

IV. BARRIERS TO ACCESS TO SOCIAL SERVICES

A. Forms of accessibility

Accessibility has been termed a “slippery” concept, embodying the notion that something – a place, a service or goods – is “get-at-able”. In other words, it can be reached and used. Clearly, accessibility has at least two major aspects in the context of access to social services, the geographical and the socio-organizational, as Donabedian (1973) noted with respect to health services almost three decades ago. Accessibility has two major expressions: *potential access*, which implies the service is actually available within the vicinity of a potential user, and *revealed accessibility*, which may be interpreted as use or utilization of the service by the consumer. For many reasons, potentially accessible social services in many parts of the world are not used properly or effectively. Their potential accessibility is an insufficient condition for their usage (effective or revealed accessibility). Therefore, there must be several intervening variables that prevent effective usage and these may be thought of as barriers to access to social services. These variables often relate to need, and in particular, knowledge of and ability to use the services in question. Reviews of the concepts of accessibility and usage can be found in Joseph and Phillips (1984) and of accessibility measures in Geurs and van Eck (2001).

At least three components of accessibility can be recognized: (a) locational (spatial); effective (individual); and (c) temporal. All of them are affected to a greater or lesser degree by individual/personal variables.

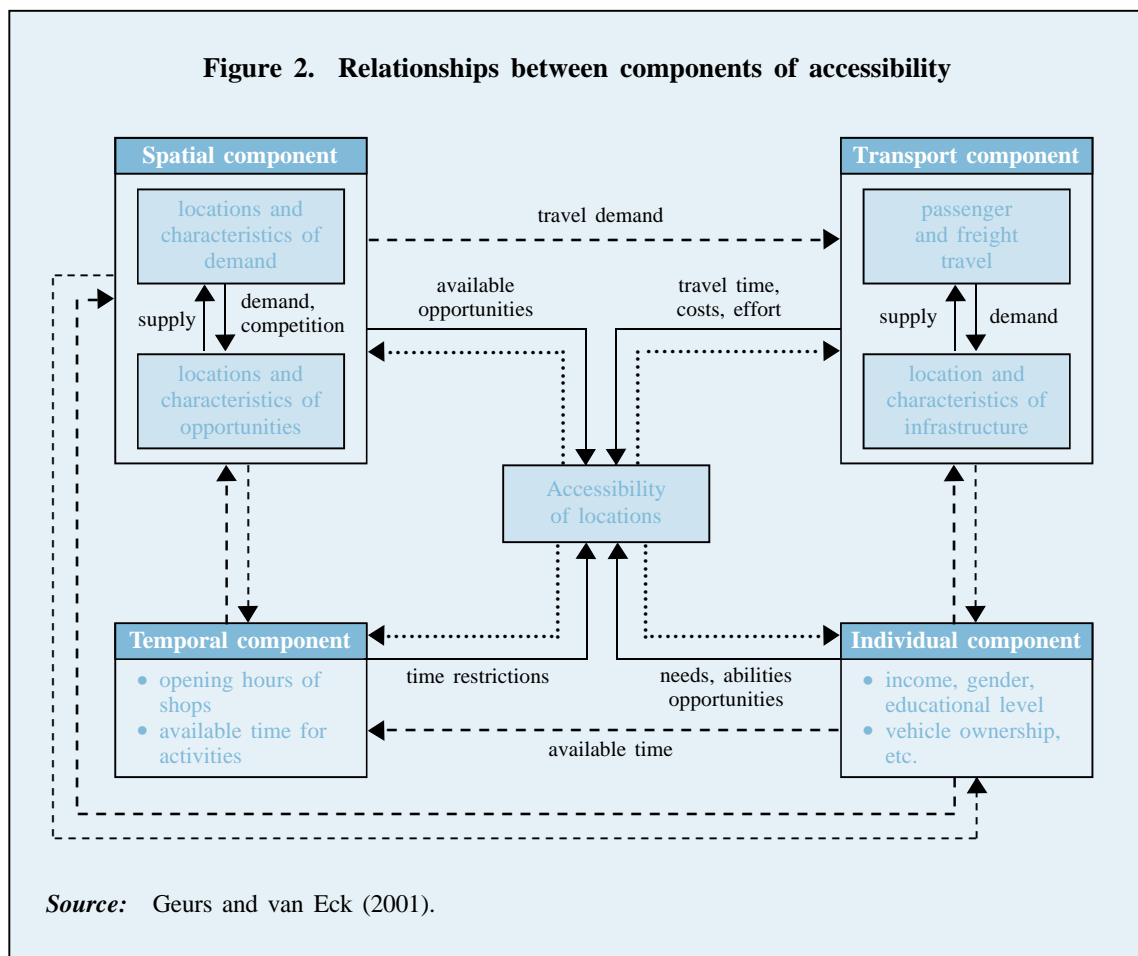
1. Locational accessibility

This is the most commonly recognized form of physical accessibility – that of distance to a service or facility outlet or offering. It relates to the locations and characteristics of the demand and the supply or opportunities aspects of the service in question (see figure 2). It is often stated in poorer countries in terms of walkable distance (say the availability of a service within eight kilometres or five miles). Geographical distance, as discussed further below, can be a very potent barrier to utilization. A particular social service is not accessible for people in dire need if the distance is too great. But geographical distance can be modified by, for example, the provision of mobile or peripatetic (outreaching) services, common in many forms of social services. Geographical physical distance may also be overcome by the use of transport and/or modern communications. For example, the pioneering of basic school education

provided by radio to residents of small localities and farms in the Australian outback has been superseded in many parts of the world by the effective use of the Internet and email for education and learning.

2. Temporal accessibility

