



Inequalities in access to healthcare

A study of national policies 2018

Rita Baeten, Slavina Spasova, Bart Vanhercke
and Stéphanie Coster
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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER), APPLICA and the European Social Observatory (OSE).

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PREFACE

The right of everyone to timely access to affordable, preventive and curative care of good quality is one of the key principles of the recently proclaimed European Pillar of Social Rights¹. This means that access to healthcare should be effective for each person: it should be provided when people need it, through a balanced geographical distribution of healthcare facilities, professionals and policies to reduce waiting times. Costs should not prevent people from receiving the healthcare they need. Curative care, health promotion and disease prevention should be relevant, appropriate, safe and effective. Progress towards this principle is currently monitored by the European Pillar of Social Rights' Social Scoreboard indicator on "self-reported unmet need for medical care"². Promoting access to healthcare has also been one of the core objectives — alongside achieving high quality healthcare and financial sustainability of health systems — of the healthcare strand of the Social Open Method of Coordination since 2004. More recently, reduction of health inequalities, both in order to achieve social cohesion and to break the vicious circle of poor health contributing to poverty and social exclusion, has been advocated in key European Commission documents (including the Social Investment Package and the Annual Growth Surveys). Member States' health systems have received increasing attention in the European Semester process, including through the Country-Specific Recommendations and the Commission's Country Reports.

Achieving universal healthcare coverage, including financial risk protection for all, is furthermore a key target (target 3.8) of the United Nations' Sustainable Development Goals (SDG), with a view to implementing Goal 3: ensuring healthy lives and promoting well-being for all at all ages.

Health systems face the challenge of ageing populations and increasing demand, which can also result from non-demographic factors such as the emergence of new (often expensive) treatments. In some European countries, costs and waiting time remain important barriers to accessing healthcare. Against a background of rising demand for healthcare resources, and public budgets which are often under pressure, ensuring universal and timely access to high quality healthcare — whilst also guaranteeing the financial sustainability of health systems — is a challenge which requires increased efforts to improve the efficiency and effectiveness of health systems.

According to a European Commission (2014) Communication, access to healthcare includes the following dimensions: a) population coverage; b) affordability of healthcare (cost-sharing); c) basket of care; and d) availability of healthcare (distance, waiting times).

These dimensions are interlinked. Thus, a lack of public healthcare coverage, or the provision of only a limited set of services by the public health system, may result in higher costs and affordability problems for some groups. Similarly, some types of coverage (e.g. occupational health insurance schemes) may result in easier or faster availability of healthcare for people in a better socio-economic position. Finally, the different dimensions of access, in particular population coverage, may be affected by the financing structure of healthcare³ and by the mechanisms linking payments into the system to access to healthcare.

People on a low income have more difficulties accessing healthcare. The share of self-reported unmet healthcare needs (especially due to cost) is usually higher among low-income households. However, other groups may also potentially have limited effective access to healthcare, such as single person households or informal workers. Moreover, people without documents do not normally have full access to healthcare.

¹ Principle 16 – "Healthcare". The full text of the European Pillar of Social Rights and various accompanying documents are available [online](#).

² The Social Scoreboard is available [online](#).

³ Pooled resources for healthcare funding mostly come from general taxation, social security contributions and/or premiums for compulsory private insurance.

The characteristics of the individual patient — such as poor literacy, language or culture, social inhibition, isolation, lack of trust between the provider and the patient as well as geographical mobility — can also hinder accessibility to healthcare. Inequalities in these characteristics of the population can, to some extent, generate inequalities in access to healthcare. While access can be affected by public policy beyond the health system — including by policies related to income protection, education, employment and costs of other basic services and transport — the extent to which these characteristics effectively affect access also depends on the design and functioning of the health system and its interaction with the characteristics of the population (EXPH 2016).

A Synthesis Report from the European Social Policy Network

With a view to supporting its analysis and forthcoming initiatives, the European Commission asked the national experts of the European Social Policy Network (ESPN) to describe the extent of inequalities in access to healthcare in their country, to analyse country-specific challenges and to provide good practices.

The present Synthesis Report describes the main features of health systems enabling access, analyses the main challenges in inequalities in access to healthcare identified in the 35 countries under scrutiny and how they are tackled, and briefly discusses the indicators available at national and European level on access to healthcare.

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 35 ESPN national experts' reports⁴. 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 report. Readers wishing to follow up the original sources should consult the individual expert reports.

The report does not deal with inequalities in health per se, nor the important socio-economic determinants outside the health system underlying these inequalities. Indeed, education, housing, food and employment all have a crucial impact on health but are beyond the scope of this report. Similarly, the quality of the healthcare provided, although a crucial aspect of access, is not addressed in this report (see e.g. OECD/WHO/World Bank Group, 2018).

The main challenges identified regarding inequalities in access to healthcare are: a) inadequacy of the public resources invested in the health system; b) fragmented population coverage; c) gaps in the range of benefits covered; d) prohibitive user charges, in particular for pharmaceutical products; e) lack of protection of vulnerable groups from user charges; f) lack of transparency on how waiting list priorities are set; g) inadequate availability of services, in particular in rural areas; h) problems with attracting and retaining health professionals; and i) difficulties in reaching particularly vulnerable groups. The Synthesis report also identifies national reforms aimed at tackling these challenges and proposes policy recommendations, at both national and EU levels.

This Synthesis Report draws on the national contributions prepared by the 35 ESPN Country Teams⁵. It was written by Rita Baeten, Slavina Spasova, Bart Vanhercke and Stéphanie Coster of the ESPN's Network Core Team⁶, with helpful comments and suggestions from the ESPN Country Teams and from colleagues in the Network Management Team⁷.

⁴ Here and throughout the report, the countries in brackets are provided as examples and the lists are not necessarily exhaustive.

⁵ For a presentation of the ESPN Network Core Team and the 35 ESPN Country Teams, see Annex 5. The 35 ESPN national experts' reports on inequalities in access to healthcare can be downloaded [here](#) (ESPN page on the European Commission website).

⁶ The authors are from the European Social Observatory (OSE, Brussels). They are grateful to Paola Signorelli (University of Milan) for substantial graphical support.

⁷ We wish to thank Hugh Frazer (Maynooth University, Ireland) and Eric Marlier (Luxembourg Institute of Socio-Economic Research, LISER) for their valuable feedback on the draft report and especially for their excellent drafting suggestions concerning the policy recommendations.

Comments and suggestions from the European Commission are also gratefully acknowledged⁸.

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Based on the in-depth national contributions prepared by 35 ESPN Country Teams, the Synthesis Report outlines the following **ten key findings**.

First, there is a **huge variety** in the amount of **public resources**⁹ spent on healthcare in the countries analysed, ranging from 3% of GDP in Cyprus to 9.4% of GDP in Germany. This leads to important differences in the share of the cost of services that has to be paid by the patient as well as to large variations in the availability and quality of services. In some countries, public healthcare funding has been drastically reduced as a result of expenditure cuts following the 2008 economic and financial crisis (e.g. CY, EL, ES, IS, IT, PT). Since 2015, healthcare budgets in most of these countries have shown a slight recovery.

Second, most countries for which the national ESPN experts stressed that their **system** is **underfunded** (e.g. BG, CY, EE, EL, HR, HU, IE, IT, LT, LV, PL, RO, RS), **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 large shares of the cost for healthcare to be paid by the patient.

Third, while a large majority of European health systems cover **nearly the whole population** for a comprehensive basket of healthcare benefits, in some countries, a **significant percentage** of the population **is not covered** by the statutory health system, ranging from 5% in Hungary to more than 20% in Cyprus. 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 people in non-standard employment, some categories of self-employed, people who did not contribute a sufficient number of years to the system, undocumented people and asylum seekers.

Fourth, the **high out-of-pocket payments (OOP)**¹⁰ for medicines, but also dental care and mental healthcare, are a cause of concern in most European countries. In particular, 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. This may have an important impact on the effectiveness of the healthcare provided.

Fifth, the outcome with regard to access to healthcare can be quite different between countries spending similar amounts of public money on healthcare. Thus, some countries with below EU average public spending on healthcare as a proportion of GDP (e.g. CZ, ES, UK) perform rather well with regard to access to healthcare and preventing inequalities in access to healthcare among income groups. In many of the **well-performing systems, user charges are relatively low** or healthcare is free at the point of use.

⁸ As mentioned above, the report reflects the views only of the authors and the Commission cannot be held responsible for any use which may be made of the information contained therein.

⁹ Public resources include both general taxation and compulsory insurance contributions.

¹⁰ Different forms of OOP exist. They include: 1) direct payments: 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)).

Sixth, inequalities in access to healthcare do not seem to be linked to the model of health system funding. Health systems can be broadly categorised into three models, depending on how they are funded: National Health Service (NHS); Social Health Insurance (SHI) or Private Health Insurance systems.¹¹ Well-performing countries can be found among all three models. This suggests that the performance of systems in terms of safeguarding access is, instead, related to the country-specific **details of the organisation of healthcare provision** and the **way in which vulnerable groups are protected from user charges** within each of the systems.

Seventh, while in many countries the provision of healthcare facilities is generally considered to be sufficient by the ESPN country experts, in many others the supply of health services is reported to be inadequate: this is referred to as an implicit form of rationing. Many countries experience **shortages of health professionals** and, in particular, reduced numbers of professionals working in the publicly funded system. Factors which make working in the public system less attractive include poor wages and working conditions. Serious **shortages** of healthcare, particularly primary care, provision have frequently been reported in rural areas.

Eighth, waiting lists are an issue in a large majority of European countries. 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. According to many ESPN country experts, **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, RS, TR).

Ninth, 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. All these practices thus 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.

Finally, and crucially, several population groups have significant difficulties in accessing healthcare. The **lowest income quintiles** are among the most disadvantaged groups in terms of effective access to healthcare. The most striking example is Greece, where the lowest income quintile reports 35.2% of unmet needs and the highest only 1% in 2016. **Women** also face many more difficulties in access to healthcare than men. Access to healthcare can also be hindered by **residence status and ethnicity**. Roma populations have been reported to be among the most vulnerable with regard to access to healthcare (e.g. BG, HU, HR, MK, SI, SK). Access to healthcare for **migrants** and in particular asylum seekers, refugees and undocumented migrants has also become a particularly acute issue.

Conclusions

This report explores inequalities in access to healthcare in 35 European countries. The overall conclusion is 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; and large shares of the EU population, in particular vulnerable groups, face multiple hurdles and therefore do not obtain the care they need.

The ten key findings of the report can be summarised as follows: a) there is a huge variety in the amount of public resources spent on healthcare in the 35 countries analysed; b) most of the underfunded systems perform worse than the EU average with regard to access

¹¹ National Health Service (NHS) systems are mainly funded through general taxation. Social Health Insurance (SHI) systems are financed by a mix of social contributions and general taxation. In Private Health Insurance (PHI) systems, premiums are directly paid by the insured members to the insurance company on an individual basis or are paid by the employer and deducted from the salary of the employee.

to healthcare; c) in some countries, a significant percentage of the population is not covered by the statutory health system; d) high out-of-pocket payments, in particular for pharmaceuticals, are a cause of concern in most European countries; e) between countries spending similar amounts of public money on healthcare, the outcome with regard to access to healthcare can be quite different; f) inequalities in access to healthcare are linked to the country-specific detailed organisation of healthcare provision and the way in which vulnerable groups are protected from user charges, rather than to the type of health system; g) the supply of health services is inadequate in many countries (esp. shortages of health professionals and in rural areas); h) waiting lists are an issue in a large majority of European countries; i) the growth in voluntary and occupational health insurance may exacerbate inequalities; and j) several population groups (which include the lowest income quintiles, women, ethnic minorities and migrants) have significant difficulties in accessing healthcare.

The main challenges identified regarding inequalities in access to healthcare are: a) inadequacy of the public resources invested in the health system; b) fragmented population coverage; c) gaps in the range of benefits covered; d) prohibitive user charges, in particular for pharmaceutical products; e) lack of protection of vulnerable groups from user charges; f) lack of transparency on how waiting list priorities are set; g) inadequate availability of services, in particular in rural areas; h) problems with attracting and retaining health professionals; and i) difficulties in reaching particularly vulnerable groups.

In several countries that do not cover the whole population, important reforms are underway to provide improved coverage. Yet reforms are often very slow, opposition from vested interests may be substantial and financial means are often insufficient to ensure proper implementation.

A substantial increase in unmet needs was noticed during the crisis years: from 3% of the respondents reporting unmet needs for medical care in 2009 to 3.6% in 2014. This may be explained by the austerity policies in many countries, loss of entitlement for some groups, reduced household budgets available for healthcare (due to rising unemployment and increased costs for other basic services) and, at the same time, an increasing need for healthcare. Since 2015, a gradual recovery has taken place, and in 2016, unmet need, at 2.5%, is for the first time below the level of 2008. However, in some countries the situation is deteriorating further.

Access to healthcare is generally considered as a human right¹² and has been recently enshrined in the European Pillar of Social Rights. The analysis contained in this report may provide input for policy discussion at country and EU level on how to better guarantee this right for the people of Europe.

Recommendations

It is hoped that the recommendations formulated below can provide a useful framework for the European Commission and the Member States, to help them assess and enhance their efforts to implement the European Pillar of Social Rights principle on access to healthcare. These recommendations are based upon an analysis of the 35 ESPN country reports and further analysis by the ESPN Network Core Team.

a) Recommendations to countries

The following set of recommendations are issued to the Member States. It should be noted that the best-performing countries have already implemented many of these recommendations, but all European countries have some areas where improvements are needed.

¹² See e.g. Art. 25(1) of the United Nations *Universal Declaration of Human Rights* (1948) and Art. 35 of the Charter of Fundamental Rights of the EU.

Financing of health systems

- First and foremost, **sufficient public funding**, from general taxation and compulsory health insurance contributions, should be allocated to the statutory health system, in order to meet the health needs of the population.

Health coverage

- The **whole population should be covered for a comprehensive range of healthcare benefits**. Efforts are needed to ensure that all people, including those on low incomes or in precarious or unstable jobs, are covered by the health system.
- The **inclusion of undocumented people, asylum seekers and homeless people** in the system is strongly advisable and may well come at only a marginal additional cost.
- Differences in coverage lead to unequal access to healthcare. **The range of services covered should be uniform** for all people and include cost-effective hospital care, outpatient primary and specialist care and pharmaceutical products. Coverage for **mental healthcare and dental care** should be improved.

User charges

- User charges for healthcare must not hamper effective access to healthcare. The **annual level of user charges should be capped** at a sufficiently low level and should take into account household income. **Vulnerable groups**, such as low-income earners, patients with chronic conditions or infectious diseases, beneficiaries of certain social benefits, pregnant women, children and old age pensioners, **should be protected from user charges**.
- In particular, **coverage for pharmaceutical products should be substantially improved** in many countries and the annual amount of user charges for pharmaceutical products should be capped.

Availability of services

- In order to shorten waiting lists for medical services, countries should **invest sufficiently in healthcare provision** and ensure a sufficient supply of health professionals. It is therefore necessary in many countries to **improve the working conditions of healthcare staff and ensure sufficient pay** for health professionals working in the publicly funded system.
- To avoid patients jumping the queue by first consulting private doctors or providing informal under-the-table payments, **transparency on priority-setting in waiting lists** is crucial.
- To prevent practitioners having an incentive to prioritise patients who pay more, **tariffs for statutorily covered healthcare should be uniform**, irrespective of whether or not the health professional is contracted by the statutory system.
- Particular efforts should be made to ensure **access to healthcare in remote and sparsely populated areas**. Health professionals should be incentivised to settle there. Countries should invest considerably in **integrated primary care services**, not only, but in particular, **in rural areas**.

Voluntary health insurance

- Countries should prioritise investing available public resources in improving the statutory health system and should **not financially support — directly or indirectly — voluntary health insurance schemes**.

Initiatives targeting vulnerable groups

- A **proactive approach** is needed **to reach particularly vulnerable groups**, such as homeless people, drug addicts, ethnic minorities, Roma, asylum seekers and refugees. **Targeted solutions** should be set up to ensure access to healthcare for these minorities, such as regular health campaigns, preventive actions and cultural mediators. Specific information campaigns are needed to inform them about their rights.

b) EU-level recommendations

While fully respecting the competencies of the Member States with regard to the organisation and funding of their health systems, the EU should support Member States in their efforts to reduce inequalities in access to healthcare, in particular by collecting and analysing comparative data related to access to healthcare, by monitoring progress, by organising exchanges of good practice and by flagging Member States lagging behind in the context of the European Semester process.

