand there are costly systems (as measured in % of GDP expenditure) like in Germany, Switzerland and France, which often provide more treatment than would be necessary on rational grounds. Governments in Eastern Europe are in the process of restructuring their health care systems, decentralising the soviet style (polyclinic) system and putting emphasis on primary health care and GPs in a gate-keeping role, while at the same time introducing market mechanisms and economic incentives. The public funds dedicated to health care are limited in these countries, resulting in low wages for health care professionals and high co-payments (or under the table payments) for patients.

The extent of the national health care provisions may have an influence on how individuals in these countries define their health and may also influence their attitudes towards care seeking. One would expect high aspirations regarding health (WHO definition) and high expectations regarding care in countries with systems with abundant supply and generous social security. This phenomenon has been referred to as 'medicalisation' (Moynihan, Smith, 2002). Alternatively, health concepts that are instrumental 'good health is being able to function or work' and reliance on self-care are to be expected in countries where only a basic level of care is provided. It should be noted however that these opinions are by no means determined by features of the health care system alone but may stem from deeply rooted and culturally determined views. Alternatively, the shape of the system itself may be the expression of values dominant in a particular society.

Our proposal would aim at providing data with which to map the interrelationships between structure and culture regarding the topic of health and care seeking. In addition, when one conceives the 2004 survey as a baseline measurement, a replication of the survey in, say, 2009 would offer the possibility of charting the results of changing institutions in East and West and how these impinge on health concepts and help seeking attitudes. Generally, it is expected that in the West the accessibility to services will become more restricted, due to rising costs. In the East, public funding of health care is expected to remain sparse, and out-of-pocket (or under the table) payments will remain an important feature of the system. Payment of health personnel is generally low in Eastern Europe, obliging doctors to have second jobs. Accession to the EU may result in migration to the West of the best-qualified staff.

In this proposal we suggest the inclusion of either a short or long module that covers population attitudes about health and illness, the seeking of ambulatory health care and taking medicines. In addition it would be meaningful to combine these with questions about utilisation of care. The proposal is based on earlier work of the applicants (e.g. in: Britten, Ukoumunne, & Boulton 2002; Hansen, Holstein, Due & Currie, 2003; Kooiker, 1996).

The proposed topic lends itself well for a survey among a population sample. Self-care including the use of over-the-counter medicine is the predominant response to ill health. In every European country ambulatory health care is the area of health care that citizens are most familiar with. Almost the entire population has contact with a family physician or GP at least once a year. Population surveys estimate that between 50 to 80 percent of those contacts result in the prescription of medicines. Seeking health care is the result of a complicated interplay between factors on the supply side and demand related factors. Among the latter not only economic factors play a role but also social and cultural factors. The ESS covers most of these factors in its core module like perceived health status, level of education, religion, ethnic background and value orientation. Precisely because of the coverage of 'culture' and 'cultural diversity' would the ESS be the appropriate vehicle for such a research project. National Health interview surveys would cover health status and health care utilisation well but would be less likely to pay attention to variables measuring culture.

What we have in mind is the following:

Concepts of health (5 questions).

Health means different things to different people. A comparison of the 'subjective health' levels across Europe (see 'Self-reported health in the European Community') reveals large differences that cannot be explained by underlying illness levels alone. Earlier studies, carried out in the 1970s and 1980s used open-ended questions to map the concepts that people employ to define good and poor health (D'Houtaud and Field, 1984; Blaxter, 1990). In a later study D'Houtaud's concepts were condensed into a smaller number of categories (Furer, 2001). In this module it would probably be sufficient to use four or five concepts to define health (good health as: 1. a feeling of energy, 2. not to think of illness, 3. visit the doctor minimally, 4. being able to handle the problems of life). Including these as questions would offer the possibility of comparing the health indicators in the ESS core module with health concepts: can the differences in subjective health across nations be explained by differences in perceptions of health?

Importance of Health (1 question).

How important is health in comparison to other aspects of life (work, family, income etc)? The SCP in the Netherlands has a tradition in measuring personal values like health longitudinally. The value of health has rapidly increased since 1966 and is considered the most important value in life by 60% of the Dutch population (Kooiker & Mootz, 1996). Would that be a common trait of all European countries? And how would the value of health tie in with health and illness concepts and care seeking?

Concepts of illness (5-10 questions).

