

ACCESS TO HEALTHCARE IN THE EU: AN OVERALL POSITIVE TREND BUT IMPORTANT INEQUALITIES PERSIST¹

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INTRODUCTION

Most European health systems provide nearly universal population coverage for a wide range of benefits. Notwithstanding this, people on a low income and vulnerable groups, in nearly all countries, have more difficulties obtaining access to care. At the same time, vulnerable and marginalised groups in societies tend to have more health problems and thus have more healthcare needs (Mackenbach et al., 2007).

Access to care can be hindered by various hurdles, which can be financial, organisational or personal. Financial hurdles relate to the extent to which the needed health services are financially covered; organisational hurdles can relate to waiting times, availability of quality care, the level of provider choice, or available information; individual patient characteristics which can hinder access to care include poor literacy, language or culture, and low levels of trust between the provider and the patient (Busse et al., 2006).

The 2008-2009 economic and financial crisis, and in particular the ensuing austerity measures, exacerbated problems relating to access to care in many countries. Since 2015, a gradual recovery has taken place, both in terms of self-reported unmet needs for medical care and with regard to investments in the health system. However, for some countries, levels of unmet needs have continued to increase.

This article explores the main factors which may be associated with inequalities in access to healthcare in the 28 Member States of the European Union (EU). To do so, we analyse health system characteristics with regard to healthcare financing, organisation and delivery. We furthermore assess health system reforms since the financial and economic crisis, addressing (in)equalities in access to healthcare.

Our approach is mainly qualitative, drawing on a Synthesis Report (Baeten et al., 2018) written by the authors in the context of the European Commission-funded European Social Policy Network (ESPN). The article analyses evidence from country reports (ESPN Thematic Reports 2018) on inequalities in access to healthcare, written

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by ESPN country experts.³ In producing their reports, national ESPN experts cite many different sources in support of their analysis. References to these are not included in the present article. Our analysis is accompanied by a quantitative assessment of Eurostat and OECD data.

We first describe which groups in society face the most important hurdles in accessing healthcare (Section 1). Next, we analyse the main factors which may impact inequalities in access to healthcare (Section 2). In section 3 we present trends in health system reforms addressing access to healthcare. Section 4 summarises the key findings and concludes.

1. WHO FACES THE MOST SERIOUS DIFFICULTIES IN ACCESSING HEALTHCARE IN EUROPE?

Different population groups may have different access to healthcare. Income, gender, age and activity status may determine to an important extent inequality in access to healthcare. Some specific groups may be particularly vulnerable as they are exposed to a multitude of risk factors: for example, single mothers on a low income, the unemployed and Roma people.

Based on the EU indicator on self-reported unmet needs for medical examination and care, this section examines which groups in society face the most serious difficulties in accessing healthcare and what the main reported reasons are.⁴

1.1. UNMET NEEDS FOR MEDICAL EXAMINATION AND CARE: THE OVERALL PICTURE FOR THE PERIOD 2008-2017

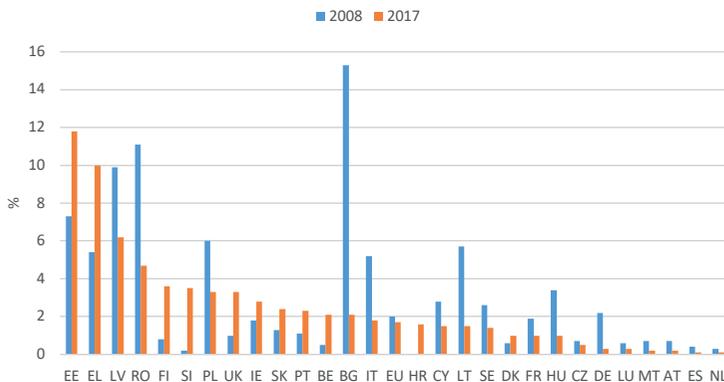
Costs and waiting times are the main reported barriers for access to healthcare. Here, we present the overall picture, before describing, in Section 1.2, which groups are mostly impacted by these factors.

(3) The study illustrates the main challenges and trends in national policies through examples. Countries which have developed along similar lines are listed in brackets (e.g. AT, BE, BG) so that the reader interested in knowing more about these can examine the EU ESPN national experts' country reports. For the used country codes, see Annex.

(4) Different approaches and indicators are available to measure the accessibility of healthcare and to assess the extent of inequality in access to services. The most common approach to monitoring inequalities in access to healthcare is through a proxy indicator on the self-reported unmet needs for medical care. Indicators on self-reported unmet needs measure people's subjective perception of their health needs, and thus do not objectively capture health needs. Despite this, it is commonly agreed that they are the best available proxy to measure unmet medical needs (EXPH 2016). While various surveys include questions on self-reported unmet need for medical care, the main source in Europe is the EU Statistics on Income and Living Conditions (EU-SILC). The questions recommended to the Member States to use for this indicator are: "Was there any time during the past 12 months when you really needed medical examination or treatment (excluding dental) for yourself?"; and if the answer is positive "What was the main reason for not having a medical examination or treatment?" This dataset has the undeniable advantage of facilitating cross-country comparisons and providing a first indication of inequalities and problems regarding affordability and accessibility. Nevertheless, many ESPN experts have pointed to its limitations and emphasised the need for caution in interpreting the results (See also EXPH 2016; European Commission 2017).