The temporal component of accessibility relates to the opening hours of services and the time people have available for using them or undertaking activities (see figure 2). The occasional or part-time doctor's surgery that opens only on occasional days or sporadic hours can be used to spread a service more widely, as can the use of mobile or occasional branch services as noted above. However, while increasing geographical spread and hence, a reduced distance for most consumers to services, these occasional offerings inevitably give



a temporally restricted availability of the service in question. Naturally, relatively few social services are available on a 24-hour basis (exceptions often being hospital accident and emergency services and on-call social work services in some countries, as well as the “social welfare” aspects of fire, police and ambulance services). Nevertheless, temporal restriction on service availability is a form of reduced accessibility, and any diminution from 24-hour, 365 days a year availability is an example of reduced temporal accessibility. The temporal component of accessibility, involving space-time studies, as they are often termed, has a long history although these studies have been relatively infrequently applied to social services in the countries in the region, perhaps, with the exception of Australia and New Zealand.

3. Effective accessibility

As noted above, the fact that a service is geographically available (even on a 24-hour basis) does not guarantee its utilization by its intended clients. For this to occur, there must be a recognized need and an ability to use the service, termed individual or personal aspects of accessibility (see figure 2). This can be much modified by many variables, such as gender, income, education, availability of vehicles, and the like. Thus, revealed or effective accessibility is governed by a range of personal and societal factors as discussed below.

B. Information and knowledge of service types and availability

It is commonly observed that “knowledge is power”. Conversely, lack of knowledge is often a weakness, rendering those without the information less able to take advantage of opportunities and rendering them more vulnerable. This is particularly important with respect to social services, many of which are targeted at the more needy members of society, and who, by definition, may have less knowledge and ability to seek information. A simple example is that a person who is without access to a telephone, through poverty or deprivation in the locality, may find it difficult to contact assistance or find the availability of particular services. Likewise, a person who cannot read or has only functional literacy will need others to inform him or her of written notices of availability of services, opening hours, costs and the like. Education also undoubtedly plays an important part in the filtering of information and the interpretation and expression of need for a given social service.