The following initiatives are therefore recommended:

- the EU's Social Protection Committee (SPC) and the European Commission should develop a **roadmap for the implementation of Principle 16 of the European Pillar of Social Rights**, which states that "Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality";
- the SPC and its Indicators Sub-Group have an important role to play in **monitoring access to healthcare** in Member States and in **sounding an alert when the situation is deteriorating**. An appropriate Joint Assessment Framework (JAF) on healthcare should be developed and used as an evidence-based policy instrument in dialogue with national authorities;
- the European Commission should **strengthen the monitoring and reporting on inequalities in access to healthcare in the European Semester process**, with the use of Country Reports and Country-Specific Recommendations for those countries lagging behind. **Countries lagging behind with regard to the percentage of GDP spent on healthcare should be flagged**;
- **EU funding** (notably the European Social Fund+ [ESF+]) should be used **to improve access to healthcare**, in particular for vulnerable groups;
- the Commission should foster the **exchange of experience and good practice between Member States** on policies promoting equal access to healthcare, including through peer reviews and the collection of case studies. The Commission and the SPC should set up **a peer review on initiatives specifically aimed at reaching ethnic minorities**, in particular the Roma population, and promoting targeted solutions to improve access to healthcare, such as health campaigns and cultural mediators. The results could be used in the National Roma Integration Strategies;
- the Commission should invite the **Expert Group on Health System Performance Assessment (HSPA)**, made up of representatives of EU Member States and international organisations, to **focus discussions on inequalities in access to healthcare**;
- the **quality and comparability of the measurement of access to healthcare should be improved in EU surveys**, so as to better capture and monitor national situations and strengthen comparability across countries. Measurement of **access to prescribed pharmaceutical products** should be included in these surveys.

1 DESCRIPTION OF THE FUNCTIONING OF COUNTRIES' SYSTEMS FOR ACCESS TO HEALTHCARE

This section provides an overview of the main features of the health systems, relevant for ensuring access to healthcare and addressing inequalities in this area, in the 35 countries analysed. Section 1.1 discusses how resources are generated for the health system. Section 1.2 discusses how the countries perform on the different dimensions of health coverage. Voluntary health insurance is discussed in Section 1.3 and the availability of health services is addressed in Section 1.4.

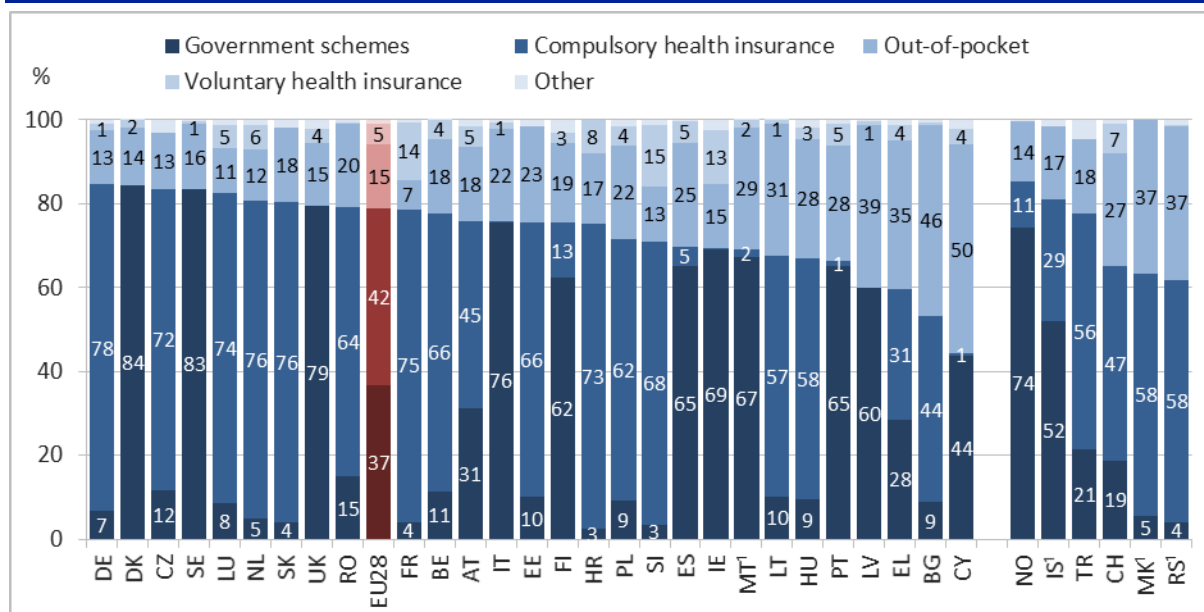
1.1 Health system financing

Healthcare in European countries is financed through a mix of financing schemes. These include: first, government spending generated through general taxation; second, compulsory health insurance generated through employer and employee contributions and/or premiums paid to private health insurance companies; third, out-of-pocket (OOP) payments by households and fourth, voluntary health insurance (VHI) schemes.

Government spending and compulsory health insurance are the sources of public spending for healthcare, implying strong solidarity mechanisms and regulation. Private health spending consists of OOP and VHI.

Different forms of OOP exist. These include: a) direct payments: payments for goods or services that are not covered by any form of third-party payment; b) 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; c) 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 d) informal payments: unofficial (under-the-table) payments for health goods or services¹³.

Figure 1: Current health expenditure by type of financing, 2014



Source: OECD/EU (2016), *Health at a Glance: Europe 2016*; * ESPN countries not included in the dataset: LI.
 Note: Countries are ranked by government schemes and compulsory health insurance as a share of current health expenditure. ¹ Includes investments.

Voluntary health insurance can cover healthcare benefits not included in the statutory healthcare basket; as well as user charges or a greater choice of providers. In some countries, in particular in those where such schemes are important to ensure access to

¹³ Own elaboration based on Rechel, Thomson and van Ginneken (2010).

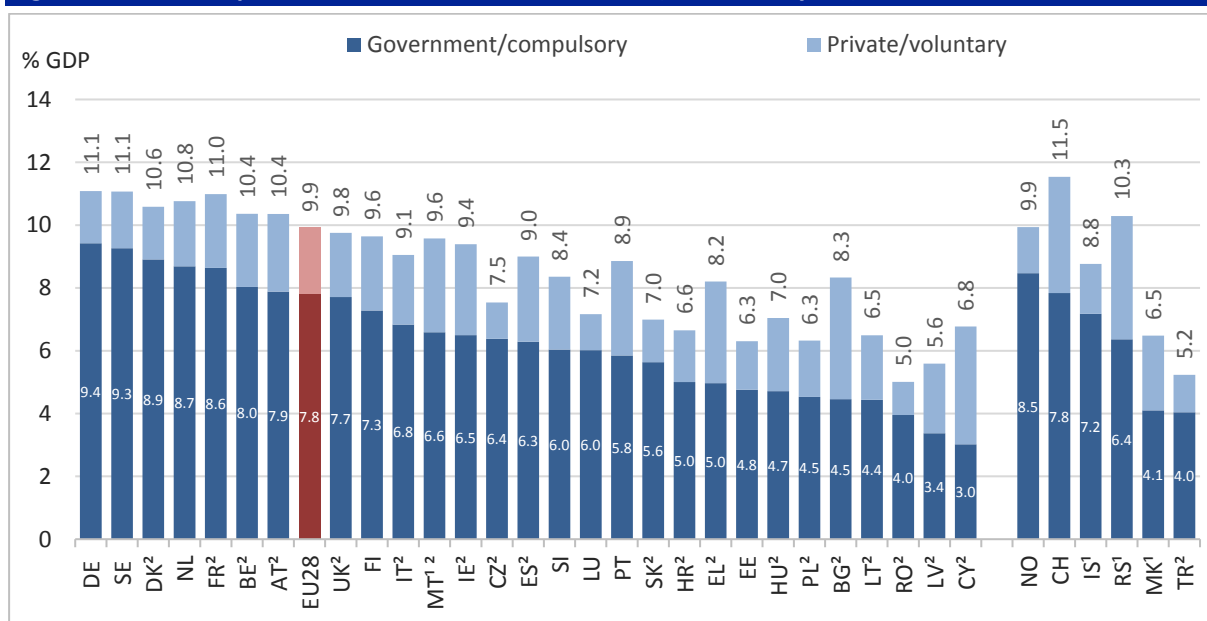
healthcare for specific groups, they may involve some solidarity elements, regulation and direct or indirect public funding (e.g. CY, FI, FR, HR, HU, IE, LV, SI).

Overall, nearly 80% of health spending in the countries analysed is funded through general taxation or compulsory health insurance schemes, 15% by households through OOP, and 5% through VHI. The rate of OOP spending nevertheless reaches more than 25% in some countries (e.g. BG, CH, CY, EL, HU, LT, LV, MK, MT, RS, PT) and is as high as 50% in Cyprus. VHI funds more than 10% of health spending in Ireland, France, and Slovenia (See Figure 1).

Adequate health system funding is fundamental to securing the required levels of quality services to meet the population’s needs. Inadequate public funding for the health system creates and exacerbates barriers to access (SPC 2016).

There is a huge variety in the public resources made available to the health systems in the countries analysed, ranging from 3% of GDP in Cyprus to 9.4% of GDP in Germany (see Figure 2)¹⁴.

Figure 2: Health expenditure as a share of GDP, 2015 (or nearest year)



Source: OECD/EU (2016), *Health at a Glance: Europe 2016*; ¹ Includes investments; ² OECD estimate; * ESPN countries not included in the dataset: LI.

Health systems can be broadly categorised into three models, according to how they are funded: National Health Service (NHS) systems; Social Health Insurance (SHI) systems or Private Health Insurance (PHI) systems (see Table 1). National Health Service systems are primarily tax-funded (e.g. CY, DK, ES, IE, IS, IT, LV, MT¹⁵, NO, PT, SE, UK).

Social Health Insurance systems are financed by a mix of social contributions and general taxation (e.g. AT, BE, BG, CZ, EE, FR, HR, HU, LT, LU, MK, PL, RO, RS, SI, SK, TR), with the state — in principle — contributing to the system for non-contributing groups such as children and pensioners (Section 1.2). The share of the insured population not directly contributing to the system can be very high: from 30% in Austria up to 60% in the Czech Republic. Finland and Greece combine a tax-funded NHS model with compulsory social health insurance, and in Cyprus a systemic reform is being implemented, shifting from an NHS system toward a SHI system.

¹⁴ The data include healthcare-related long-term care expenditure.

¹⁵ In Malta, economically active persons pay a percentage of their income to cover social security. The money thus collected is however not kept in a specific fund but goes into a consolidated state-run fund, from which money is allocated to cover social security, pensions and health expenses.

In a few countries, a mandatory Private Health Insurance (PHI) system is implemented. In PHI systems, private health insurers play a pivotal role in providing a statutory defined package of benefits through compulsory health insurance (e.g. CH, LI, NL). Premiums are directly paid by the insured members to the insurance company on an individual basis, or are paid by the employer and deducted from the salary of the employee. Germany has a SHI and for some specific groups a compulsory PHI.

Table 1: Models of health systems in Europe

| NHS systems | SHI systems | PHI systems |
|--|--|-------------|
| CY ¹ , DK, ES, IE, IS, IT, LV ¹ , MT, NO, PT, SE, UK | AT, BE, BG, CZ, EE, FR, HR, HU, LT, LU, MK, PL, RO, RS, SI, SK, TR | CH, LI, NL |
| EL, FI Mixed systems NHS/SHI | | |
| | DE Mixed system SHI/PHI | |

Source: authors' own elaboration drawing on ESPN country reports. ¹ Country in transition towards a SHI system (see Section 2.2).

The share of the state contribution to social health insurance (SHI) based systems varies a great deal, from 12.6% of the health insurance budget in Estonia to 40% in Luxembourg and Lithuania. In countries where the state contribution for the non-contributing groups is very low (e.g. BG, EE, HR, PL), the health systems run a deficit: in these countries, healthcare for non-contributing groups has to be financed from resources collected via employer/employee contributions. In some countries, plans have been made to increase the state contribution for non-contributing groups (e.g. CZ, EE).

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, RS), 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.

In some countries where the system is structurally underfunded, public funding has gradually increased or governments have decided to increase public funding in the near future (e.g. EE, LV, PL, RO). In an attempt to broaden the funding base for the system, some of the systems that are underfunded are currently in a transition from tax-funding to a contribution-based SHI (e.g. CY, LV). In Serbia, however, the compulsory contribution rate was reduced in 2013 from 12.3% to 10.3%, which led to a significant drop in the revenue of the health insurance fund.

In several countries, public healthcare funding has been drastically reduced as a result of expenditure cuts following the economic crisis and, for some of these countries, due to the implementation of the Economic Adjustment Programmes agreed with the EU lenders. Since 2015, healthcare budgets in most of these countries have shown a slight recovery (e.g. CY, EL, ES, IE, IS, IT, PT). Box 1 illustrates this point.

Box 1: The impact of the crisis on public funding of healthcare in some countries

In Greece, healthcare funding was reduced by approximately 36.5% during the period 2009-2016. In absolute numbers, total public expenditure on health decreased from €16.1 billion in 2009 to €9 billion in 2016, whereas total private funding decreased from €7 billion in 2009 to €5.6 billion in 2016. Total funding of health expenditure followed a downward trend until 2014, while a slight recovery can be observed in 2015 and 2016.

In Iceland, healthcare expenditure fell from 9.3% of GDP in 2007 to 8.6% of GDP in 2016 (public 7.1% and private 1.5%).

In Ireland, financing of the Health Service Executive (HSE) fell by 22% between 2009 and 2013, amounting to almost €3.3 billion less in public funding. The 2015 budget was the first in seven years where health expenditure was not cut, and the country has seen reinvestment in health expenditure since then.

In Italy, the annual growth rate of expenditure on public healthcare in real terms was on average -2.4% between 2010 and 2014.

In Spain, the financial resources devoted to healthcare decreased by 13% between 2010 and 2014. Although public healthcare expenditure increased by 3.5 billion in 2015 and by an additional €600 million in 2016, the process of fiscal consolidation in the healthcare sector continues. Public healthcare expenditure, which amounted to 6.8% of GDP in 2009, fell to 5.9% in 2017, and is to be further reduced to 5.6% by 2020¹⁶.

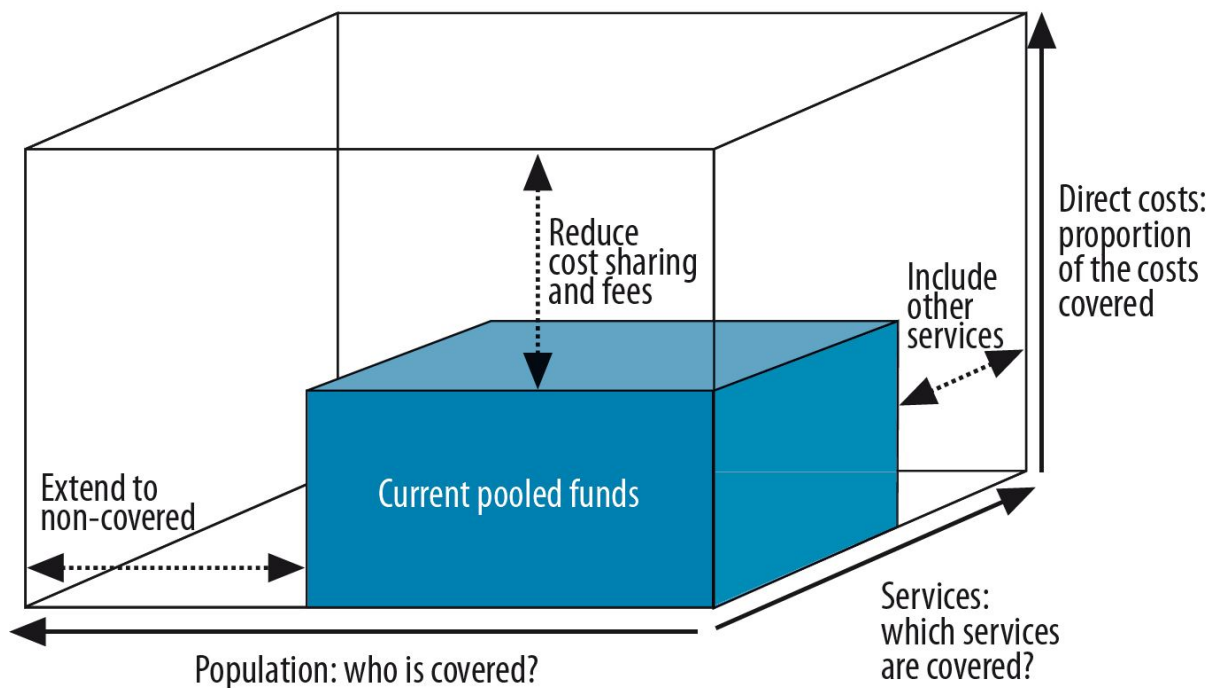
Source: ESPN country reports

1.2 Health coverage

Health coverage has three dimensions: the share of the population entitled to publicly financed health services (population coverage), the range of health services covered (benefit package), and the extent to which people have to pay for these services at the point of use (user charges) (WHO 2010). Services that are wholly or partially excluded from public provision must be paid for by patients, either through direct private spending or through the purchasing of voluntary health insurance. Universal health coverage, as defined in the United Nations' Sustainable Development goals, implies that the whole population is covered for a broad range of health services and products and that they are covered for the full cost.