In 2017, on average only 1.7% of the EU population had unmet needs for healthcare due to cost, travel distance and waiting times taken together (see Figure 1). However, this relatively low value hides significant differences between countries: from more than 5 times the average in Estonia (11.8%) and Greece (10%) to only around 0.1% of the population in Spain and the Netherlands.

FIGURE 1: SELF-REPORTED UNMET NEEDS FOR MEDICAL EXAMINATION AND CARE DUE TO COST, DISTANCE AND WAITING TIME



Source: Eurostat [hlth_silc_08].

The 2008-2009 economic crisis exacerbated problems relating to access to care in many countries. While, for the EU as a whole, 3.0% of the EU population reported that they had been unable to obtain the healthcare they needed in 2009, this percentage rose to 3.6% in 2014. As we will see in section 2.1, public expenditure on health dropped substantially in this period. Austerity measures in many countries included increasing user charges, reducing service provision and the salaries of health staff. In some countries, increasing numbers of people in a precarious employment situation lost their entitlement to healthcare. Furthermore, household budgets available for healthcare decreased as a result of reduced income levels (due to rising unemployment and reduced wages) and increased costs for other basic services (Eurofound, 2014).

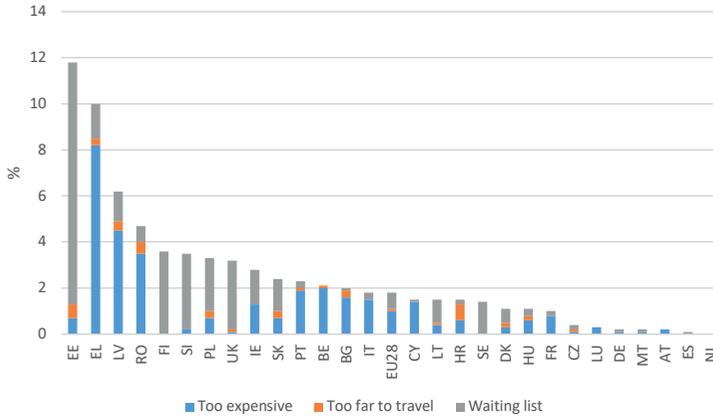
From 2015 onwards, the share of the population reporting unmet needs for healthcare gradually decreased to reach a relatively low level (1.7%) in 2017 (Eurostat, 2018).

There were however significant variations in trends between Member States and between social groups within Member States. While in most countries there has been an increase in unmet needs for medical care during the crisis years, there has been a steady decrease since then in many countries (e.g. BG, CY, HR, HU, LT, LU, LV, RO). However, in some countries, the upward trend continued until 2017, in particular in Greece and Estonia. But also in Belgium the numbers continued to increase from

1.5% in 2011 to 2.1% in 2017. The most significant fall in unmet needs was observed in Bulgaria in the period 2008-2015: from 15.3% to 4.7%.⁵

When looking into the three factors separately, cost is the most important factor impeding effective access to healthcare (Figure 2).

FIGURE 2: SELF-REPORTED UNMET NEEDS FOR MEDICAL EXAMINATION AND CARE: MAIN REASONS (2017)



Source: Eurostat [hlth_silc_08].

The most extreme case is Greece, with 8.2% of self-reported unmet needs due to cost alone. Belgium takes, with 2% of the population reporting unmet needs due to cost, a not so glamorous fourth place, after Latvia and Romania (with respectively 4.5% and 3.5% of self-reported cost-related unmet needs). At the opposite end of the spectrum, Denmark, the Netherlands, Spain and Sweden have zero values for unmet needs driven by cost. The second most significant factor impeding effective access to medical care is the issue of waiting lists — with the highest score being 10.5% in Estonia, followed, at a considerable distance, by Finland (3.6%). Finally, there is the factor of travelling time, which is far less important in all countries: Croatia has the highest score here: 0.7%.

The following section analyses how personal characteristics relate to these systemic factors.

(5) There have been breaks in time series for the indicator on unmet needs for medical examination or care in the Eurostat data set for the following countries and years: Belgium (2011), Bulgaria (2016), Finland (2015), Poland (2017) and the United Kingdom (2017). We therefore use different time periods for these countries, to ensure comparability over time.

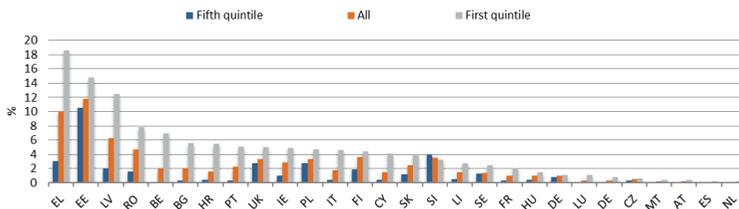
1.2. WHICH POPULATION GROUPS ARE IMPACTED THE MOST?