How serious must symptoms be in order to be considered as illness? In post-industrial societies new concepts of illness abound, that are not found in 'traditional' societies (ME/chronic fatigue syndrome, irritable bowel syndrome, fibromyalgia, whiplash, repetitive strain injury; syndromes such as attention deficit hyperactivity disorder). What do people consider illness? Do these concepts differ from country to country (and within countries) and is there a trend related to modernisation? We intend to list a number of symptoms and ask respondents how serious they are and if consulting a doctor/taking medicine etc is considered necessary. (See also Lüschen, Cokerham and Van der Zee, 1995 and the special issue of the BMJ on medicalisation (13 April 2002)).

Concepts of medicines (5-10 questions).

When is a product a medicine? An increasing number of Prescription Only Medicines (POM) have switched to over-the-counter medicine. Lifestyle drugs (Viagra etc) blur the line between medicines as benign poisons and consumer products. Are these products still considered medicines or just pills that help you to lead a better life? Ebba Hansen is currently doing research on this topic in Denmark.

Attitudes towards medicines and medicine taking (6 questions).

These include preference for natural remedies, newest medicines, brand loyalty and the dislike of (cheap) generic drugs, opinions about and experience with side effects. Here we build among others on previous work done by Nicky Britten et al (2002).

Behaviour with medicines (6 questions)

There are large differences in the handling of medicines in the home and the passing on of prescription only medicines to friends and relatives not only between countries but also between groups of different cultures within countries (Fainzang, 2001; Whyte, Van der Geest and Hardon, 2002). Questions that tap into this area may be helpful in delineating 'pharmaco-centric' cultures.

Expectations of medical care (6 questions).

The expectations of medical care vary from country to country, and partly depend on the structure of the health care system (Grol, Wensing et al, 1999). In Western Europe the expectations of patients seem to be rising and repeated measures could provide valuable trend information. These expectations can be measured with a simple list of statements. A list of 12 statements used previously showed a high level of internal consistency and was a good predictor of using prescribed medicine (Kooiker, 1996). Because of the redundancies in this list, a short list of 6 statements would probably be sufficient.

Social distance (5 questions).

The medical encounter is always one of a social distance between doctor and patient. The perceived distance may have an effect on how satisfied patients are and how likely patients are to follow a doctor's instructions. Compliance may be a matter of perceived legitimacy of authority (Stevenson, Britten, Barry, Bradley & Barber, 2002). The inclusion of questions on social (in)equality, stratification and perceived social distance between professions and lay people in the ESS would provide this and other projects valuable data on the social environment in which the professional interaction takes place.

Illness behaviour (10 questions).

Questions on illness actions when respondents had common symptoms of illness that are usually treated in ambulatory care: what did you do the last time you had a headache, stomach problems, a sore throat etc. Did you use a home remedy, see a doctor, etc.

Policy relevance.

In all European countries health care is a provision that depends to a large extent on government policy. The individual European citizen has little influence on the quality and accessibility of the health care in his or her country. While the supply of health care may depend on government policy, the demand and utilisation of care only partly depends on policy. In particular the utilisation of medicines is beyond government control and often shows an increase in costs higher than any other element of the health care bill. The inclusion of this module allows for statistical analysis of health care utilisation that pays attention to social and cultural factors, which may prove very useful in cross-country comparison from a policy perspective. It may help to identify cultures with varying levels of medicalisation. The aim of the analysis would be to offer policy makers advice on how to counter medicalisation without sacrificing the accessibility of health care in general.

Academic relevance.

Differences and changes in popular concepts of health and illness can be conceived as a case study of modernisation (Therborn, 1995). In this respect this topic is derived from 'medical sociology' as valuable in studying social change as opinions on 'family life', the 'value of work' etc, that are receiving more attention these days than medical sociology. The data can also be very useful to researchers outside the social sciences, who often find differences between countries in, for example medicine use, and attribute these to cultural factors without being able to pinpoint what these cultural factors are and how they operate. They may want to analyse the ESS data for this purpose. The Departments of General Practice involved in this study and the Department of Social Pharmacy are keen to analyse the cross-national data on expectations of medical care, which may also be of interest to others involved in academic research on the doctor-patient relationship.

Publication Plans

All applicants are involved in international projects and their work would benefit greatly from the availability of survey data that cover so many nations encompassing East and West and Northern and Southern Europe. In addition, it would provide them with the opportunity to extend their work carried out with national data to include cross-country comparisons. Most applicants publish regularly in international scientific journals and edited volumes in English and/or in their national language. The principal applicant recently carried out an expert opinion survey in 9 European nations that roughly covered the same topics. The ESS would offer a much-welcomed opportunity to test hypotheses derived from this study among a sample of the general public. The European Observatory on Health Care Systems, which has its own series of books published by the Open University Press, expressed its interest in studies about the relationship of health care and culture (conversation with R.Saltman). This would provide another outlet for papers based on the ESS data.

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