Figure 3 provides a visual image of the three dimensions of health coverage. The small cube presents the actual coverage ("Current pooled funds"), while the spaces between the small and the large cube represent the gaps in coverage between actual coverage and universal health coverage, in terms of the population, services and costs covered.

¹⁶ Plans to further reduce healthcare expenditure to 5.6% by the year 2020 were made by the former government. The new government (June 2018) has committed itself to reverse the cuts made to healthcare budgets and to bring these back to levels previous to the fiscal consolidation measures adopted in 2010.

Figure 3: The dimensions of health coverage

Source: WHO 2010.

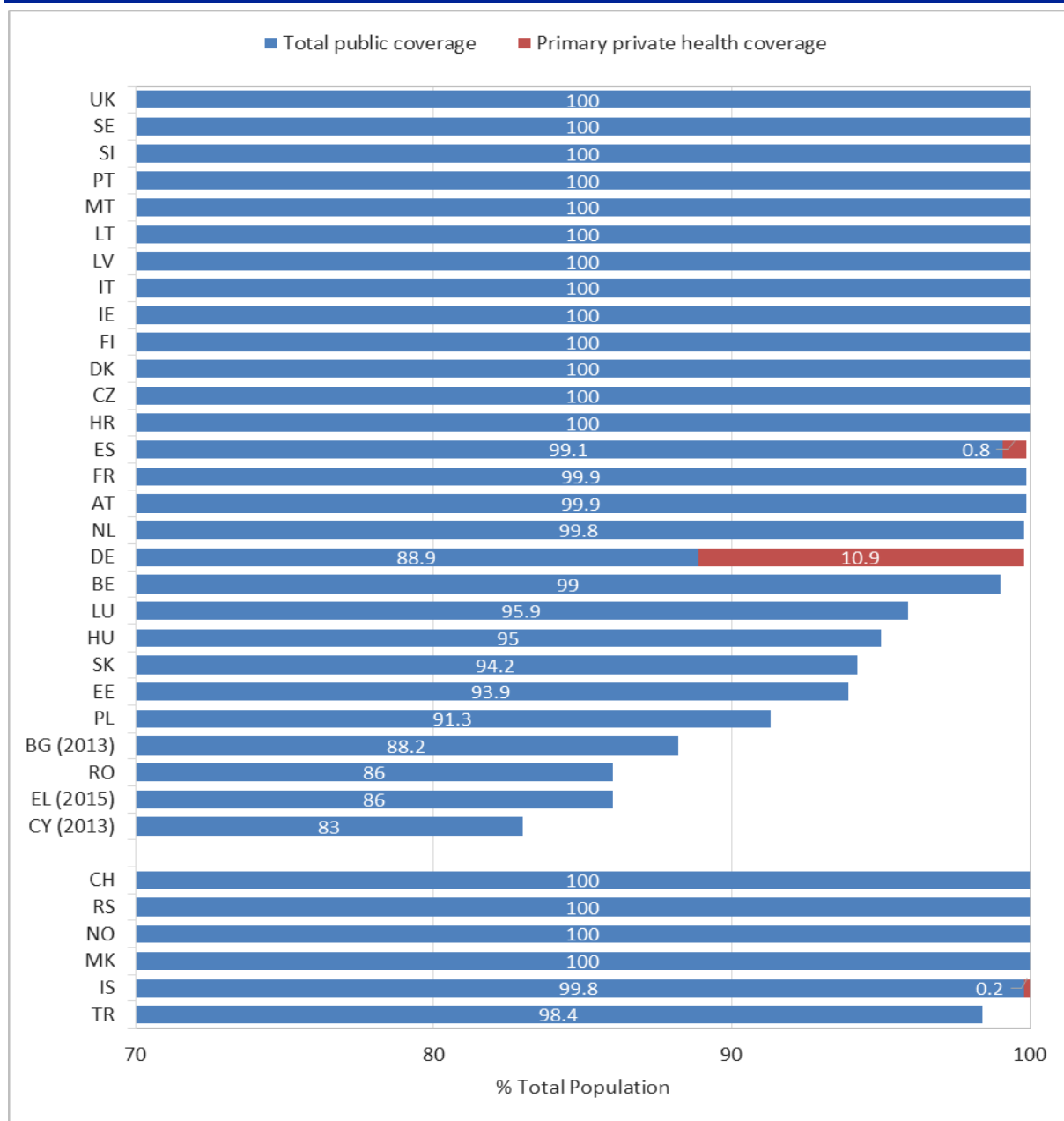
In this section, we assess, based on the ESPN experts' country reports, how the 35 European countries under scrutiny perform on each of the three dimensions of health coverage. We therefore discuss who is covered (Section 1.2.1); what is covered (Section 1.2.2); and how much is covered (Section 1.2.3).

1.2.1 Who is covered? Population covered by the statutory health system

Covered groups

A large majority of European health systems provide nearly universal population coverage for a defined basket of healthcare benefits (for the range of benefits covered, see Section 1.2.2) (e.g. AT, BE, CH, CZ, DE, DK, ES, FI, FR, HR, HU, IE, IS, IT, LI, LT, LU, LV, MT, NL, NO, RS, SE, SI, SK, UK) (see Figure 4).

Figure 4: Percentage of the population covered for a defined set of services, 2014 (or nearest year)



Source: OECD/EU (2016), *Health at a Glance: Europe 2016*; * ESPN countries not included in the dataset: LI.

In principle, the systems that are tax-funded (NHS systems) provide universal population coverage based on residency (e.g. DK, ES, IS, IT, LV, MT, NO, PT, SE, UK). However, this is not the case in Cyprus, where access to public healthcare is based on income criteria. Groups which are not covered may access public health services but must pay for the healthcare out of their own pocket, while an annual means-tested ceiling on out-of-pocket payments applies. Coverage may be extended to some categories of non-residents/citizens such as students and undocumented migrants (e.g. MT, PT).

In principle, systems based on Social Health Insurance (SHI) cover people who contribute to the system. In these systems, people in gainful employment (employees and self-employed) are therefore covered. In some countries, pensioners (e.g. EL, HR¹⁷, MK, PL), recipients of replacement benefits (e.g. LU) and those not employed but able to work (e.g.

¹⁷ In Croatia, this only applies to pensioners with an income above a certain threshold.

HU, LT, LU, MK), as well as their spouses (e.g. HU, LT), have to pay mandatory health insurance contributions. For pensioners, contributions may also be paid by the pension funds (e.g. RS, SI). Premiums for households on a low income may be fully or partially paid by the public authorities (e.g. LU, TR).

In practice, however, most SHI systems provide nearly universal population coverage, by extending insurance coverage to non-contributing groups. These include: dependent family members of the contributing persons, such as (studying) children (e.g. AT, BE, BG, DE, EE, EL, HR, HU, LI, LT, LU, MK, PL, RO, RS, SI, SK, TR) and partners (e.g. AT, BE, DE, EL, MK, PL, RO, SI, SK, TR), those receiving social insurance benefits, such as pensioners (e.g. AT, BE, BG, DE, EE, HR, HU, LT, RS, SK, TR) and the unemployed (e.g. AT, BE, BG, DE, EE, EL, HR, HU, LT, PL, RS, SI, SK), recipients of social assistance benefits (e.g. disabled people) (e.g. AT, BE, DE, EE, EL, HR, HU, LT, LU, PL, RO, SI, SK, RS), caregivers and personal assistants to severely disabled citizens (e.g. RO, SI, SK). In some of the social insurance-based systems, entitlement to health insurance coverage is based on permanent residence (e.g. CZ, FR). In principle, the state pays the contribution for the non-contributory groups (see Section 1.1)

In health systems based on mandatory private health insurance (PHI), premiums are directly paid by the insured members to the insurance company on an individual basis or are paid by the employer and deducted from the salary of the employee (e.g. DE,¹⁸ LI, NL). They may also be paid by the unemployment insurance (e.g. LI). Premiums are as a rule not related to income. In the Netherlands, insured persons additionally pay an income-related contribution through their employer. In principle, insurers must accept all applicants (open enrolment) (e.g. CH, LI, NL). Whilst in some of these countries all persons covered by the same insurer pay the same premium regardless of age, gender and health status ("community rating") (e.g. LI, NL), in others rates may be based on the individuals' health risk at the time of the conclusion of the contract (e.g. DE). Differences in the levels of premiums between insurers may also be subject to limits (e.g. NL). In Switzerland, premiums are fixed by the Cantons and there is a large variation in premium levels between them. Children and spouses with no income have to be insured individually in all these countries (e.g. CH, DE, LI, NL). Reduced premiums may apply to children (e.g. CH) and young adults (e.g. CH, LI) as well as low income earners (e.g. NL). Alternatively, the state may also pay the premiums for children (e.g. LI, NL) and subsidise the premium for lower income groups (e.g. CH, LI). The premiums for vulnerable groups, such as asylum seekers, may be covered by social assistance (e.g. CH, LI). Since the PHI scheme was introduced in Switzerland (1996) and the Netherlands (2006), both premiums and national health expenditure have increased constantly. In Liechtenstein, the state contribution has been steadily decreasing since 2010, whilst the PHI premium contributions have increased.

In some countries, different schemes of statutory coverage exist for different population groups (see Box 2).

¹⁸ In Germany, this only applies to people above a certain income threshold who choose not to opt into the SHI.

Box 2: Different schemes of statutory coverage for different population groups: within-country variation

In Austria, particular social groups are insured with a specific fund and therefore face user charges — for instance the self-employed, farmers and civil servants.

In Germany, most people are insured in the SHI system. However, tenured civil servants, the self-employed and employees whose gross wages exceed a defined threshold may opt for private health insurance or choose to join the SHI system. The benefit package in the PHI is not fully standardised and the individuals may partially choose the range of benefits to be included in the individual scheme.

In Greece, in 2016, health coverage was extended to the whole population, including uninsured groups such as the unemployed. However, uninsured persons have access only to public health services, while insured persons also have access to private contracted providers, on a cost-sharing basis.

In Ireland, 54% of the population (in particular those on higher incomes) are, under the statutory system, only entitled to hospital care.

In Liechtenstein, the Netherlands and Switzerland, all three countries with mandatory PHIs, individuals have a certain level of choice in their insurance policy. They can opt for a policy with lower insurance premiums but higher deductibles, i.e. the cost of healthcare to be fully paid by the patient, before the health insurance kicks in. Individuals may furthermore choose between policies with more or with less free choice of providers. In the Netherlands, individuals may choose any insurer, while many employers, sports clubs and unions offer access to discounted collective insurance.

In Spain, specific categories of public employees and their dependent family members have their own specific social health insurance scheme (more than 2 million people in 2016), which allows them to choose between healthcare provided by the public system, or by private healthcare providers. Most of them have opted for private health insurance. Civil servants from the central government hired after January 2011 can no longer join this system.

Source: ESPN country reports

Groups which are not covered

While most European health systems provide nearly universal population coverage, in some countries more than 5% of the population is not covered by the statutory health system (e.g. BG, CY, EE, HU, IE, LT, PL, RO, SK, TR) (see Figure 4). Cyprus has the highest score, with nearly 20% of the population not covered for healthcare. But even in countries with 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 benefits¹⁹ (e.g. AT, BE, BG, EE, RO, TR); specific categories of people in non-standard employment and precarious jobs (e.g. AT, DE, EE, PL); some categories of self-employed (e.g. EE, RO, TR); people performing undeclared work (e.g. BG, EE, PL, RO, RS, TR); undocumented people (e.g. AT, BE, CY, DK, ES²⁰, FI, FR, HR, LU, NO, UK); asylum seekers (e.g. DE²¹); some categories of migrants (e.g. CY, CZ, MT); and finally, people who have not yet contributed a minimum number of years, including adolescents entering the labour market (e.g. CY). Continuity of insurance coverage has been raised as an issue by the Estonian ESPN experts: in 2015, 11% of the population aged 20-64 were covered for less than 11 months per year. This affects mainly those in unstable employment situations.

¹⁹ If they are not covered as dependent family members.

²⁰ The new government reversed the exclusion of undocumented migrants from healthcare in September 2018, going back to a strictly residence-based entitlement logic.

²¹ During the first 15 months of their stay in Germany.

A number of ESPN experts mention that some people are not paying their compulsory insurance contributions (e.g. BG, EE, HU, RS, TR and to a lesser extent HR) and that there are an increasing number of people on atypical contracts (e.g. EE, PL), which may explain the relatively high or increasing rates of people not covered for healthcare in their country. Furthermore, the relatively low coverage rate in some countries may be (partially) explained by people working abroad (e.g. BG, EE, LT, LU, RO, SK) or working for international institutions with a different health insurance regime (e.g. LU). In Serbia, an increasing number of employers (including public companies) do not pay the health insurance contributions for their employees. In the City of Belgrade 47,000 employees were not able to exercise their right to healthcare in 2016 as their employers did not pay health insurance contributions.

1.2.2 What is covered: the range of healthcare benefits

The range of benefits fully or partially covered by the health system is usually comprehensive, including prevention, outpatient primary and specialist care as well as hospital care (e.g. AT, BE, BG, CY, DE, DK, EE, EL, ES, FI, FR, HR, HU, IS, IT, LI, MT, NL, NO, PL, PT, RO, RS, SI, SK, TR, UK). 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. Nevertheless, even services included in the benefit package may be inaccessible if they are not available in sufficient numbers. We will discuss the availability of health services in Section 1.4.

Most dental care may be excluded from the benefit package (e.g. CH, IT, LI, LV) and be only — sometimes partially — covered for specific groups, such as children or the chronically ill (e.g. DK, IS, LV, MT, NL, NO, PT, RO, RS, SE). Outpatient psychological services (e.g. BE, IS) and outpatient physiotherapy and rehabilitation (e.g. IS, LV, NL), may also be excluded from the range of benefits. While over-the-counter pharmaceuticals²² are in principle not covered by health insurance in all of the countries studied, in some countries, patients pay the full cost of prescription pharmaceuticals — with exemptions for some specific groups such as the chronically ill (e.g. IS, NO, SE), or with the exception of medicines included in a positive list, which are provided for free (e.g. MT). An annual cap on OOP may nevertheless apply for pharmaceuticals (e.g. IS, NO, SE). Some medical devices, such as prosthetics, orthodontics, glasses or hearing aids, may also be excluded from the statutory benefit package (e.g. CY, CZ, EE, LV, NL).

If patients wish to access health services and products which are not covered by the benefit package, they have to fully pay for them out of pocket, or coverage may be provided through VHI.

In most countries, groups which are not covered by the statutory system only have access to urgently necessary healthcare (e.g. AT, BE, BG, DE, DK, EE, EL, ES, FI, HU, IE, LT, NL, RO, SI, SK, UK) and often also to some types of preventive care, in particular for infectious diseases (e.g. EE, ES, IE, RO), and pregnancy/maternity care (e.g. BG, DE, ES, IE, RO)²³. The concept of “emergency care” is often subject to interpretation, and in some countries there are geographical differences in how the relevant legislation is interpreted (e.g. ES, FI).

Some countries, in particular those where important shares of the population are not covered, provide some additional access to healthcare for the uninsured, which may include free access to primary care (e.g. PL, RO, TR) or hospital care (e.g. BG).