1.2.1. Low income as the key factor associated with unmet needs for medical care

Those on a low income have the highest unmet needs for medical examination and care (Figure 3). However, there are important variations between countries. The EU average of unmet needs for the lowest incomes is 3.3%; for the highest incomes the proportion is 0.8%. Some of the countries display differences of more than 5 percentage points between the lowest and highest income quintiles in self-reported unmet needs for medical examination and care (BE, BG, EL, LV, RO). The most striking example is Greece, where those in the lowest income quintile report 18.6% of unmet needs due to cost, with only 3% in the highest. Only a few countries – those with the lowest scores on unmet needs due to cost – report barely any difference between income groups (AT, CZ, DE, ES, MT, NL).

It should be noted that Belgium performs rather poorly on this indicator. In spite of the fact that public expenditure on healthcare is relatively high in Belgium (see Section 2), there are strong inequalities in access to healthcare between socio-economic groups. Even more importantly, while the number of people reporting unmet needs in the lowest income quintile decreased from 6.1% in 2011 to 3.3% in 2017 for the EU as a whole, it increased in Belgium from 4.8% to 6.9%. Most Belgian respondents reported that they were unable to have access to necessary medical care because it was too expensive for them.

FIGURE 3: SELF-REPORTED UNMET NEEDS FOR MEDICAL EXAMINATION AND CARE DUE TO COST, WAITING TIME AND TRAVELLING DISTANCE BY INCOME QUINTILE (2017)



Source: Eurostat [hlth_silc_08].

The crisis and the ensuing austerity measures played a significant role in aggravating unmet needs among low income populations in countries such as Greece and Portugal. Health system characteristics may aggravate or offset the impact of low income on unmet needs for medical care (see Section 2).

Activity status also impacts access to medical care in some countries (Eurostat, 2019b). In general, the unemployed have serious difficulties accessing healthcare. In Greece (11.2%), Latvia (14.2%) and Estonia (15.2%) the unemployed face substantial problems in having access to care in 2017. But even in countries where the percentage of unmet needs for medical examination and care among the entire population is below the EU average, the unemployed may have a significant level of unmet needs for medical care (e.g. BE, BG, FR, FI). Several factors may explain problematic access

for the unemployed, such as low incomes, absence of legal coverage or lack of occupational health insurance (see Section 2).

In some countries pensioners' access to healthcare is even significantly more impeded than that of employed people. This is mostly the case in Central and Eastern European countries (BG, EE, HU, HR, LT, LV, RO, SI, SK), but also in Greece and Finland. Estonia and Greece top the charts, with, respectively, 16.4% and 15.8% of pensioners declaring unmet needs for medical examination and care in 2017 (Eurostat, 2019b).

1.2.2. Composition of household and gender matter

Gender is also a factor having an impact on unmet needs for medical care: women are clearly (far) more disadvantaged than men in most EU countries, with some exceptions, such as Ireland, Denmark, the Netherlands. In some countries the gender gap in unmet needs is particularly striking: 4.6 percentage points in Estonia and around 2.5 percentage points in Romania, Greece and Finland (Eurostat, 2019a).

Single person households are another vulnerable group with regard to access to healthcare (e.g. BE, FR). Single persons with children, and in particular single women, are among the categories reporting most difficulties in paying the costs of health services (Eurostat, 2016).

1.2.3. Particularly vulnerable groups: homeless people, migrants and ethnic minorities

Homeless persons (and other marginalised groups such as alcoholics and drug addicts) are a particularly vulnerable category with regard to effective access to healthcare in most countries. Many factors may explain their lack of effective access, including their lack of a registered address, lack of information regarding their rights and the services available to them as well as poor health literacy. These people also have a significantly worse health status.

Roma populations are also among the most vulnerable with regard to access to healthcare, especially in Central and Eastern Europe, due to the lack of health insurance, incomes which are too low to afford healthcare, as well as poor health literacy. Asylum seekers, refugees and undocumented migrants have been reported to be in a particularly vulnerable situation in several countries regarding access to healthcare. Asylum seekers and undocumented migrants have restricted formal access to healthcare in most countries under scrutiny.

2. HEALTH SYSTEM FEATURES ASSOCIATED WITH INEQUALITIES IN ACCESS TO HEALTHCARE

In this section we explore the main features of the healthcare systems with a view to understanding the differences in access to healthcare between countries, within countries and over time, as discussed in Section 1. We explore three main characteristics of health systems: first, we look at differences in health system financing between countries and over time (Section 2.1), second, we look at the various dimensions of health coverage: who is covered for healthcare (population coverage), what are the health services and products

covered (benefit package) and how much is covered (user charges policies) (Section 2.2). Third, we discuss availability of health services and health professionals.