Today, services are increasingly promoted by radio, television, newspapers or via the Internet. If a family or locality does not have access to these forms of media, they may often lack information about services to which they are entitled or to find out what is available. Therefore, over the years, public social services and many provided by NGOs, charities and the private sector have used various forms of public awareness raising campaigns to inform potential users of their availability. Health promotion campaigns (for immunizations, tuberculosis, hepatitis, clean water, HIV/AIDS and many others) have often been at the forefront of such dissemination of knowledge. Likewise, schools have promoted their basic services as do adult literacy classes, libraries, and mobile clinics. Yet, there is still a widespread lack of knowledge in many countries about the availability and entitlement criteria for many forms of public service and some bureaucracies seem inclined to maintain this ignorance. Like waiting lists, lack of publicity acts as a sort of rationing system, and it often takes a determined attempt on the part of potential clients to find out what services are actually available. The local equivalents of citizens' advice bureau can be very helpful, especially when targeting advice to particular groups, such as senior citizens, single mothers, handicapped persons or people on low/nil incomes.

C. Barriers to social services

1. Economic barriers: costs and affordability

After the geographical non-availability, costs are generally perceived to be the greatest barrier to the use of social services. People may simply not be able to afford the services, especially the poor in developing countries. Even when ostensibly free at the point of use (like many health and welfare services), there is a hidden cost, for example, of transport to the service, time lost from work, costs of childcare, and costs of prescribed medicines. There are various ways of trying to minimize the direct costs of many forms of social services: provision free or highly subsidized from general taxation, insurance schemes, prepayment schemes, means testing, cost recovery (to minimize ongoing charges) and the like.

Affordability and the direct costs of using social services have been widely studied by health and welfare economists, but the actual impacts of costs on usage seem to vary greatly by societies and according to the types of services. Parents may make considerable sacrifices from minimal incomes for food and medicines for their children. However, their readiness and ability to absorb ongoing costs such as those associated with education, especially secondary and tertiary education and professional training, may be much less. Clearly, economic barriers do exist in many countries and especially within societies to the

use of social services (effective, revealed accessibility). Co-payments by users (for example, for home helper services by older persons) may deprive the most needy of these services and may render them institutionalized. Therefore, service cost levels, transport costs and other associated indirect costs need to be very carefully computed and subsidized appropriately at the local level, where the ability of local people to pay is known.

2. Geographical barriers

As noted above, geographical distance is readily recognized as a barrier, but its effects are neither consistent from one society to another nor uniform within the society. The concepts of distance and mobility become crucial. Consider, for example, two households living nearby in a suburban area, one with access to a private car or vehicle, the other having no car. The household with a car has much greater mobility, the ability to attend a variety of services within easy driving distance, whenever wished. The car-less, or bicycle-less, household members are effectively less mobile and dependent on public transport routes (buses, taxis), costs and timetables to govern when they can use services and where, and they may depend on those within walking distance. Consider further the household with a car: if the vehicle is used on a daily basis for work by a member of the household, or if all members of the household cannot drive through age or infirmity, then the other members are in the same situation as the car-less household to access social services when the car is used elsewhere. Thus, statistics depicting car ownership rates, especially in more remote areas, are often misleading as a measure of average household mobility. In many developed societies, this has been conceptualized as the distance a mother with a small infant can readily push a pram and return, in clement weather, maybe up to a kilometre on level ground. In many developing countries, this is of course much further, and many development agencies look at distances of eight kilometres to human services as being “walkable” (Phillips 1990).

The other geographical barriers include those related to terrain (mountains, rivers and lakes) and features such as island nations, common in many parts of the ESCAP region (for example, Fiji, Indonesia, Papua New Guinea, the Philippines and others). In these circumstances, island barriers to access can be ameliorated or worsened by air and ferry schedules and costs, or temporarily affected by adverse weather conditions or local security situations. In addition to the macro-features of the geographical environment, the local micro-scale features of the built and natural environments can also produce barriers to services. These include design features of buildings and homes (for example, steps, stairs and lack of elevators in high-rise buildings) and barriers to effective access to public transport (Phillips and Yeh 1999).