²² Medicines sold directly to a patient without a prescription from a health professional, as opposed to prescription drugs, which may be sold only to consumers possessing a valid prescription.

²³ Access to urgently necessary healthcare is in principle provided from an ethical perspective and emerges from the duty to assist someone in need and to provide healthcare in life- or organ threatening situations. Preventive care for infectious diseases may be provided from a public health perspective, to avoid spreading the disease.

1.2.3 How much is covered: user charges, excess fees and informal payments

If the full cost of healthcare is covered by the public system, patients do not have to pay user charges. In other circumstances, patients will have to bear part of the costs. In this section we explore the different aspects of user charges policies. We will first discuss the general policies in the countries under scrutiny, then the user charges that apply to specific services and products, and finally, the provisions to protect vulnerable groups from prohibitive user charges. We wrap up the section by discussing excess fees and informal payments.

User charges: general policies

In most countries, user charges apply to some health services and products (see sub-section on coverage of specific health services and products below). 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 2). For some examples on levels of user charges, see Box 3.

Table 2: 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, CH, DE, EE, FI, FR, HR, IE, IS, IT, LU, LV, MK, NL, NO, PT, RS, SE, SI, TR |

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

An annual cap on user charges, set per household or insured person, applies in many countries (e.g. AT, BE, CH, DE, FI, HR, IE, IS, LU, LV, MK, NO, RS, SE, 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 (e.g. BE, CZ, DE, DK, IS, RS). There is a huge variation in the maximum annual amount to be paid by the patient between countries, ranging from €110 in Sweden to €569 in Latvia (see also Box 3).

Municipalities may (e.g. FI, SE) opt to apply lower cost-sharing rates or may provide the relevant service free of charge. In some countries, extra charges may apply for extra services (e.g. a better room) from contracted healthcare providers (e.g. BE, HU, SK).

In countries with statutory private health insurers (PHI), high deductibles may apply (e.g. CH, DE, LI, NL) for insured persons who have opted to pay a lower insurance premium. This means that a defined annual amount of healthcare costs must be fully borne by the patient before the health insurance kicks in and covers the remaining costs. As an example, in Switzerland, a mandatory deductible up to a maximum annual amount applies. On top of this, individuals can opt for a voluntary deductible which can vary between €300 and €2,150 per year. About 60% of individuals opt for such a deductible in exchange for lower insurance premiums. In Liechtenstein, the voluntary deductible can be up to €4,340. In the Netherlands, the costs of general practitioner (GP) consultations, maternity care and healthcare for children under 18 are exempted from the mandatory deductible. Private insurers can furthermore offer a "bonus" to those who have not used any health services during a year (e.g. NL).

Increases in user charges were one of the austerity measures implemented following the economic and financial crisis in most of the hardest-hit countries, and were usually part of the Economic Adjustment Programme agreed between the Eurozone countries in difficulty and their EU lenders (e.g. CY, EL, ES, IE, IS, IT, PT).

Box 3: Country examples on level of user charges

In Austria, a fee for medicines of €6 per prescription (2018) and a daily allowance for in-patient care, amounting to between approx. €12 and 19 per day for the first 28 days in hospital per year, apply.

In Croatia, co-payments range from 10.00 HRK (€1.3) for one visit to a family physician to up to 2,000 HRK (€266) for hospital treatment, irrespective of length of stay.

In Estonia, there are no user charges in primary care, except for home visits. Co-payment for specialised outpatient care with a contracted specialist is €5. The reimbursement system for prescription-only medicines is defined based on the category of the medicine, with a 100%, 90%, 75% or 50% reimbursement rate (in addition to a €2.50 basic co-payment) and is based on the severity of the disease, the efficacy of the medication and the social status of the patient. If the cost of the medicines per calendar year is €100-€300, then 50% of the cost is reimbursed to the person; if the cost exceeds €300, then 90% is reimbursed.

In Ireland, 54% of the population have to pay the full price of GP care but are entitled to public hospital care, albeit with charges. For example, acute inpatient care requires a co-payment (€80 per day), capped at €800 per year, as do visits to emergency and outpatient departments (€100). Co-payments also exist for prescribed medicines, but are capped at €144 per household per month.

In Germany, co-payments apply to medicines and usually amount to 10% of the cost per prescription, with a minimum of €5 and a maximum of €10. Inpatients have to pay a maximum of €10 per day for 28 days per year. The annual sum of co-payments for SHI patients is limited to 2% of their annual income and to 1% if they are chronically ill.

In Serbia, for the majority of procedures a co-payment is required, unless the patient belongs to a vulnerable group. The co-payments are in the range of €0.5-€10. Regularly insured persons may be exempted from user charges, depending on the household's financial status. For a single member household, the threshold is an income below 130% of the official minimum wage (€263 in April 2018) and for a multiple member household the threshold is the minimum wage per household member (€230)

In Slovenia, user charges amount to 20% of the price of the service for primary care, between 20 and 30% of the price of services in secondary healthcare and up to 90% for non-urgent medical transport. To cover the high user charges, voluntary complementary health insurance was introduced and covers 95% of the population (see Section 1.3).

In Sweden, patient fees for primary care normally vary between 150 and 200 SEK (€15 and 20). Fees for specialist care vary between 100 SEK (€10) to at most 400 SEK (€40). Patient fees for in-patient care range from 40 SEK/night (€4) to 100 SEK/night (€10). There is a national ceiling for outpatient healthcare costs set at SEK 1,100 (€110) over a 12-month period. When the ceiling has been reached, the individual pays no further charges for the remainder of the 12-month period. For out-of-pocket payments of prescribed drugs, a separate ceiling exists. Up to SEK 1,100 (€110), the patient has to pay the full amount, and the maximum amount over 12 months is SEK 2,250 (€225).

In Turkey, in case of use of secondary and tertiary health services, a user fee is charged of 6 TL (€1.2) for public provider use and 15 TL (€3.01) for private healthcare.

Source: ESPN country reports

User charges: coverage of specific health services and products

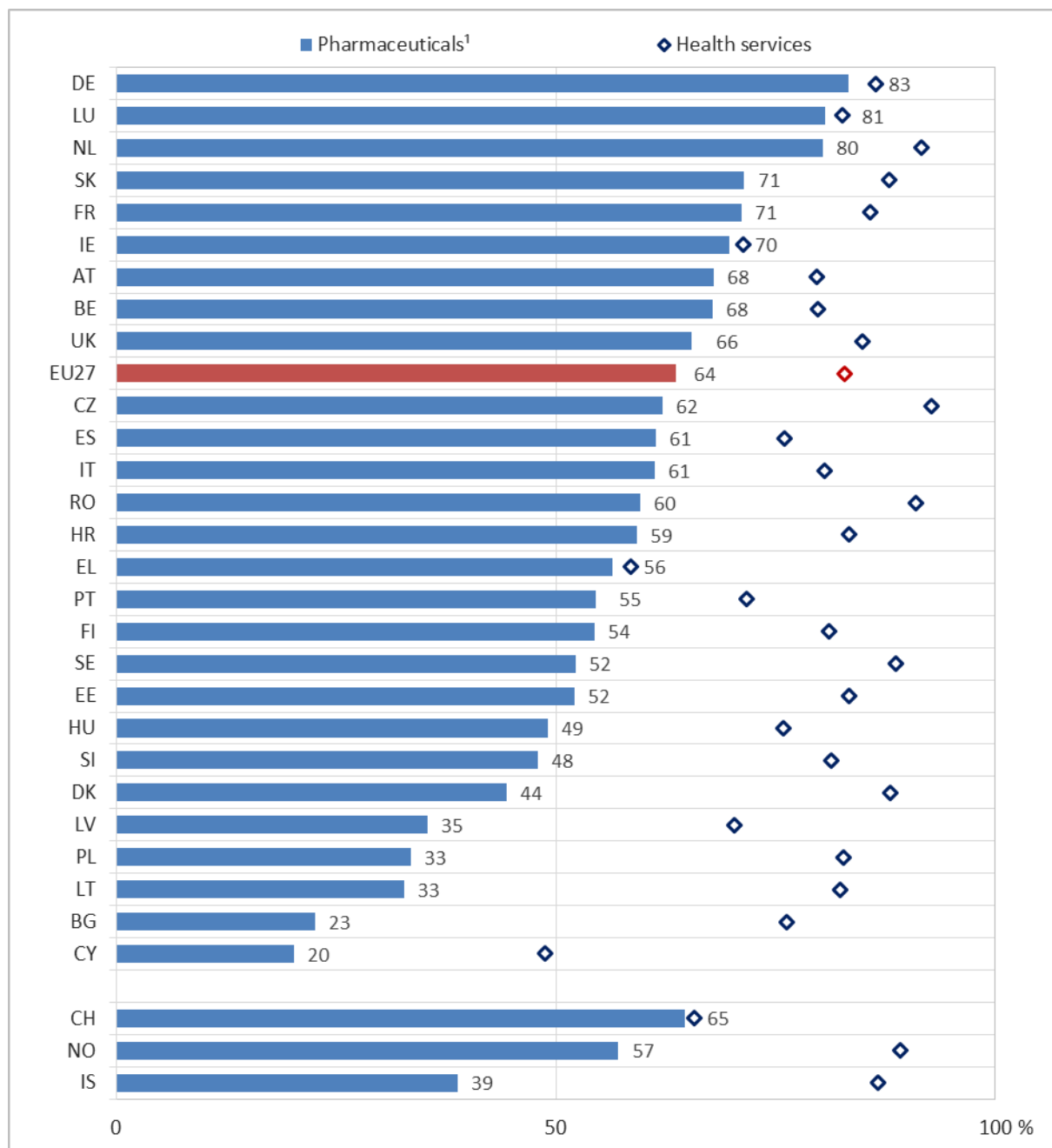
The next paragraphs discuss specific health services and products that are often only partially covered by the health system.

In the vast majority of countries, co-payments, often substantial, apply for medicines provided in outpatient care (e.g. AT, BE, BG, CH, DE, DK, EE, EL, ES, FI, FR, HR, HU, IE, IS, IT, LT, LU, LV, NL, PL, PT, RO, RS, SE, SI, SK, TR, UK). The level of user charges for medicines may differ depending on the severity of the disease, the efficacy of the medication and the health and socio-economic situation of the patient (e.g. AT, BE, EE, EL, FI, HR, HU, NO, PL, PT, SK). User charges for medicines can also be limited depending on

the total annual amount paid (e.g. EE, NL) or an annual cap on user charges may apply, above which patients are exempted (e.g. AT, CZ, DK, ES, FI, IE, IS, SE, SK). Some vulnerable groups may be exempted from user charges for pharmaceuticals (see next subsection) and some medicines may be fully reimbursed (e.g. BG, FI). Several ESPN experts emphasise that user charges for medicines are problematically high in their country (e.g. EE, HR, LT, LV, PL, PT, SI, SK).

Figure 5 presents the public share of spending on pharmaceuticals compared with health services in 2014. It shows that, in all countries analysed, public funding for health services is higher than for pharmaceutical products and thus that private spending accounts for a larger share of payments for medicines.

Figure 5: Public share of spending on pharmaceuticals compared with health services, 2014 (or nearest year)



Source: OECD/EU (2016), *Health at a Glance: Europe 2016*; ¹Includes medical non-durables; * ESPN countries not included in the dataset: LI, MK, MT, RS, TR.

In many countries, user charges apply for dental care (e.g. AT, BE, BG, CY, CZ, DE, DK, EE, ES, FI, FR, HR, HU, IE, LI, LU, SE, SI, TR, UK), while some groups, in particular children, may be exempted from user charges (e.g. DK, FI, HR, IS, LV, SE, UK) or be eligible for reduced user charges (e.g. BE, EE). In some countries, outpatient visits to psychologists (e.g. DK, IS, PT) and outpatient physiotherapy and/or rehabilitation (e.g. BE, CH, DE, DK, EE, FI, FR, HR, IE, IS, IT, LU, NO, PT, SE, SI, TR) are subject to user charges.

Coverage of medical devices, including prosthetics, orthodontics, glasses, hearing aids and health services using these devices is usually limited (e.g. AT, BE, BG, CH, CZ, DE, DK, EE, ES, FR, HU, SI, SK, TR, UK), while for most of these products providers can freely set their price.

In some countries, the services and products discussed under this heading are fully excluded from the benefit package. These were discussed in Section 1.2.2.

User charges: protection of vulnerable groups

Some vulnerable groups may be exempted from cost sharing (e.g. AT, BG, CY, ES, FI, HR, HU, IE, IT, LU, NO, PL, PT, RO, RS, SE, SI, UK and more recently FR), pay lower user charges (e.g. BE, DK, IS, SK) or qualify for a broader benefit package (e.g. IE). These protection mechanisms 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. Some vulnerable groups may be exempted from user charges for specific benefits such as pharmaceuticals (e.g. AT, EL, HU, MT, PT, UK) or dental care (e.g. DK, FI, HR, UK).

In some countries, patients pay up-front for the healthcare and obtain reimbursement from their health insurer afterwards (e.g. for outpatient care in BE, FR and LU, for the privately insured in DE and CH). Vulnerable groups may be protected from having to provide up-front payments through direct payment by the third-party payer to the healthcare provider (e.g. BE, FR, LU).

For some examples on national policies to protect vulnerable groups, see Box 4.

Box 4: Protecting vulnerable groups from user charges

In Austria, user charges for prescription drugs have been capped at 2% of annual net income per calendar year for people with low incomes and high drug consumption.

In France, patients with the lowest incomes benefit from almost total coverage of their health expenses through complementary universal health coverage and thus do not pay any user charges.

In Greece, certain vulnerable social groups, such as those on a very low income, asylum seekers, refugees, prisoners, disabled persons, etc. are exempted from any co-payments for pharmaceuticals.

In Luxembourg, the user charges are generally limited and cannot exceed 2.5% of taxable income.

In the UK, children, the elderly and members of low-income households are exempt from user charges on prescription medicines, as are pregnant women and those with children up to one year and people with certain medical conditions such as cancer, diabetes and epilepsy.

Source: ESPN country reports

Excess fees

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, IS, PT). In this case, the providers are free to set their tariffs, with the exception of Portugal, where tariffs are agreed upon with the Ministry. In France, since recently (2016), providers are no longer allowed to claim excess fees for vulnerable groups.

Informal payments

There are indications that informal payments (under-the-table payments) made by the patient or her/his family to physicians are common practice in several countries (e.g. BG, EL, HU, LT, LV, RO, RS, TR). These payments are made in order to bypass waiting lists and have access to healthcare of better quality. In Bulgaria, informal payments are estimated to make up half of the total out-of-pocket payments.

1.3 Voluntary health insurance (VHI)

Voluntary health insurance may supplement, complement or replace publicly financed coverage and thus can have different functions (Sagan and Thomson 2016). It can cover a) healthcare benefits not covered by the statutory healthcare basket,²⁴ for instance dental treatment (e.g. AT, BG, CH, DE, DK, ES, HU, IE, LU, LV, NL, PT); b) user charges²⁵ (e.g. AT, CH, DK, EL, FR, HR, HU, IE, LU, PT, SI); and/or c) a greater choice of providers,²⁶ for instance access to private/non-contracted providers, faster access to healthcare or enhanced amenities, such as admission to a private room in hospital (e.g. AT, BE, CH, CY, DE, DK, EL, ES, FI, HR, HU, IE, LI, LV, NO, PT, SI, TR).

VHI can be provided by for-profit and not-for-profit actors. Although a large share of the population is covered by voluntary health insurance in several countries (e.g. AT, BE, FR, DE, DK, FI, HR, HU, NL), such coverage only represents a small share of total health expenditure. In some countries the role of VHI is relatively important in ensuring access to healthcare (e.g. FR, IE, SI). Both in France and Slovenia, complementary health insurance covering relatively high co-payments is taken out by nearly the whole population. In Ireland, 45% of the population is mainly covered for healthcare through VHI.²⁷ In several countries, the government provides tax advantages to purchase voluntary health insurance or provides financial support to people on low incomes, enabling them to purchase complementary VHI (e.g. FR, HR, HU, SI).

In some countries, some groups without compulsory coverage can opt into the social health insurance system (e.g. AT, BE, EE, PL). This may include, for instance, people whose income does not reach a certain income threshold. Contribution rates may be relatively affordable for lower income groups (e.g. AT), but may also be relatively high (e.g. PL).