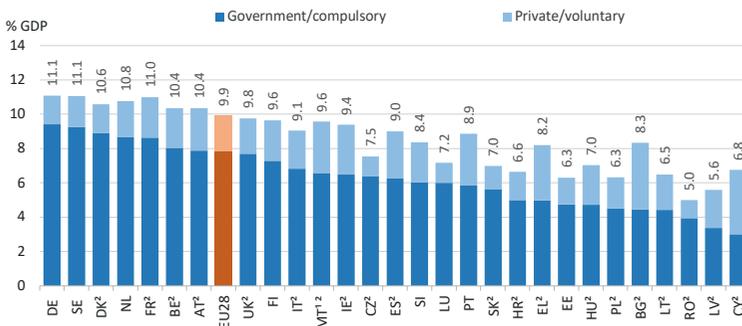
2.1. HEALTH SYSTEM FINANCING

Adequate health system funding is important for ensuring equal access to quality healthcare. Inadequate public funding creates and exacerbates access barriers (SPC 2016, Or et al., 2009).

2.1.1. Public resources spent on healthcare

There is a huge variety in the public resources made available to the health systems in EU countries, ranging from 3% of GDP in Cyprus to 9.4% of GDP in Germany. In Belgium, public resources spent on healthcare amount to 8% and private spending to 2.6% of GDP (see Figure 4). Public resources include both general taxation and compulsory health insurance contributions. Countries with relatively high public spending include most of the continental European and Nordic countries, while Southern and Eastern European countries are middle and lower-level spenders.

FIGURE 4: HEALTH EXPENDITURE AS A SHARE OF GDP, 2015 (OR NEAREST YEAR)



Source: OECD/EU (2016), Health at a Glance: Europe 2016; Includes investments; OECD estimate.

ESPN experts in many countries underline that the statutory health system in their country is underfunded (e.g. BG, CY, EE, EL, HR, HU, IE, IT, LT, LV, PL, RO) (see also Figure 4), and this low level of funding is reported to be one of the main reasons for the underdevelopment of the health system. This typically results in a limited number of contracts with health providers, underfunding of hospitals, limited supply of medical services and in some cases high out-of-pocket payments. Inadequate supply of health services is referred to in these countries as an implicit form of rationing. It should therefore not come as a surprise that these countries perform worse than the EU average with regard to both access to healthcare and inequalities in access to healthcare between income groups, as measured using the EU-SILC data on self-reported unmet needs for healthcare (see Figure 2 and 3). This corresponds with findings of earlier research that inequalities in access to care are stronger in countries where the level of public health expenditure is relatively low (Or et al., 2009).

After years of continuous growth, health spending slowed significantly across Europe in the wake of the 2008-2009 economic and financial crisis (Spasova et al., forthcoming). In many EU countries, expenditure cuts resulted in drastic reductions in public healthcare funding (e.g. CY, EL, ES, HR, IE, IT, PT). In most of these countries, this was the result of the implementation of the Economic Adjustment Programmes (EAP) agreed with the EU lenders. In Greece, *per capita* health spending dropped by as much as 8.7% on average annually during the period 2009 to 2013. In several countries, public revenue for the health sector also fell as a result of unemployment and falling wages (Jowett et al., 2015).

While for the EU as a whole, health spending *per capita* increased by about 3.1% per year between 2005 and 2009 (OECD/EU, 2016), it increased by only 0.6% between 2009 and 2013 and by around 1.9% each year in real terms between 2013 and 2017 (OECD/EU, 2018). Thus, while the negative trend has been reversed in most countries since 2013, the increase in health spending has slowed down compared to the pre-crisis period (see Spasova et al., 2019 for further analyses). Nevertheless, *per capita* health spending in countries such as Greece and Portugal was still at a lower level in 2017 than in 2009 (OECD/EU, 2018).

2.1.2. Out-of-pocket payments

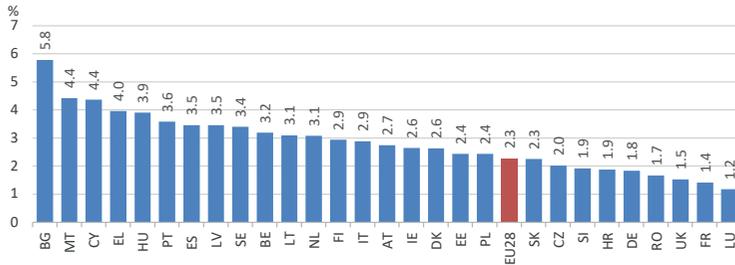
Out-of-pocket payments are an important hurdle for access to healthcare, especially for low income groups. Earlier research found a positive link between the share of households' out-of-pocket payments in total health expenditure and the probability of unmet needs (Chaupain-Guillot, S. and Guillot, O., 2015; Or et al., 2009).

For the EU as a whole, 18% of health spending is borne by households through out-of-pocket payments (OOP)⁶. This share is mirrored in Belgium, where OOP also are at 18% of health spending.

The rate of OOP spending is higher than 25% in eight EU countries (BG, CY, EL, HU, LT, LV, MT, PT) and is as high as 45% in Cyprus.