The distance, while apparently a set and immutable factor, has been shown to have differing impacts on the use of social services and indeed all services (its effects have been widely researched in terms of access to retail facilities, for example). Distance has been found to act variably and a feature called “distance decay” in utilization has been widely noted. Gravity models have been employed by researchers and planners in which the negative impacts of increasing distance to a service or facility on utilization has often been found (Joseph and Phillips 1984). Distance decay effects are complex, being influenced by many individual, social, economic and service-related factors. Basically, the concept means that a certain unit increase in geographical distance (one to three kilometres) may be met with a uniform fall-off (or change) in utilization rates, or even in an exponential decline. This is especially the case when consumers have overlapping choices of services (spheres of influence and spatial range of goods). There is a huge literature on research about various distance decay functions (the power that should be attributed to distance) and here, it is sufficient to alert policy makers and service providers that this is rarely a simple and uniform effect. Increasingly, it is recognized that it is influenced not only by the costs and difficulties of travel over distance but by the attractiveness of the service on offer, which has a cost and highly quality-oriented component.

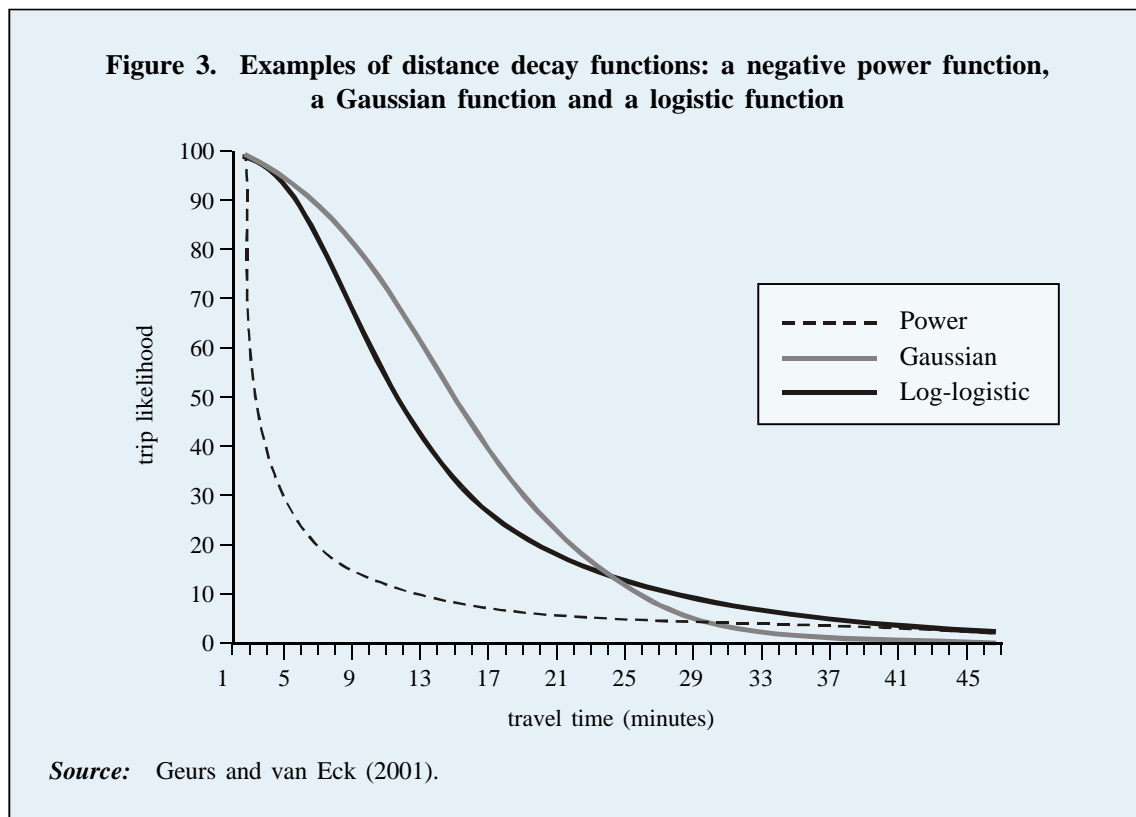
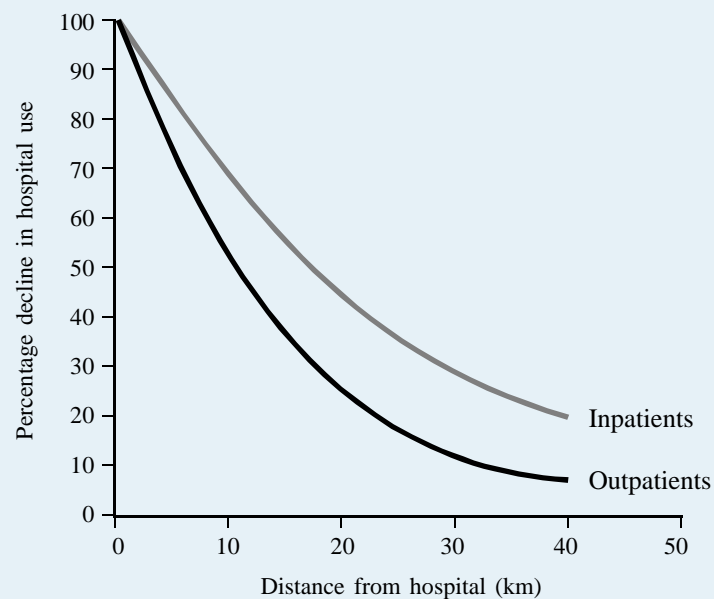