In some countries, insurers can (and do) refuse to insure people for voluntary health insurance, due to, for example, health status or age (e.g. CH, DK, EL), whilst in others (e.g. IE) private health insurers operate on the basis of community rating, open enrolment and lifetime cover (whereby an insurer may not refuse to renew cover). As an example, in Denmark, a private non-profit actor, “*danmark*”, owned by its members, covers 43% of the whole population. To become a member, the applicant must be younger than 60 and cannot have any medical condition at the time of entry.

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 thus

²⁴ Commonly referred to as supplementary health insurance.

²⁵ Commonly referred to as complementary health insurance.

²⁶ Commonly referred to as duplicate health insurance.

²⁷ Since the statutory benefit package is very limited for a large share of the population (see Section 1.2.2).

provide faster access, better quality and an increased choice of healthcare providers. In Finland, 90% of wage-earners are enrolled with various occupational VHI schemes. The schemes may be supported by public money in different ways. They may receive subsidies (e.g. FI) and they may be popular as part of the salary package since no taxes or social contributions are due on these benefits (e.g. BE). Sometimes they cover some or all categories of public service employees (e.g. CY, FI, PT). In Portugal, state support for the public service scheme has been drastically reduced. In Bulgaria, some companies have their own clinics, providing primary care for their workforce. ESPN experts from several countries mention that the share of the population covered by VHI, in particular by occupational schemes, is increasing (e.g. BE, CY, EL, ES, FR, IT, MT, NO).

1.4 Availability of health services

While the healthcare benefit package is, in principle, quite broad in most countries, sufficient services need to be available in sufficient numbers and quality to ensure access to healthcare in practice. When services are not available in sufficient numbers, patients who can afford it may seek healthcare in a parallel private sector and pay for it either out of their own pocket or through voluntary health insurance.

This section provides an overview of the availability of health services in the 35 countries. Section 1.4.1 discusses the overall supply of healthcare and the gaps in some countries. Section 1.4.2 zooms in on the availability of health professionals and staff shortages in some countries. Regional disparities in health services are discussed in Section 1.4.3. Waiting lists and policies to address waiting times are addressed in Section 1.4.4 while the role of the private sector is discussed in Section 1.4.5.

1.4.1 The overall supply of healthcare

In many countries, the hospital and healthcare facilities network is considered generally sufficient (e.g. AT, BE, CH, CZ, DE, HU, IS, LI, LT, LU, MT, SI), although often with some regional shortcomings (see Section 1.4.3). In others, however, underfunding of the health system has resulted in underdevelopment of health services as an implicit form of rationing, as illustrated in Box 5. 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, RS). Several ESPN experts stressed that healthcare for acute health conditions is prioritised over public health, preventive care and mental health in their country (e.g. BE, BG, EL, ES, HR, HU, IE, LT, RO, TR, UK). The Romanian country report furthermore stressed that a poor referral system and questionable effectiveness of the primary health services, have resulted in an increased burden on hospital medical services, and that the continuity and integration of care (primary healthcare/ambulatory clinical care/ hospital care) is not sufficiently developed.

In several countries, health services have been reduced due to cost constraints in the wake of the financial and economic crisis (e.g. EL, ES, IS).

Box 5: Country examples of implicit rationing of healthcare provision

In Bulgaria, there are no official waiting lists, but GPs, who are supposed to act as gatekeepers, have a quota of referrals to outpatient specialist care per month. They often reach their quota long before the end of the month which means that remaining cases have to wait until the next month.

In Estonia, some hospitals use up their contract volumes several months before the end of the contract period and thus postpone all elective care to the next half-year.

In Germany, it is reported that fixed budgets may lead to "informal rationing", i.e. not providing services regarded as medically necessary or (in the outpatient sector) postponing them to the next quarter or simply discharging patients too early from hospital.

The Vestmanna Islands (south of Iceland, with a population of some 4,500) previously had a mini-hospital, providing full maternity and birth care services, among other things. This has now been closed down. Couples expecting a baby thus have to move temporarily to Reykjavík well before the expected date of birth or rely on emergency services by helicopter, at a high cost and with the risk of difficult weather conditions.

Source: ESPN country reports

1.4.2 Availability of health professionals

When discussing the supply of health professionals, a distinction should be made between the overall supply of health professionals and the number of professionals working in the publicly funded system.

In some countries there are currently no overall severe staff shortages (e.g. AT, BE, BG, LU), although there may be shortages in specific regions and in specific areas/disciplines. However, many ESPN experts point to supply shortages of health professionals in their country (e.g. CY, CZ, HR, HU, LV, PL, RO, SI) and, in particular, reduced numbers of professionals working in the publicly funded system (e.g. CY, EL, LV, PL, RO). Ageing of the health workforce is also a cause of concern in many countries (e.g. AT, BE, BG, CZ, DE, EE, FR, HR, IT, LV, PL). In some countries, shortages are particularly acute in the case of nurses (e.g. BG, EE, EL, HR, HU, LV, SK) and general practitioners (e.g. BE, CY, DE, DK, EL, FR, HR, HU, PL, PT, RO, SI).

There are mainly two reasons for such shortages: a) reduced numbers of professionals entering the labour market, for instance due to quotas limiting access to university medical education (e.g. IT, PL); and b) medical professionals leaving to work in more attractive areas, in particular urban centres, to work abroad (e.g. BG, EE, HR, IE, LV, PL, RO, RS) or to work in the private or non-contracted sector (see below). 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, RS).

Understaffing of health institutions in the publicly funded system may also be the result of budget cuts, in particular in the wake of the financial crisis. In most of the countries heavily hit by the crisis, austerity measures included important 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.

1.4.3 Regional disparities in health services

Substantial inequalities in the supply of health services between regions (e.g. CH, EL, ES, IT, LV, PL, PT, SI, TR, UK) and across urban and rural areas (e.g. BG, CH, CZ, EL, FI, FR, HR, HU, LT, LV, PT, RO, RS, SI, TR) are frequently reported in the ESPN country reports. Shortages of medical practitioners are particularly acute in rural areas (e.g. AT, BE, CH, CZ, DE, EL, FR, HR, HU, LT, LV, NL, RS, SI, SK, TR). For instance, in France, 23% of the

mainland population experience difficulties finding a general practitioner closer than a thirty-minute drive from their home. However, in some countries shortages of medical professionals have also been reported in disadvantaged urban areas (e.g. DE, FR). Several ESPN experts furthermore emphasise that the shortages of medical doctors in disadvantaged regions have become more serious over recent years or they foresee important human resources challenges in the near future (e.g. BE, BG, CZ, DE), while in some urban agglomerations there may be oversupply (e.g. DE). The situation is a particular cause of concern in relation to general practitioners and primary care services (e.g. BE, DE, DK, EL, FR, HR, HU, PT, RO, SI). Some ESPN experts also point to important differences in quality of healthcare between regions (e.g. LV, NO, UK). This may, among other things, be related to the lack of sufficient experience of specialists and to the low numbers of patients to be treated in specific medical disciplines. Some countries have taken measures to incentivise physicians to work in rural areas, in particular for primary care services (e.g. BE, FR, LT, PT).

1.4.4 Waiting times

Health systems where healthcare is, as a general principle, free at the point of use, more often apply supply restrictions, as a key instrument to contain costs. The number of healthcare providers available is thus more strictly planned and free choice of healthcare provider is limited (Siciliani *et al.*, 2013). Supply restrictions may imply waiting times, used as a tool for priority setting and supply management. Waiting lists may, however, become a form of implicit rationing if the health system is unable to provide healthcare within an acceptable time to patients, taking into account their health condition.

While in some countries waiting times do not seem to be a major problem (e.g. BE, LI, LU), they are an issue of considerable concern in a large majority of European countries (e.g. AT, CY, CZ, DE, DK, EE, EL, ES, FI, FR, HR, HU, IE, IS, IT, LT, LV, MT, NL, NO, PL, PT, RS, SE, SI, SK, TR, UK) and are a focus of public debate. Underfunding of the health system and staff shortages in the publicly funded sector are often mentioned by ESPN experts as the reason for problematically long waiting lists (e.g. CY, EE, EL, ES, HR, IS, LV, PL, RS, SI, TR, UK). In some countries, additional funding has resulted in a reduction in the average waiting times in general, or for specific treatments (e.g. HU, IS, LV, MT, NL, NO, PT) while in others they are steadily increasing (e.g. ES, PL, RS, SI, UK).

In some countries, waiting lists are an issue for the entire health system, while in others they only exist for access to certain types of care. For some examples, see Box 6. Waiting times may also differ between different regions (e.g. ES, FR, HU, IS, IT, SE).

In some countries, official waiting lists for specific treatments (e.g. AT, DK, MT, PT, SI) or official criteria for priority setting (e.g. NO) exist, while in others there is a complete lack of transparency on priority setting or no monitoring of waiting times (e.g. BE, CY, CZ, FR, HR, LU, LV,²⁸ PL, RO). But even in some countries with official waiting lists, these lists can be, and are in practice, bypassed, for instance by arguing that a case is urgent (e.g. AT, MT).

Many countries have established maximum waiting time guarantees or targets (e.g. DE, DK, EE, FI, IS, NL, NO, PT, SE, SI, UK). Patients waiting longer than the maximum waiting time in principle obtain more freedom to choose a healthcare provider, for instance a private/non-contracted provider or a provider outside their health region. For some examples, see Box 6.

²⁸ In Latvia, since mid-July 2018, waiting times in the various medical institutions are publicly accessible online.

Box 6: Country examples on waiting times and waiting time guarantees

In Austria, there are waiting lists for some specific medical examinations or specific types of surgery in public hospitals.

In Belgium there are no waiting times for GPs, but patients must wait some time for certain specialist doctors (in particular for mental healthcare).

In Cyprus, the long waiting lists and the lack of transparency are highlighted as the most serious problem affecting the system at present, responsible for widening inequalities in access to healthcare. During the crisis years, when even more people turned to the public sector, the problem worsened further and waiting lists grew even more. Knee and hip replacements are being delayed by 30 months; cataract surgeries by 15 months.

In Estonia, the accessibility of primary care is very good, while in outpatient specialised care, half of patients cannot access services within the specified maximum waiting time.

In Germany, associations of statutory health insurance physicians (Kassenärztliche Vereinigungen) are obliged to establish appointment service points, where patients can request a specialist appointment within an appropriate timeframe. However, it was reported that appointment service centres were not always available in practice.

In Ireland in 2015, 10% of patients had to wait more than a year to get first access to outpatient services in hospitals.

In Latvia, the waiting time for out-patient health services fluctuates between 20 days and 680 days.

In Portugal, in 2016 approximately 28% of medical appointments took place beyond the maximum guaranteed response time. Compliance with the maximum waiting times improved substantially between 2010 and 2016, in particular for cases identified as very high priority.

In Sweden, despite the guaranteed maximum waiting time, around 25% of patients in specialist care presently have waiting times exceeding 90 days.

Source: ESPN country reports

1.4.5 The role of private sector health providers and healthcare fully paid out-of-pocket

In several countries a large private sector, fully paid out-of-pocket or through voluntary health insurance, co-exists with the publicly covered sector (e.g. CY, EL, FI, HU, MT, PL, PT, RS, RO). In other countries there is an important segment of physicians providing healthcare outside the contracting system and who are thus free to set their tariffs, while qualifying for partial reimbursement from the public purse (e.g. AT, BE, EL, FI, FR, IS, PT). In most countries, doctors, in particular specialists, can work in the public or contracted sector and also have a private practice (e.g. BE, DE, EE, ES, FI, HR, LT, LV, MT, PL, RO, SI). Some ESPN experts highlight a growing private for-profit sector, funded by the public system (e.g. AT, FI, SE).

The private sector is mainly used by patients who want to avoid long waiting times, by people who can afford it (e.g. AT, CY, EE, ES, FI, HU, IE, LT, MT, PL, PT, RS, SI). According to many ESPN country experts, patients can bypass waiting times in the public sector if they (first) consult the specialist privately and therefore pay additional fees.

Voluntary health insurance plays a crucial role in the development of the private sector in many countries, in particular when it is used to circumvent the waiting lists (e.g. DK, ES, FI, LV, PT, SE). Similarly, in countries where voluntary health insurance is used to cover user charges, excess fees, or private rooms in hospital, VHI appears to encourage the development of a sector of non-contracted providers (e.g. BE, FR).

In some countries, doctors are leaving the public sector to work in the private sector (e.g. CY, LV). Several ESPN experts from countries where non-contracted physicians (who are free to set their prices) qualify for partial reimbursement from the public purse, flag that

the number of providers leaving the contracting system is increasing (e.g. AT, DE, FR). The interaction between the public/contracted sector and the private sector is illustrated in Box 7.

**Box 7: Interaction between physicians working in the public/
contracted sector and in the private sector**

In Austria, the number of non-contracted physicians is steadily increasing. As the fees of non-contracted GPs and specialists are largely unregulated and only partly covered by social health insurance, access to ambulatory healthcare is increasingly based on ability to pay rather than medical need.

In France, there has been a steep increase in practices charging excess fees. The proportion of general practitioners authorised to charge excess fees rose from 39.2% in 2006 to 44.3% in 2015. 84% of gynaecologists and 69% of ophthalmologists are authorised to charge extra fees. These physicians are highly concentrated in some regions.

In Germany, social health insurance (SHI) patients often face significantly longer waiting times than members of the private health insurance (PHI). Since general practitioners and outpatient specialists are allowed to charge PHI patients considerably higher fees, privately insured patients can be seen as priority consumers. The current SHI/PHI-divide is considered a crucial reason for the disparities in the geographical distribution of doctors.

In Iceland, private providers have pushed for more freedom of access to public funding of services, in light of longer waiting periods, such as for hip or knee replacements. It is expected that the transposition of the EU Directive²⁹ allowing patients on waiting lists to seek operations in other EEA countries will further increase pressure for increased private provision in some of the areas most affected by excessively long waiting lists.

In Ireland, physicians can treat patients on a private basis in public hospitals. A block grant system used to reimburse hospitals for public patients, in contrast to per diem charges for private patients, creates an incentive to treat fewer public patients. This represents a subsidisation of private health services by public resources.

In Latvia, the disparity between the state-established tariffs and the actual costs of services results in a situation whereby health service providers refuse to conclude agreements on provision of state-paid health services and provide only paid services.

In Luxembourg, all medical professionals must apply the tariffs agreed with the national health insurance institute. There is thus no non-contracted sector in Luxembourg.

In Malta, although strictly speaking any patient can have access to in-patient treatment through the public primary healthcare system, people feel the need to accelerate their access to healthcare by first visiting the same specialists manning the public sector privately.

Source: ESPN country reports

²⁹ European Parliament and Council of the EU (2011).

2 Tackling challenges in inequalities in access to healthcare

This section first analyses the existing and newly emerging inequalities in effective access to healthcare, provides insights into the reasons behind them (Section 2.1) and discusses recent reforms (Section 2.2). Many strengths and weaknesses of health systems in ensuring equal access to healthcare are country-specific. There are, however, also common features across countries. Although it is not possible to determine a causal relationship between effective access to healthcare and system characteristics, we will, where possible, highlight system features as described in Section 1, to provide potential explanations for the observed inequalities in access to healthcare. Section 2.1.1 provides a general picture of inequalities in access to healthcare. We then discuss inequalities in access to healthcare between population groups (Section 2.1.2). Section 2.1.3 then looks at the different reasons for unmet needs, linking them, where possible, to system characteristics. Section 2.1.4 discusses some cross-cutting findings on weaknesses and strengths of health systems with regard to access. Finally, Section 2.2 reviews recent and planned reforms and on-going debates.