OOP medical spending levels as a share of overall household consumption are quite significant in most European countries. Bulgaria (5.8%), Malta (4.4%), Cyprus (4.4%) and Greece (4%) have OOP figures (almost) double the EU average of 2.3% while Luxembourg (1.2%), France (1.4%), the UK (1.5%), Germany (1.8%) and Romania (1.7%) have the lowest scores in this respect (see Figure 5).

(6) Out-of-pocket payments (OOPs) are direct payments made by individuals to healthcare providers at the time of service use (https://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/, last accessed 29/04/2019). Different forms of OOP exist. They include: 1) payments for goods or services that are not covered by any form of third-party payment; 2) cost-sharing (user charges): a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of the healthcare received; 3) excess fees: payments due on top of the regulatory defined user charges, for healthcare provided by health providers who are free to set their tariffs; and 4) informal payments: unofficial (under-the-table) payments for health goods or services (own elaboration based on Rechel, Thomson and van Ginneken (2010)).

FIGURE 5 : OUT-OF-POCKET MEDICAL SPENDING AS A SHARE OF FINAL HOUSEHOLD CONSUMPTION, 2014 (OR NEAREST YEAR)

Source: OECD/EU (2016), Health at a Glance: Europe 2016.

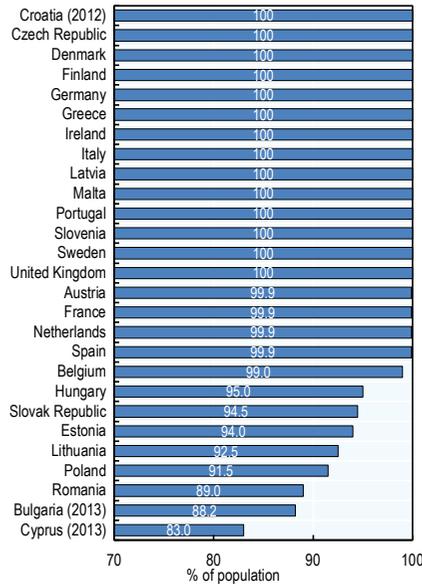
In several countries, a significant share of the population, in particular low-income earners, face “catastrophic” health expenditure (e.g. CY, EL, HU, LV, PT) (ESPN Thematic Reports, 2018). Health spending is considered catastrophic for households when falling ill induces sizeable and unpredictable shocks to a household’s living standards, pushing many of them into poverty. It is defined in relation to a household’s capacity to pay for healthcare.⁷ In countries where the incidence of catastrophic health spending is very low, unmet need also tends to be low and without significant income inequality (Thomson et al., 2019).

2.2. HEALTH COVERAGE

In this section we will discuss 1) who is compulsorily covered for healthcare (population coverage); 2) what is covered (benefit package) and how much is covered (user charges policies) and 3) voluntary health insurance coverage.

While a large majority of European health systems cover nearly the whole population for a comprehensive basket of healthcare benefits, in eight EU countries a significant percentage of the population is not covered by the statutory health system, ranging from 5% in Hungary to 17% in Cyprus (See Figure 6). But even in countries providing nearly universal population coverage, some specific population groups may fall through the safety net. Groups not mandatorily covered include, in some countries: non-active people of working age without entitlement to cash social protection benefits, some specific categories of people in non-standard employment and precarious jobs, some categories of self-employed, people who have not (yet) contributed a sufficient number of years to the system, people performing undeclared work, homeless people, some categories of migrants, asylum seekers and undocumented people.

(7) The threshold has been defined at 40% of total household spending net of subsistence needs (i.e. food, housing and utilities), See K. Xu et al., 2003.

FIGURE 6: POPULATION COVERAGE FOR A CORE SET OF SERVICES, 2016 (OR NEAREST YEAR)

Note: This includes public coverage and primary private health coverage. Data for Luxembourg is not available.

Source: OECD/EU (2018), Health at a Glance: Europe 2018.

In Greece, millions of people lost coverage during the crisis years, mainly those who became unemployed or could no longer afford to pay contributions (such as the self-employed). Since 2016, a reform has provided comprehensive coverage for the whole population, including irregular migrants and refugees (OECD/EOHSP, 2017). As a result, while in 2015, 14% of the Greek population was not covered for healthcare (OECD/EU, 2016), as of 2016 the whole population is covered. This seems to have had an immediate and extraordinary effect on access to healthcare. Unmet needs for medical care for the lowest income quintile increased dramatically in Greece between 2010 and 2016: from 9% to 35.2%. In 2017 this figure fell again to 18.6%, which is nearly half the level of 2016. This evolution illustrates the enormous importance of universal population coverage to ensure equal access to healthcare.

The range of benefits fully or partially covered by the health system is comprehensive in nearly all Member States, including prevention, outpatient primary and specialist care as well as hospital care. In Ireland, however, over half of the population covered, in particular those on higher incomes, are only covered for hospital care; and in Latvia the range of benefits covered is relatively limited.

Several Member States reduced the benefit package in response to the financial and economic crisis. Requirements for cuts in the benefit package, usually for drugs,

were included in the Economic Adjustment Programmes concluded between the EU institutions and Greece, Cyprus and Romania.