Figure 4. Distance decay in the utilization of hospital services in New South Wales



Source: Joseph and Phillips (1984).

Figures 3 and 4 and table 1 illustrate these concepts. The table shows the relative potential effects of three forms of transport (car, bus or bicycle/walking) within the transport component of accessibility. Figure 3 shows the various distance-decay curves and functions that might affect trip likelihood and given travel time. These are highly likely to vary according to the nature of the social services in question. For example, the distance decay effect is likely to be much less for an urgent visit to a hospital accident and emergency room than for, say, an elective visit to a personal service such as a hairdresser. Figure 4 shows the effects of distance on the hospital use rates for inpatients in rural New South Wales, which is less steep than for outpatients in Australia. Nevertheless, distance exerts a potent barrier to access even for such hardy rural travelers. For example, at 20 kilometres from the one hospital serving the area, inpatient patronage had declined to 40 per cent of what it was immediately around the hospital, and outpatient attendance had fallen yet further to some 25 per cent (Joseph and Phillips 1984).

Table 1. Elements within the transport component of accessibility

<i>mode</i> <i>elements</i>	<i>Car</i>	<i>public transport</i>	<i>bicycle/walking</i>
time	walking to parking place in vehicle travel time congestion time finding a parking place walking to destination	hidden waiting time travel time of access/egress mode waiting time at station in vehicle travel time transfer time	travel time bicycle parking
costs	fixed costs fuel costs maintenance costs parking costs road-pricing costs	costs of tickets/fares	fixed costs maintenance costs
effort	level of (dis)comfort physical effort reliability stress accident risk information status	level of (dis)comfort physical effort reliability stress accident risk social safety information status	level of (dis)comfort physical effort social safety

Source: Geurs and van Eck (2001).

3. Administrative barriers

The use of social services often requires a certain amount of administrative formality. For instance, users may need some form of identification, insurance numbers, identity cards, or registration with a specific facility. This inevitably entails paperwork and can disadvantage some groups of people, especially illiterate persons, some very old people or those with mental or psychological problems who do not live with caring relatives. In the ESCAP context, administrative requirements in some countries may accidentally or deliberately exclude some indigenous people from using public or other forms of social services. Lack of education or illiteracy, as well as a lack of access to technology, can be cross-cutting issues that act on their own, or compound other barriers to services.

Administrative impediments have long been recognized as one set of barriers to access to services. These may be formalized in the specific administrative structure of the social service in question, and/or they may be adopted more or less vigorously by front-line practitioners and managers. In the national health service of the United Kingdom, for example, bureaucratic gatekeeping mechanisms have been identified that aim to limit the numbers of applicants requiring a full community care assessment. In this case, front-line practitioners were said to be acting as street level bureaucrats (Rummery and Glendinning 2000).