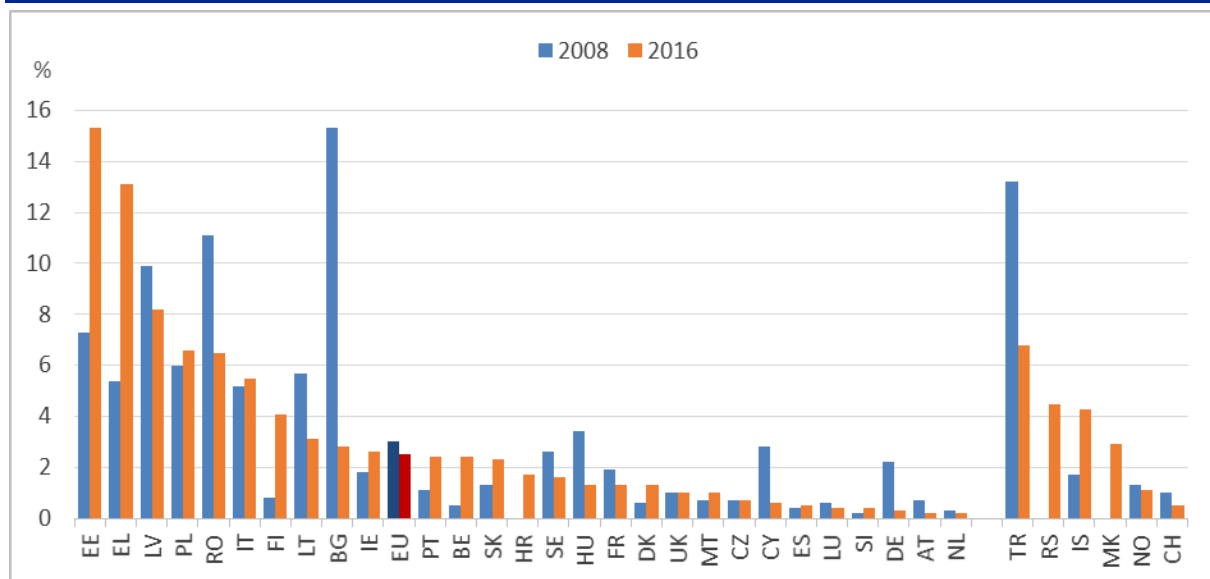
2.1 Effective access to healthcare: explaining unmet needs

2.1.1 Inequalities in effective access to healthcare: the general picture

As described in Section 1, in most of the 35 countries under scrutiny, and in particular the EU Member States, the majority of the population is covered under the statutory health system for a broad range of services (see Figure 4). However, in all countries there are specific – sometimes small – population groups falling through the safety net of the statutory health system, and in some countries gaps in coverage are substantial (see Section 1.2.1). Furthermore, Section 1 has also shown that in some countries there are significant issues due to the funding, the design and the functioning of the system which may lead to unmet needs for healthcare. Thus, even if people are statutorily covered by the health system, they may have significant unmet needs due to cost, waiting times and travelling distance. In order to capture these unmet needs, we use the EU indicator on self-reported unmet needs for medical examination. Although indicators on self-reported unmet needs have their limitations when it comes to objectively capturing health needs, since they measure people's subjective perception of their needs, they are the best available proxy to measure unmet medical needs (see also Section 3)³⁰.

Figure 6 shows the overall self-reported unmet needs for medical care due to cost, travel distance and waiting time in 2008 and 2016. While only 2.5% of the EU population reports unmet needs for medical examination, there are significant differences between countries. Estonia, Greece and Latvia score highest on this indicator, with figures of 15.3%, 13.1% and 8.2% respectively, while Austria (0.2%), the Netherlands (0.2%) and Germany (0.3%) perform well in this respect. Compared to eight years ago (2008), the situation has improved in several countries. The most significant fall in unmet needs is observed in Bulgaria, with a drastic decrease from 15.3% to 2.8%; Romania (from 11.1% to 6.5%); and Germany (from 2.2% to 0.3%).

³⁰ As argued in the opinion on Access to health services in the European Union, produced by the Expert panel on effective ways of investing in health, "Health need has been defined as the ability to benefit from healthcare. This implies that there is information on the presence of a health problem and the existence of a corresponding treatment. It also implies that there is a defined threshold above which treatment is appropriate. In practice, this type of information is not readily available. (...) Given the challenges of undertaking such studies on a large scale, social surveys typically use questions that seek to elicit self-reported unmet need, with a focus on quantifying instances in which people are not able to obtain the health (or dental) services they need because they face barriers to access. This is achieved by asking respondents whether they were unable to obtain care or treatment when they believed it to be medically necessary." (EXPH 2016).

Figure 6: Self-reported unmet needs for medical examination due to cost, distance and waiting time

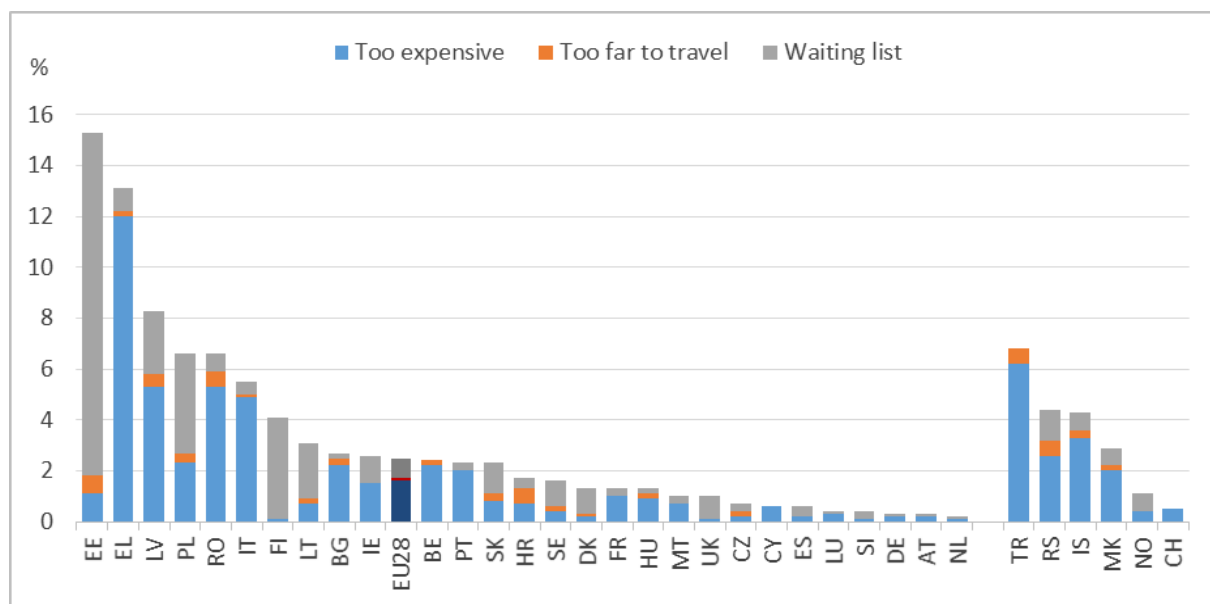
Source: Eurostat [hlth_silc_08]; * ESPN countries not included in the dataset: LI; **No data for 2008 for the following ESPN countries: HR, MK, RS; *** Data for IS and TR refer to 2015, no data available for 2016.

Importantly, the 2008 economic and social crisis had a significant effect on access to care. There was a substantial increase of the EU average during this period (2009-2014) — namely from 3.0% (2009) to 3.4% (2012), with the highest value in 2014 (3.6%). This may be explained by the austerity policies in many countries, loss of entitlement for some groups and, at the same time, an increasing need for healthcare. Since then, a gradual recovery has taken place, and unmet need in 2016, at 2.5%, is, for the first time, below the level of 2008. Furthermore, and more importantly, there were significant variations between Member States. There have been five countries with significant increases in unmet needs, especially during the crisis years (2011-2014): Belgium, Estonia, Greece, Iceland and Finland. In Belgium, Estonia and Finland in particular, there is still an upward trend (2016) (see Figure A1 in Annex 1). In other countries (e.g. BG, CY, HR, HU, LT, LU, LV, MK, RO, RS, TR), there was a slight increase between 2011-2014 and a steady decrease since then (see Figure A2 in Annex 1).

When looking more closely at the reasons for unmet needs, cost is definitely the most important factor, in most countries, impeding effective access to healthcare. The most extreme case is Greece, with 12% of self-reported unmet needs for this reason alone. It is followed by Turkey with 6.2% and by Romania and Latvia, both with 5.3% (see Figure 7). The second most significant factor impeding effective access is the issue of waiting lists — with the highest score 13.5% in Estonia, followed by Finland (4%). Finally, there is the factor of travelling time, which is far less important: Estonia has the highest score here: 0.7%.

These inequalities in effective access to healthcare can be explained by two interlinked groups of factors, which we discuss below: a) those related to characteristics of population groups, such as income, activity status, age, gender, ethnicity, disability status and health literacy; and b) those involving the health system design, including costs, waiting lists and territorial disparities. Moreover, the characteristics of the health system may address the needs of some population groups more comprehensively than others.

Figure 7: Self-reported unmet needs for medical examination by main reasons (2016)



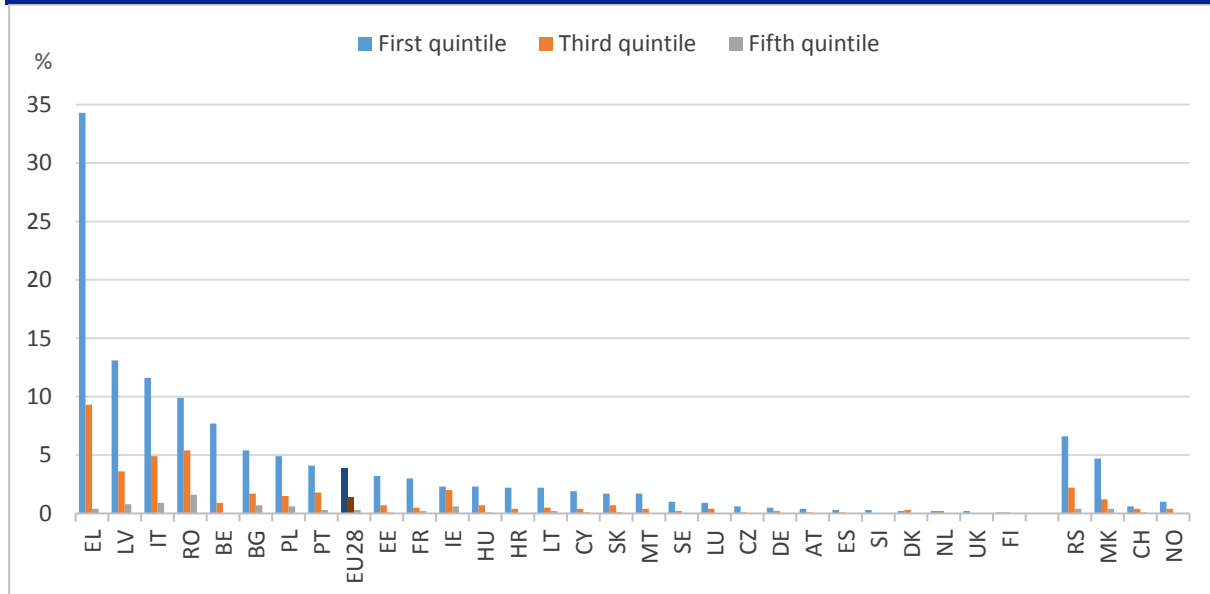
Source: Eurostat [hlth_silc_08]; * ESPN countries not included in the dataset: LI; ** Data for IS and TR refer to 2015, no data available for 2016.

2.1.2 Explaining unequal access: population groups

Inequalities based on income

Unsurprisingly, several ESPN experts point to income as a key factor explaining inequalities in access to healthcare: the lower the income, the more unmet needs (e.g. BE, BG, EE, EL, ES, FR, HU, IE, IS, IT, LV, RO, RS, SE). Indeed, as Figure 8 shows, some countries display substantial differences in self-reported unmet needs for medical examination due to cost between the lowest and highest income quintiles (BE, EE, EL, LV, RO, RS). The most striking example is Greece, where those in the lowest income quintile report 34.3% of unmet needs due to cost, with only 0.4% in the highest. Only a few countries – namely those with the lowest scores on unmet needs due to cost – report barely any difference between income groups (AT, CZ, DE, DK, FI, NL, SI, UK).

Figure 8: Self-reported unmet needs for medical examination due to cost by income quintile (2016)



Source: Eurostat [hlth_silc_08]; * ESPN countries not included in the dataset: LI; ** ESPN countries with no data for 2016: IS, TR.

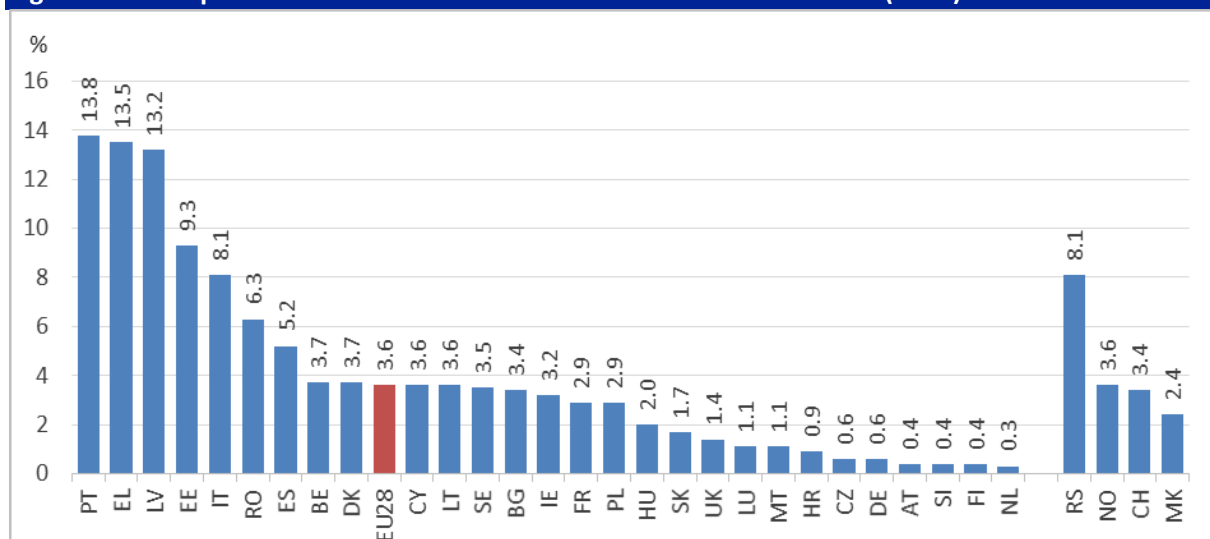
In some countries, the economic crisis had a significant impact on access to healthcare for the lowest income earners. The Greek ESPN experts report that unmet needs for medical examination increased dramatically from 2010 to 2016: by 26.2 percentage points (p.p.), i.e. from 9% in 2010 to 35.2% in 2016 for the lowest income quintile. This substantial increase is mainly due to a 26.6 p.p. increase in the number of people in the first quintile who reported unmet medical needs due to cost (i.e. from 7.7% in 2010 to 34.3% in 2016). Similarly, the Belgian ESPN experts report an increase in social inequalities in access to healthcare during the crisis period: between 2011 and 2016, unmet needs in the lowest income quintile increased from 4.2% to 7.7%.

The reasons for inequalities in unmet needs due to cost between income groups are complex, and several factors should be considered carefully. The countries topping the charts for unmet needs due to cost, are those where out-of-pocket payments as a share of total health expenditure are highest (e.g. BG 46%, LV 39%, EL 35%, IT 22%, RO 20%, see Figure 1). Furthermore, among the countries with the highest unmet needs, in particular in the first income quintile, are most of the countries for which ESPN experts stressed that the system is underfunded (e.g. BG, EL, IE, IT, LV, PL, RO, RS, see Section 1.1).

Ireland is a specific case, since there the middle-income groups also have substantial unmet needs. As mentioned in Section 1.2.2, over half of the population covered, in particular those on higher incomes, are entitled only to public hospital care. According to the Irish country report, there is a significant difference in the use of GP and prescription services between those with and without coverage for primary healthcare. In particular, people on a (lower) middle income may have difficulty in bearing the costs of healthcare and may not be able to afford private health insurance.

The situation concerning unmet needs due to cost is even more acute with regard to dental care (3.6%, compared to 2.5% for medical examination): seven EU countries report unmet needs significantly higher than 5% for dental care (EE, EL, ES, IT, LV, PT, RO), as can be seen in Figure 9.