In most countries, user charges apply to some health services and products. However, there are substantial differences in the general approach to user charges. In many countries, health services covered by the statutory health system are predominantly available free at the point of use, while in others, cost-sharing applies for most inpatient and/or outpatient care services (see Table 1).

TABLE 1: GENERAL POLICIES ON USER CHARGES IN EUROPE

Health services predominantly free at the point of use	Cost-sharing for most inpatient and/or outpatient health services
AT, CZ, CY, DK, EL, ES, HU, LI, LT, MT, PL, RO, SK, UK	BE, BG, DE, EE, FI, FR, HR, IE, IT, LU, LV, NL, PT, SE, SI

Source: authors' own elaboration drawing on ESPN country reports (2018).

An annual cap on user charges, set per household or insured person, applies in many EU countries (e.g. AT, BE, DE, FI, HR, IE, LU, LV, SI). Above this threshold, the patient does not pay any further user charges. The level of the cap can vary according to income, the health status or age of the person insured. There is a huge variation between countries in the maximum annual amount to be paid by the patient between countries. For instance, in Latvia, the co-payments are capped at EUR 569 per person per year. This cap does not apply to co-payments for pharmaceuticals and medical devices (ESPN Thematic Reports 2018). In Belgium, the annual cap has been set per household and includes nearly all care that is included in the benefit package. It ranges, depending on the income of the household and health situation of the family members, from EUR 371 to EUR 1,910.

Coverage for medicines, dental care, (outpatient) mental health services, physiotherapy, rehabilitation and medical devices is often limited and in many countries some of these services and products are excluded from the benefit package. In general, the share of OOP spent on pharmaceuticals is among the most significant. This is especially true in Central and Eastern European countries (e.g. CZ, EE, HR, HU, PL, RO, LV, SK) and Greece (OECD, 2017).

Most countries apply some mechanisms to protect specific vulnerable groups from prohibitive healthcare expenditure. They may be exempted from cost-sharing, pay lower user charges or qualify for a broader benefit package. These measures may apply, for instance, to patients on a low income, patients with chronic conditions or infectious diseases, recipients of certain social benefits, pregnant women, children and old age pensioners. In Austria, about a quarter of the population and in Portugal more than half of the population are exempted from cost-sharing. In Belgium, insured

persons with a low income, about 20% of the population, pay substantially lower user charges.

Some vulnerable groups may also be exempted from user charges for specific benefits such as pharmaceuticals or dental care. In Belgium for instance, where user charges apply for dental care, dental care is free for children. However, in many countries vulnerable groups are not protected from high user charges for pharmaceuticals, and pharmaceuticals are often exempted from annual caps on user charges.

In some countries, patients who are entitled to public or contracted outpatient and inpatient care also have access, on a cost-sharing basis, to health services delivered by private or non-contracted providers (e.g. AT, BE, EL, FI, FR), in which case the providers can in principle freely set their tariffs. In France, a strong increase in practices charging excess fees led to a reform in 2016, prohibiting private providers from claiming excess fees from vulnerable groups. In Belgium excess fees have been prohibited for hospital care in common rooms (but continue to be allowed in single rooms).

In the wake of the crisis, most EU countries increased user charges (Thomson, 2015). In the countries most heavily hit by the crisis, increasing user charges was one of the conditions set in the Economic Adjustment Programme agreed between the Eurozone countries in difficulty and their EU lenders (e.g. CY, EL, ES, IE, IT, PT). Strikingly, this requirement was not accompanied by conditions to protect vulnerable groups from user charges (Thomson, 2015).

In many of the healthcare systems that perform well with regard to access to care and preventing inequalities in access to healthcare among income groups (see Figure 2 and 3), healthcare is in general free at the point of use (see Table 1) or user charges are relatively low and measures are in place to protect vulnerable groups from user charges. Strikingly, this also applies to some of the countries with below EU average public spending on healthcare as a proportion of GDP (e.g. CZ, ES, UK) (see Figure 4). This suggests that user charges policies are key to ensuring equal access to care. This corresponds with the findings of the WHO that exemptions for poor people are the single most effective co-payment design feature in terms of access (Thomson et al., 2019).

In some countries the role of voluntary health insurance (VHI) is relatively important in ensuring access to healthcare. Both in France and Slovenia, complementary health insurance covering relatively high co-payments is taken out by nearly the whole population and is financially supported by public policies. In Ireland, where the statutory benefit package is very limited for a large share of the population, 45% of the population is mainly covered for healthcare through VHI. In Belgium, an estimated 83% of the population is covered for VHI (2016) and it represents 5% of total health expenditure (OECD, 2018).

Several countries have well-developed VHI schemes paid for by the employer (occupational VHI schemes), providing access to private and non-contracted providers free of charge (e.g. BE, CY, FI, HU, IT, MT, RO) or on a cost-sharing basis (e.g. PT).