In many cases, such bureaucratic or administrative practices, wherever formal or informal in the service in question, act as a filtering and rationing system, to restrict access to and by “qualified” people. Their use is understandable and sometimes justified and necessary, but if taken to the extreme, they may merely become bureaucratic hurdles and impediments to the civil rights of many people who are legally entitled to a certain social service. This can ultimately lead to disturbances or legal challenges in the courts by the people who feel that the system has denied them access to an entitled service, and breached their civil and social rights. In the main, however, they often make life more uncomfortable for poor people who really need the service in question to survive or reach some minimum standard of living. In some countries in Asia and the Pacific, the creation of waiting lists for long-term care with largely non-urgent cases on them is a by-product of the perceived need to register older relatives for a long-term care place just in case it is needed. This is because of the queuing systems in operation. The introduction of proper assessment systems can create more effective and realistic waiting lists, reduce unnecessary administration, and generally create more efficient access to those in need.

4. Social and other barriers

There are numerous social barriers to access and utilization of social services, which means that some potential clients do not “fit” into the service in question. These can be considered at the individual or family level and also at the societal level.

At the individual or household level, age, gender, income, education and health status all come into play in influencing who will use certain services and how often. Evidence is not clear even with respect to the same types of service. For example, gender has been found in different country settings to increase or decrease the use of health services. Much is dependent on additional factors such as costs and cultural norms. An important concept of equity must be considered in this context.

Guers and van Eck (2001) summarize the individual components of accessibility in which the characteristics of individuals play an important role in the level of access (and by implication the barriers to access) to social and economic opportunities. Three groupings of determinants are often identified in psychosocial studies: (a) needs; (b) abilities; and (c) opportunities.

The needs for social services, as discussed earlier, are in part influenced by such characteristics as age, income, educational level, phase of life and household situation. They are also heavily influenced by health status and any levels of disability in the household. Households with children will have higher needs for access to schools and certain child-health services, older persons may need more help in home care, long-term care and geriatric-related health services, and others.

Abilities can also affect access to social services. For example, whether someone can drive a car will influence the range of accessible services. People with cognitive, sensory, intellectual or physical difficulties may have restricted abilities to access some services and a concomitant need for greater use of other services.

Opportunities of people will be related to income and travel budgets. In some European countries such as the Netherlands, for example, 80 per cent of the people in the low-income groups do not own a car and thus depend on public or non-motorized forms of transport to reach to services.

Lack of knowledge (and literacy) can be a potent barrier to the use of services. People may not know of the availability of a service, or they may not recognize their need. Once illiterate or with limited functional literacy, people may be unable to apply for a service or to complete any administrative requirements to use it. Many campaigns in developing and other countries have attempted to raise knowledge and awareness of service provision, using a range of popular media, cartoons, diagrams, posters and word of mouth technology to lessen the barrier posed by a lack of knowledge.

As common in sociological and social geography studies, the analysis of the distribution and concentration of these individual characteristics aggregated to the group level will give indications of socio-spatial distributions. In particular, areas of need and/or deprivation and multiple deprivation can be identified. This has frequently been used as a basis for planning the spatial allocation of resources (specific types of social services) and can form an important component of social planning to increase the accessibility of poor or other disadvantaged groups to appropriate services.

At the aggregate level, religious and cultural barriers to access to some social services can exist. Although it is relatively unusual in some countries, certain religious groups might provide social services, especially residential, long-term care and educational social services, specifically for their own members. This can, in effect, mean that although there are services in a given neighbourhood, they are not equally available to all residents. In other words, a social filtering barrier may be in place.

5. Conflict and disaster situations

A further group of barriers to access to social services, especially for the poor, stem from wars or civil conflicts and natural disasters. In these circumstances, social service delivery systems are often disrupted or even abandoned in the case of some war zones, or the civil aid functions usurp the wider welfare aspects following natural disasters. A key point about this set of barriers, which are often specific to certain local settings and time periods, is that the people who require the services are almost inevitably in urgent and long-term needs. Many will be refugees or displaced persons, and many may also be physically or psychologically harmed. Therefore, large numbers of poor people may be deprived of services because of local or wider conflicts and disasters.