Figure 9: Self-reported unmet needs for dental examination due to cost (2016)



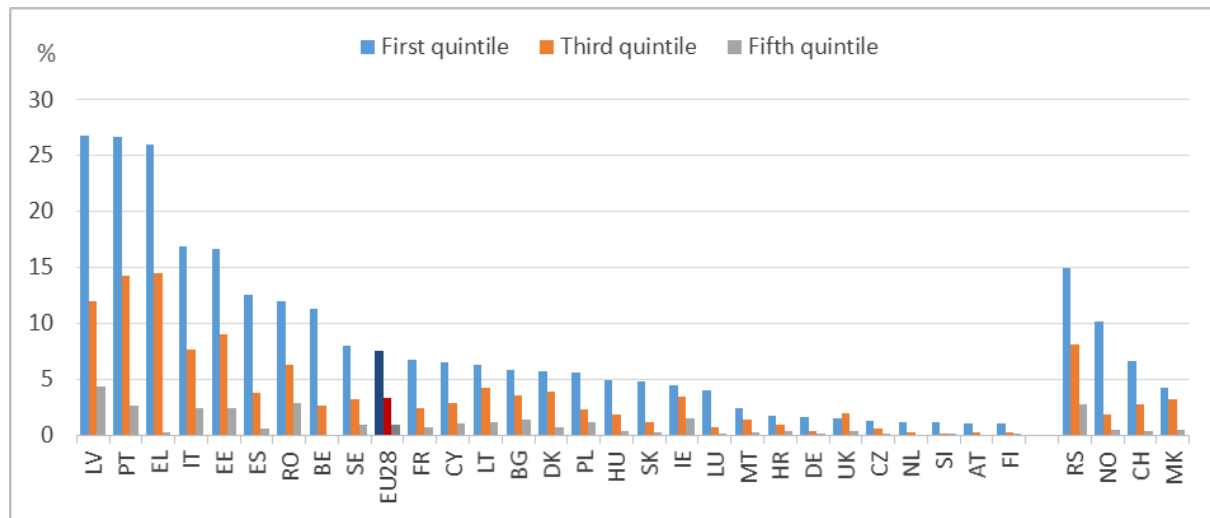
Source: Eurostat [hlth_silc_09]; * ESPN countries not included in the dataset: LI; ** ESPN countries with no data for 2016: IS, TR.

Importantly, for dental care there is a clear gap between the lowest and the highest income quintile for significantly more countries than is the case for medical examinations. The middle-income quintile is also significantly affected by self-reported unmet needs for dental examination in several countries, compared to unmet needs for medical examination (see Figure 10). This can be partly explained by the fact that in several countries dental care services are included only partially, or not at all, in the healthcare basket (see Section 1.2.2) and people have to provide high out-of-pocket payments for these treatments.

Voluntary insurance schemes may be unaffordable for those on a low income (see Section 1.3).

Clearly, countries with low coverage for dental care (see Section 1.2.3) perform substantially worse in access to dental care, in particular for low income groups. It should be noted that this includes some of the countries with an excellent performance for access to medical examinations (e.g. DK, ES, IS, NO, SE).

Figure 10: Self-reported unmet needs for dental examination due to cost, per income quintile (2016)

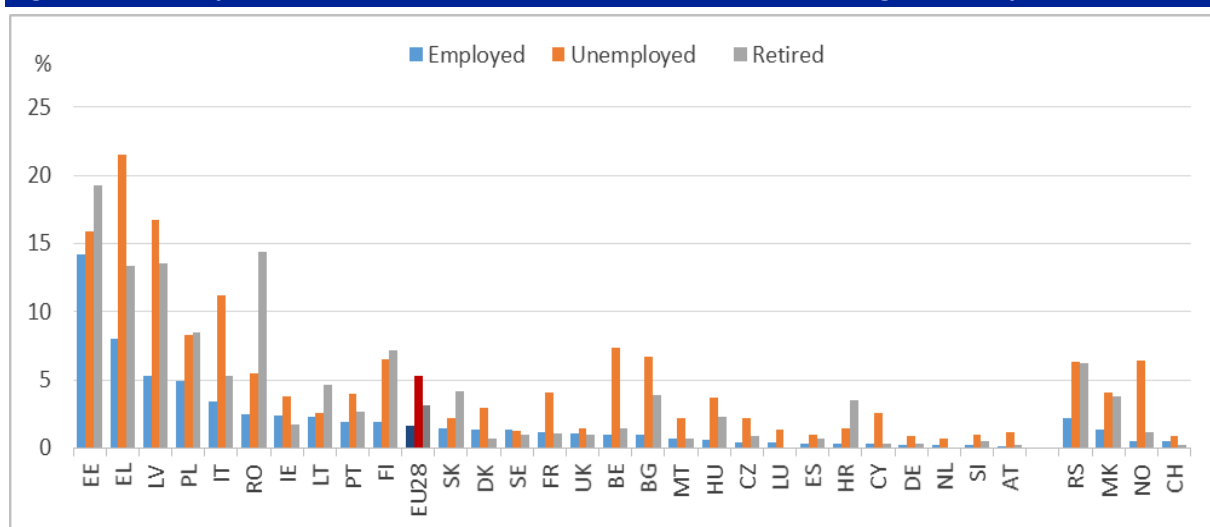


Source: Eurostat [hlth_silc_09]; * ESPN countries not included in the dataset: LI; ** ESPN countries with no data for 2016: IS, TR.

Inequalities based on activity status

Activity status may also play an important role in explaining problematic access to medical care in some countries. Most countries show significant differences between activity statuses. The unemployed in particular (and to a lesser extent pensioners) may encounter considerable difficulties in accessing healthcare (see Figure 11). In Greece 21.5%, in Latvia 16.7% and Estonia 15.9% of the unemployed report unmet needs for medical examination. As discussed in Section 2.1.1, these are countries where unmet needs are important in general. In Greece most of the unemployed have only been covered for healthcare since 2016 (see Box 13 below) and this may not yet be visible in the 2016 data.

Figure 11: Self-reported unmet needs for medical examination according to activity status (2016)



Source: Eurostat [hlth_silc_13]; * ESPN countries not included in the dataset: LI; ** ESPN countries with no data for 2016: IS, TR.

But even in countries where the percentage of unmet needs 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, FR, FI, HU, NO). In countries with well-developed (often occupational) VHI schemes, providing access to private and non-contracted providers free of charge (e.g. BE, CY, FI, HU, IT, LV, MT, RO), inequalities in self-reported unmet needs for medical examination according to activity status appear to be important (see Box 8 for some examples).

Box 8: Country examples on the link between occupational health insurance coverage and inequalities in access to healthcare

According to the Finnish ESPN expert, the main factor behind the observed inequality in access to healthcare is the fragmented health coverage in the country. Those with low financial resources and in difficult labour market positions mainly depend on the municipal healthcare, where they may face long waiting times. For most employed people, rapid and free access to primary healthcare is guaranteed through occupational healthcare. In addition, those on a higher income may top up the healthcare provided by the two other sectors with private healthcare, and thus trade off high co-payments for easy access to healthcare.

In France, 95% of the population has taken out complementary health insurance to cover relatively high co-payments. Yet, a noteworthy 5% of the French population do not have complementary coverage. This is mainly true for the unemployed and retired people with low pensions.

According to the Italian ESPN experts, the growth in occupational health insurance coverage (created by social partner agreements or companies' own decisions) may increase inequalities in access to healthcare. Occupational welfare generosity depends strongly on companies' characteristics (size, productivity level, etc.). The expansion of occupational healthcare funds is explained by various factors: these include the cuts to the NHS expenditure during the last decade, the relatively low level of public expenditure compared to other Western European countries and the high share of out-of-pocket expenditure.

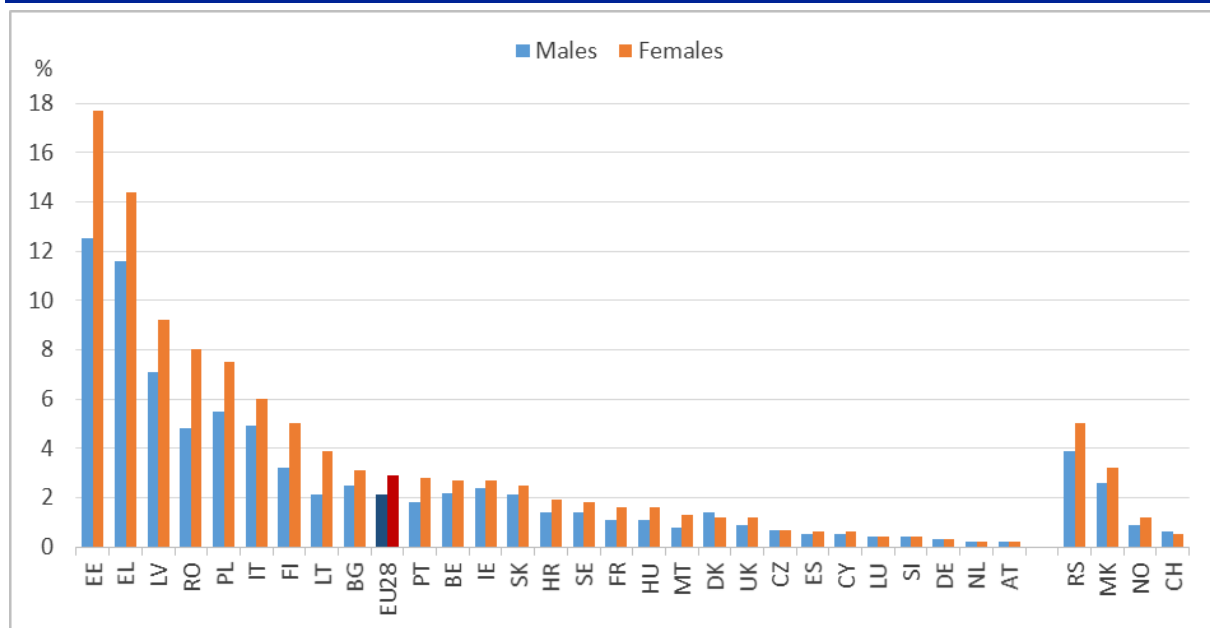
Source: ESPN country reports

Pensioners are among the most vulnerable groups, and their access to healthcare may be significantly impeded, mostly in Central and Eastern European countries (BG, EE, HR, LV, MK, PL, PL, RO, SK,), but also in Greece, Ireland and, to some extent, Italy. Estonia and Romania top the charts, with 19.3% and 14.4% of pensioners declaring unmet needs for medical examination. Strikingly, apart from Cyprus, this includes all the countries where more than 5% of the population were not covered for healthcare in 2014 (e.g. BG, EE, EL, PL, RO, SK) (see Figure 4). In some of these countries, pensioners have to pay mandatory health insurance contributions (e.g. EL, MK, PL) (see Section 1.2.1), but may in practice be unable to pay.

Inequalities based on gender and household type

Gender is also a factor having an impact on unmet needs for a medical examination: women are (far) more disadvantaged than men in the majority of the 35 countries under scrutiny (see Figure 12). In some countries, the gender gap in unmet needs is particularly striking: around 5 p.p. in Estonia, 4 p.p. in Romania, 3 p.p. in Greece.

Figure 12: Self-reported unmet needs for medical examination by gender, due to cost, distance and waiting time, 2016



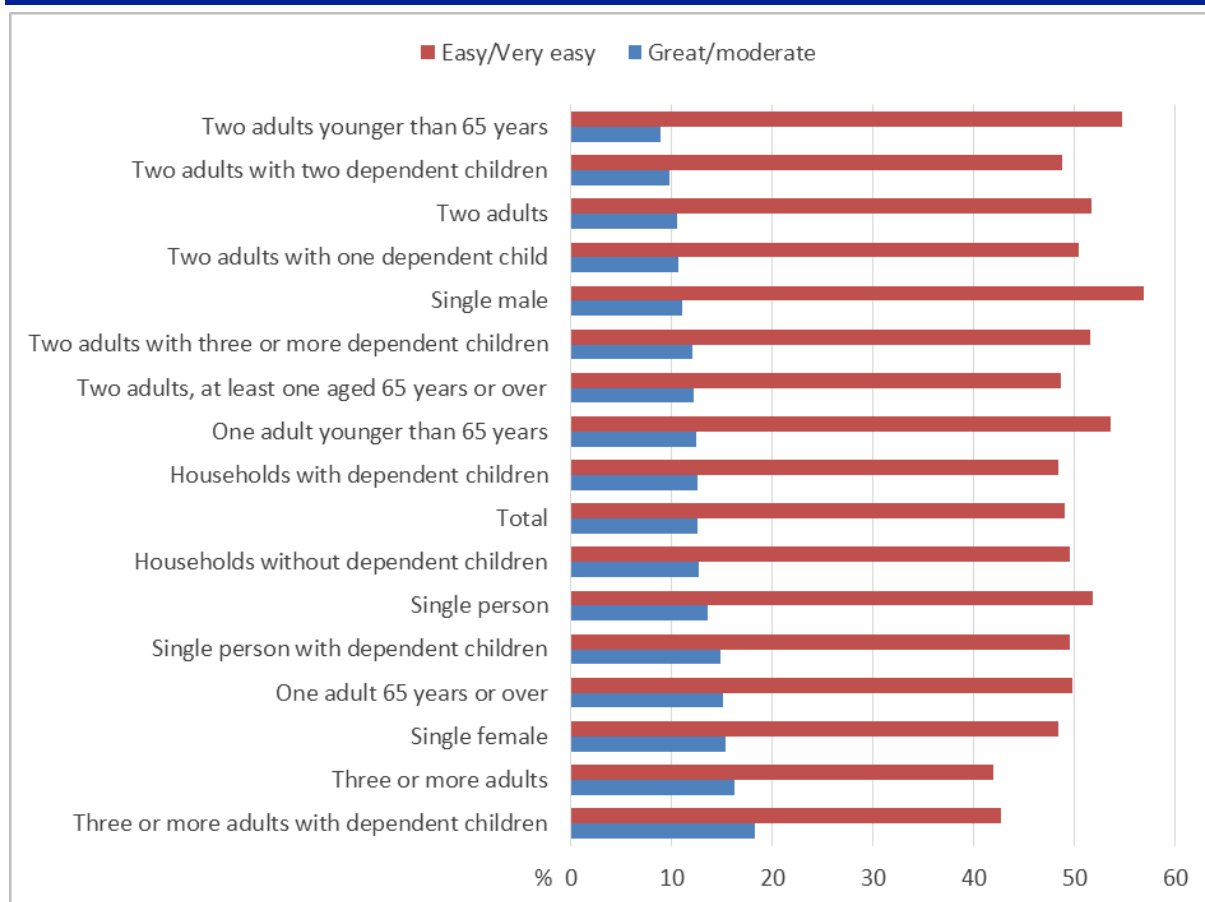
Source: Eurostat [hlth_silc_08]; * ESPN countries not included in the dataset: LI; ** ESPN countries with no data for 2016: IS, TR.

Older women can be particularly affected by unmet needs for medical examination. For instance, the Slovenian ESPN experts flag the results of a nation-wide project “Better Health and Reducing Health inequalities – Together for Health”, the aim of which was to identify vulnerable groups. Women aged 50+ were identified by the project as the most vulnerable group. Typically, this situation has been associated with unemployment, socio-economic vulnerability and mental health problems.

Single person households are another vulnerable group with regard to access to healthcare (e.g. BE, CH, FR). A study carried out in France demonstrates that single-parent families and people living on their own have the greatest unmet needs for medical examination. In Latvia, when assessing inequalities in access, one of the groups that should be mentioned is the elderly and pensioners, in particular single pensioners, the majority of whom are women.

As Figure 13 shows, single persons with children, and in particular single females, are among the most vulnerable categories with regard to their assessment of the ease of access to and affordability of health services.

Figure 13: Persons using health services by household type and level of difficulty in affording health services (EU28, 2016)



Source: Eurostat [ilc_ats12].

Particularly vulnerable groups in relation to access: homeless people, migrants and ethnic minorities

ESPN experts also identified homeless persons (and other marginalised groups such as alcohol and drug addicts) as a particularly vulnerable category with regard to effective access to healthcare (e.g. AT, BE, HU, LU, PT, SI). Often, these people are not covered by the health system, particularly if they are not entitled to cash social protection benefits (see Section 1.2.1). Many other factors may explain their lack of effective access to healthcare, 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 have a significantly worse health status and more often make use of hospital emergency services. Interestingly, in Hungary a specific indicator has been developed to monitor the access of homeless people to healthcare. The indicator is, however, biased as it only considers the fraction of the homeless population registered as homeless with the health insurance. The results are quite telling: homeless persons use emergency care services three times more than the general population and are hospitalised as emergency in-patients significantly more frequently.