These schemes provide faster access and an increased choice of healthcare providers. Such schemes may be supported by public money in different ways. Also in Belgium, there is a growing occupational and individual insurance segment for the risk of large out-of-pocket expenditures for hospitalisation and dental care. Many ESPN experts warn that (the growth in) voluntary and occupational health insurance may exacerbate inequalities in access to healthcare, particularly when the schemes are used to ‘jump the queue’ – for example, by those in better employment situations (ESPN Thematic Reports 2018). These practices indeed lead to access to healthcare based on ability to pay. They may also lead to worse availability of public healthcare if doctors leave the publicly funded sector to work in the private sector. As an example, in Finland, the main reason for unmet needs for medical care are the long waiting times in the municipal system. The hardest-hit groups are the low-income earners, since for most employees, rapid and free access to outpatient care is guaranteed through occupational health insurance coverage.

2.3. AVAILABILITY OF HEALTH SERVICES

While the healthcare benefits package is, in principle, quite broad in most countries, enough services need to be available in sufficient numbers and quality throughout the territory to ensure effective access to healthcare.

In many countries the provision of healthcare facilities is generally considered sufficient, although often with some regional shortcomings. In others, however, underfunding of the health system has resulted in underdevelopment of health services as an implicit form of rationing. Limited budgets for health services and quotas as to the number of services to be performed, have led to accumulated deficits of healthcare institutions, cuts in service provision and underinvestment in infrastructure and health technologies (e.g. BG, CY, EE, ES, HR, IE, LV, PL, RO).

Many European countries experience shortages of health professionals and, in particular, reduced numbers of professionals working in the publicly funded system. Medical professionals are leaving the health system to work in more attractive settings. Factors which make working in the public system less attractive include poor wages and working conditions (e.g. BG, CY, EE, IE, LV, PL, RO). Most Eastern European countries are confronted with a large outmigration of health professionals (e.g. BG, EE, HR, IE, LV, PL, RO). Health professionals also leave to work in the private or non-contracted sector and move from rural areas to set up practice in urban centres. Nearly all EU countries face shortages of health services in rural areas, in particular for primary care.

In several countries, health services have been reduced due to cost constraints in the wake of the financial and economic crisis. In most of the countries heavily hit by the crisis, austerity measures included closure of health services, staff reductions, freezes on hiring, limits placed on the number of contracts with health professionals in the publicly funded institutions and/or reduced wages (e.g. CY, EL, ES, IE, IT). For instance, in Greece, over the period 2010-2015, a decrease of 33.3% has been observed in the number of medical personnel employed in the health centres.

Waiting times are an issue of considerable concern in a large majority of EU countries and are a focus of public debate. Underfunding of the health system and staff shortages in the publicly funded sector often result in problematically long waiting lists. In some countries there are official waiting lists for specific treatments, while in many others there is a lack of transparency on priority-setting, or no monitoring of waiting times. In many countries, patients can bypass waiting times in the public sector if they (first) consult the specialist privately and therefore pay additional fees (e.g. AT, ES, FI, LT, MT, PL, SI). Informal (under-the-table) payments by the patient to physicians, which are common practice in several countries, are also made in order to bypass waiting lists or to have access to healthcare of better quality (e.g. BG, EL, HU, LT, LV, RO, SI). In Bulgaria, informal payments are estimated to make up half of the total out-of-pocket payments.

In some countries, additional funding has resulted in a reduction in the average waiting times in general, or for specific treatments (e.g. HU, LV, MT, NL, PT) while in others they are steadily increasing (e.g. ES, PL, SI, UK). In Cyprus, for instance, during the crisis years, even more people turned to the public sector and, as a result, waiting lists grew even more. Knee and hip replacements are being delayed by 30 months; cataract surgeries by 15 months.

Policies to improve waiting list management through the introduction of official waiting lists and maximum waiting time guarantees for specific treatments have been introduced in many countries (e.g. DE, DK, EE, FI, NL, SE, SI, UK). Patients waiting longer than the maximum waiting time obtain, in principle, more freedom to choose a healthcare provider, for instance a private/non-contracted provider or a provider outside their health region.

3. TRENDS IN REFORMS IN THE POST-CRISIS PERIOD ADDRESSING ACCESS TO HEALTHCARE

In this section we discuss some health system reforms addressing access to healthcare in European countries in the post-crisis period, that is since 2015.

Five countries — Cyprus, Greece, Finland, Ireland and Latvia — have implemented or are planning a comprehensive reform, involving an important overhaul of their health system. These are the EU countries with the most heavily fragmented health systems, with important differences in insurance coverage between different population groups, serious gaps in health coverage and important inequalities in access to healthcare. They are taking steps to move towards more uniform health coverage, by providing the whole population with coverage for the same benefit package. In Cyprus and Latvia, the reform will be funded by transforming the health system into a contribution-based compulsory social health insurance system. Yet reforms in most of these countries are slow, opposition from vested interests is substantial and financial means are often insufficient to ensure proper implementation. In Cyprus, for instance, despite the fact that the reform was unanimously voted through by the Parliament, implementation and operation of the new NHS system is being challenged, just three months before its launch, due to fierce opposition from both the Cyprus Medical Association and the Cyprus Association of Private Hospitals (Mamas, 2019). In Finland, after two years of debate in the parliament, three major aspects of the reform (increased role of private

providers; cost containment measures; and regionalisation of service provision) remain unresolved. In March 2019 the Finnish Parliament stopped the proceedings related to the reform, which triggered the Government's resignation (Keskimäki, 2019).

The countries most heavily hit by the 2008/2009 economic and financial crisis (Greece, Ireland, Spain, Portugal, Cyprus, Italy and Romania) implemented major reforms during the crisis years with the aim of reducing health spending, usually under strict surveillance from the European institutions. Austerity measures included: increasing user charges, reduction of salaries and of the health workforce, reduced prices for health services and products and closure of services. Since 2015, a cautious recovery has taken place in most of these countries, and in some countries austerity measures enacted during the crisis years, have been reversed.

Some of the countries with structurally underfunded health systems have made efforts to increase funding (e.g. CY, EE, LV, PL, RO). Additional funding has in particular been invested in policies aimed at retaining the health workforce and reducing outmigration, including by increasing wages (e.g. LT, LV, PL, RO).

Many European countries took measures to reduce user charges for specific services and products. This usually happened on an *ad hoc* basis. In some countries, such measures reversed increases in user charges enacted during the crisis years. However, some countries also took measures to further increase user charges or reduce protection from high user charges. In Slovakia for instance, the maximum limit for co-payments has been increased, while the groups of patients subject to these maximum limits have been extended.

Measures to improve access to primary care (e.g. EL, FI, IE, IT, PL, RO, UK), including initiatives to shift care from inpatient to outpatient settings and better integration of health and social services have also been a focus of policy measures.

4. SUMMARY AND CONCLUSIONS: AN OVERALL POSITIVE TREND BUT IMPORTANT INEQUALITIES IN ACCESS TO HEALTHCARE PERSIST

This article explored inequalities in access to healthcare in the 28 EU Member States, based on in-depth national ESPN Thematic Reports (2018) and statistical data.

While a substantial increase in unmet needs for medical care was noticed during the crisis years, since 2015, a gradual recovery has taken place. However, in some countries the situation is deteriorating further. Several population groups continue to have significant difficulties in accessing healthcare.

Our analysis found a link between the following health system features and inequalities in access to healthcare:

- First, underfunded systems perform worse than the EU average with regard to both access to healthcare and inequalities in access to healthcare between income groups. Indeed, underfunding leads to substantial shortages in healthcare provision, and in large shares of the healthcare cost having to be paid by the patient.

- Second, population coverage is crucial to ensure equal access to care.
- Third, user charges exacerbate inequalities in access to healthcare. In many of the healthcare systems that perform rather well with regard to access to healthcare, user charges are relatively low or healthcare is free at the point of use. In particular, the protection of vulnerable groups from user charges is crucial to ensuring equal access to healthcare. The low coverage for medicines, but also dental care and mental healthcare, are a cause of concern in many countries.
- Fourth, many countries experience shortages of health professionals, in particular of professionals working in the publicly funded system, which leads to waiting lists. Factors which make working in the public system less attractive include poor wages and working conditions. Serious shortages of healthcare providers, particularly in primary care, have frequently been reported in rural areas, thus leading to inequalities in access to care between regions.
- Fifth, patients can bypass waiting times in the public sector if they (first) consult the specialist privately and therefore pay additional fees. Informal (under-the-table) payments by the patient to physicians, which are common practice in several countries, in particular in Central and Eastern Europe, are also made in order to bypass waiting lists or to have access to healthcare of better quality. This leads to substantial inequalities in access to care. Voluntary and occupational health insurance may exacerbate these inequalities, particularly when the schemes are used to 'jump the queue'.

This article concludes that, while the general direction of travel is towards improved access to healthcare, important inequalities in access to healthcare persist, both between and within countries. Large shares of the EU population, in particular vulnerable groups, face multiple hurdles to access healthcare and therefore face multiple unmet needs. While access to healthcare is considered as a human right,⁸ most EU countries still have a way to go to ensure this right for each and every of their citizens. Some countries will have to invest more financial resources in their health system while others should reorganise their system to better protect vulnerable groups. In both cases, political courage will be needed to face opposition of vested interests.

(8) Article 25(1) of the United Nations *Universal Declaration of Human Rights* (1948) and Article 35 of the Charter of Fundamental Rights of the EU.

ANNEX: COUNTRY CODES

AT	Austria	IE	Ireland
BE	Belgium	IT	Italy
BG	Bulgaria	LT	Lithuania
CY	Cyprus	LU	Luxembourg
CZ	Czech Republic	LV	Latvia
DE	Germany	MT	Malta
DK	Denmark	NL	The Netherlands
EE	Estonia	PL	Poland
EL	Greece	PT	Portugal
ES	Spain	RO	Romania
FI	Finland	SE	Sweden
FR	France	SI	Slovenia
HR	Croatia	SK	Slovakia
HU	Hungary	UK	United Kingdom

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