Several ESPN reports, mostly from Central and Eastern Europe (e.g. BG, HU, HR, MK, RS, SI, SK), stress that Roma populations are among the most vulnerable with regard to access to healthcare, as can be seen in Box 9.

Box 9: Access to healthcare for Roma: policy challenges and good practices

In Hungary, among the Roma unmet medical need was 2.2 times higher than among the non-Roma (2015).

In the FYR (Former Yugoslav Republic) of Macedonia, a 2016 UNICEF survey on barriers to access to health insurance among Roma found that 9% of the surveyed households did not have any form of health insurance. Nearly half (45.6%) of all uninsured people cited lack of identification documents as the most common reason for the lack of health insurance, in addition to poor health literacy and scarcity of information. 26% of the surveyed Roma women declared that they do not need a family doctor, while another 12% say they do not know how to choose their doctor. The location of their health centre and doctor was an additional factor.

In Romania, about two fifths (42%) of Roma do not seek healthcare when they actually need it (vis-à-vis 25% of their non-Roma neighbours). Poverty is the most commonly reported reason for not consulting a doctor when needed – a consultation would be “too expensive” (84%), with “not having insurance” being the next most frequently cited reason (5%). The lack of identity documents for registration, coupled with the reluctance to visit healthcare facilities due to practitioners’ attitudes and uncertainty about what is to be paid, are also major concerns among Roma.

In Slovakia, almost 58% of municipalities with Roma settlements do not have a general practitioner (GP), 69% of municipalities are without paediatric services and 68% without dental provision. There have been documented examples of ethnic segregation in hospitals’ gynaecological wards (separated and overcrowded rooms for Roma women), lower quality of services, longer waiting hours and degrading and violent behaviour of hospital staff.

Measures for the improvement of Roma access to healthcare

In the FYR of Macedonia, local and national interventions have been implemented in recent years, aimed at increasing Roma healthcare coverage, with significant EU funding. Several piloted models are considered successful and ready for roll-out as cost-effective interventions (e.g. UNICEF, Norway/EEA grants, ESIF funded projects). Community nurses may provide basic healthcare when needed, but usually focus on health promotion and education, whilst Roma health mediators may serve as facilitators between Roma communities and healthcare providers. A law regulating the status of community nurses was passed in 2017 and the government is attempting to give new momentum to a comprehensive network of Roma health mediators. Yet both of these initiatives are still in their infancy. The Roma Health Mediators (RHM) programme, which was introduced in 2012, is reported to have increased the number of Roma who have access to the health system.

The Portuguese “Programme for municipal Roma mediators” has been acknowledged as good practice by the Council of Europe.

In Slovakia, as part of the Strategy for Integration of Roma up to 2020, a specific programme “Healthy Communities” was launched in 2013 to address poor health conditions and insufficient access to healthcare among Roma marginalised communities. Within the project (more than 200) health assistants worked directly in marginalised Roma communities, focusing on health education, health assistance, and increasing trust in the health system. As a follow-up to this programme, a new project called “Health regions” – funded by the ESF and run by the Ministry of Health – was launched in 2016, with the aim of further increasing access to healthcare, improving health literacy and promoting health-related behaviour.

Source: ESPN country reports

In the context of the inflow of migrants witnessed over the past decade in Europe, access to healthcare for migrants, particularly for asylum seekers, refugees and undocumented migrants, is becoming an acute issue. These groups have been reported to be in a particularly vulnerable situation in several countries with regard to access to healthcare. As Section 1.2.1 highlights, asylum seekers and undocumented migrants have restricted formal access to healthcare in most countries under scrutiny: access for undocumented migrants is typically limited to urgent medical care and preventive care. However, even where basic formal access exists, effective access may be hindered by several (cultural and other) hurdles (see Box 10).

Box 10: Access to healthcare for asylum seekers and undocumented migrants: policy challenges and good practices

In Belgium, entitlement to "emergency" and "necessary" healthcare can often not be accessed in practice, because of poor awareness of these rights, fear of being reported to immigration authorities and complex administrative procedures.

In Denmark, whereas all registered residents are entitled to a comprehensive package of health services, this is not the case for non-residents, who only receive emergency healthcare. Undocumented migrants normally receive healthcare provided by a voluntary, privately funded initiative of the Danish doctors, supported by the Danish Red Cross and Danish Refugee Aid.

In Germany, access for asylum seekers is restricted to treatment of acute diseases and pain in the first 15 months of their stay in the country. It has been established that the gap between need for and entitlement to healthcare in many cases is high, in particular as asylum seekers often suffer from not only physical but also from psychological disorders.

In Malta, asylum seekers, persons with international protection as well as certain third country nationals are at times unable to access information about health services targeting their specific needs. They may also encounter language problems due to a lack of sufficient cultural mediators and lack of health professionals trained in dealing with these groups. A Primary Health Care Migrant Unit is available to help migrants to access the health system.

In Spain, the exclusion of undocumented migrants from accessing the public health system was one of the most direct (and controversial) measures adopted in the heat of the financial crisis. Several national (Ombudsman, Tribunal de Cuentas, Constitutional Court) and international institutions (Council of Europe, UN Special Rapporteur on extreme poverty and human rights) made clear statements criticizing the exclusion of this vulnerable group from the public health system and pointed to the potential public health risks of not adequately treating patients. However, since regional health authorities have a large degree of discretion in Spain, the exclusion of this group from healthcare was implemented in a rather limited way.

Source: ESPN country reports

Access to health promotion and disease prevention for vulnerable groups

Inequalities in access to preventive services and health promotion have been highlighted by many ESPN experts, as Box 11 illustrates.

Box 11: Inequalities in access to health promotion and preventive services

In Austria, low income groups less frequently attend preventive cancer examinations and display lower rates of vaccination.

In Belgium, socio-economic inequalities persist in the use of preventive care such as breast cancer screening, vaccinations and preventive dental care.

In France it was reported that in particular women from disadvantaged groups are less likely to take up preventive care, as illustrated by disparities in access to breast cancer screening.

In Germany, inequalities in the use of secondary prevention (early detection of diseases, particularly cancer, and detection of risk factors for cardiovascular diseases and diabetes) have been reported. Access rates to secondary protection for the unemployed, the low-paid, poorly educated and ethnic minorities are clearly below average. The reasons for this phenomenon are multifaceted, including a lack of knowledge about health.

In Hungary, there are substantial regional differences in the availability and participation rate of screenings.

In Italy, differences in secondary prevention are reported in the three main Italian macro-regions.

In Romania, access to health promotion and disease prevention is unequal, based on available funds. Most affected by the uneven access to health services are children under 5 years and teenagers, who are barely covered by either preventive care or screening.

In the UK it was found that wealthier patients consume more preventive care (for example, screening and vaccination services).

Source: ESPN country reports

2.1.3 Explaining inequalities in effective access: considering health system design

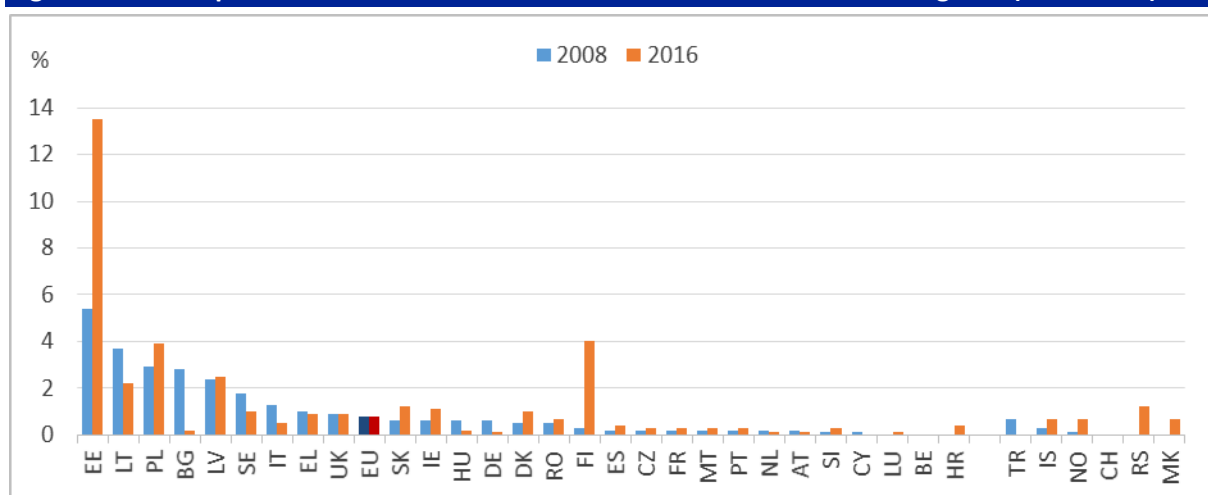
This section discusses the three main reasons for self-reported unmet needs for healthcare that can plausibly be related to system characteristics.

Among the major issues related to health system design are unmet needs due to waiting lists, geographical disparities in healthcare provision and costs. As Section 1.4 highlighted, there are significant shortcomings in the provision of health services and health professionals in some countries. Costs of healthcare have already partially been discussed in Section 2.1.2, since they are strongly related to access issues for the lower income groups. In this section we will further expand on the role of out-of-pocket payments as a barrier for access to healthcare. First, we will discuss waiting times, next, distance to healthcare and finally, the cost of healthcare and out-of-pocket payments.

Waiting times

Waiting lists are by far the most important reason for unmet needs for medical examination in some countries (e.g. CZ, DK, EE, ES, FI, LT, NL, NO, PL, SE, SI, SK, UK), compared to the two other factors explaining unmet needs (cost and travelling time) (see Figure 5). As mentioned already, Estonia has the highest share of unmet needs due to waiting lists (13.5%), followed by Finland (4%) and Poland (3.9%). There has not been a significant increase over the past ten years except for in Finland and Estonia, where unmet needs due to waiting lists increased from 0.3% to 4% and from 5.4% to 13.5% respectively. The most positive development has been in Bulgaria, where the percentage of unmet needs due to waiting lists has been reduced from 2.8% to 0.2% (see Figure 14).

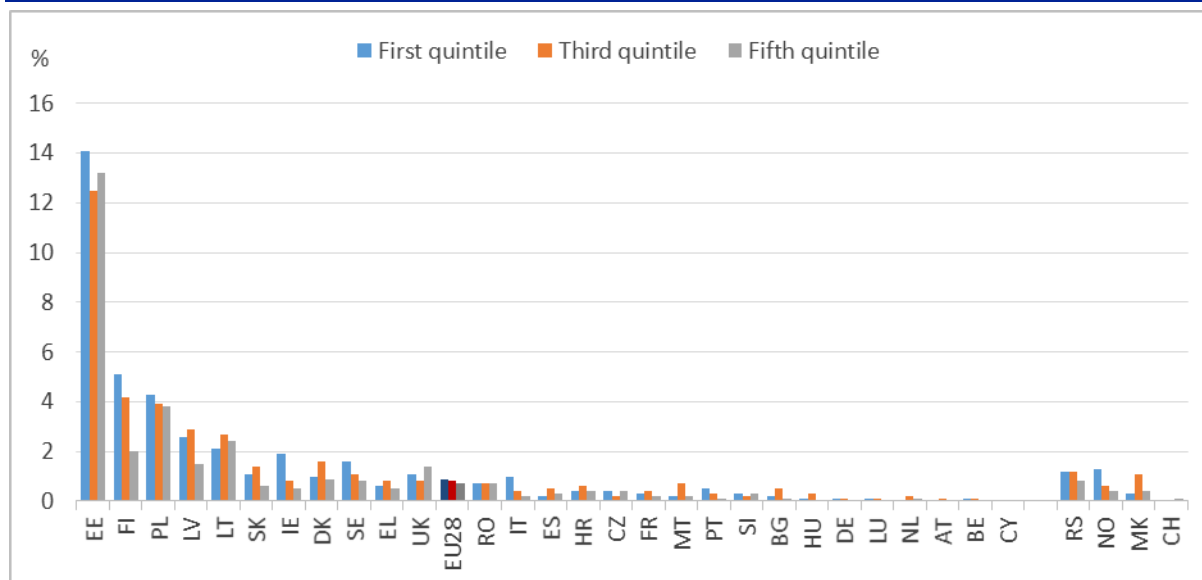
Figure 14: Self-reported unmet needs for medical examination due to waiting lists (2008-2016)



Source: Eurostat [hlth_silc_08]; * ESPN countries not included in the dataset: LI; ** No data for 2008: HR, MK, RS; *** Data for IS and TR refer to 2015, no data available for 2016.

In some countries, those in the lowest income quintile are also particularly disadvantaged compared to the highest earners with regard to waiting times (e.g. EE, FI, IE, LV; see Figure 15). Finland tops the chart with a gap of 3 p.p. (5.1% for the first quintile compared to 2% for the fifth).

Figure 15: Self-reported unmet needs for medical examination due to waiting times by income quintile (2016)



Source: Eurostat [hlth_silc_08]; * ESPN countries not included in the dataset: LI; ** ESPN countries with no data for 2016: IS, TR.

ESPN experts from countries with the most acute (subjective) unmet needs due to waiting times have reported (objective) long waiting lists (See Section 1.4.4). Underfunding of the health system and staff shortages in the publicly funded sector have been often mentioned by ESPN experts as the reason for problematically long waiting lists (see Section 1.4.1). This was also the case for Estonia, the country with the highest and increasing unmet needs due to waiting times. The Estonian ESPN country experts pointed out that, contrary to most other SHI systems, the state barely contributes to the system for non-contributing individuals (e.g. children, the unemployed, pensioners), who make up more than half of those insured. This results in a lack of funding of health services, staff shortages and thus long waiting times. For instance, some hospitals use up their contract volumes several months before the end of the contract period and thus postpone all elective care to the next half-year.

In Finland, as highlighted in Section 1.2.1, the main reason for unmet needs is the fragmented health coverage in the country, with long waiting times in the municipality 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, and this system is often more effective than the public system. For this reason, the OECD has classified the Finnish health system as one of the most unequal in the industrial countries.

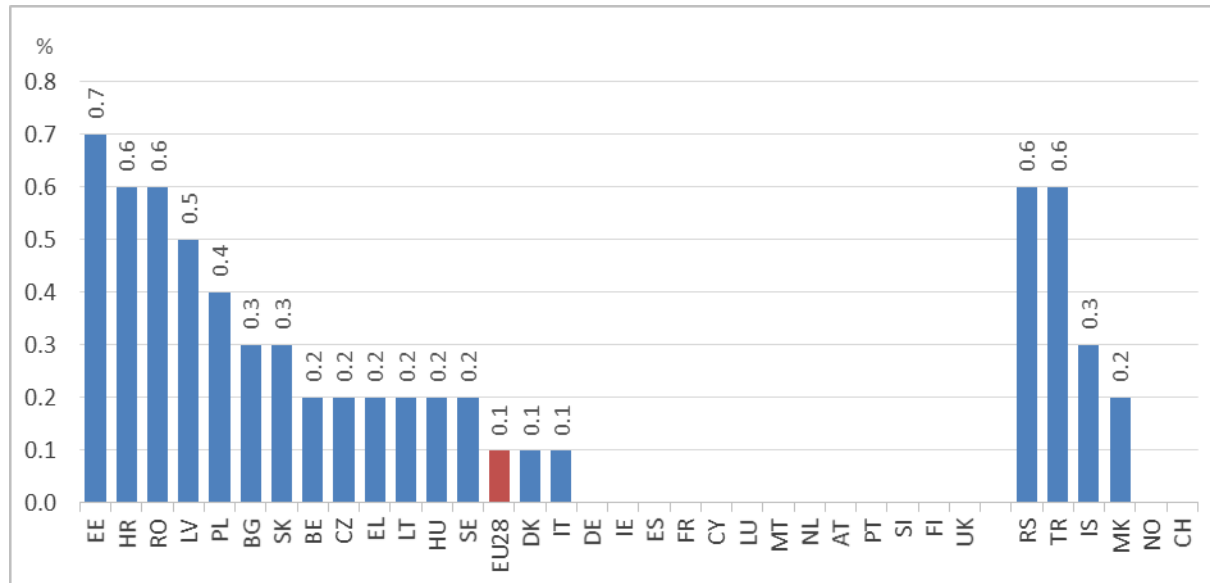
In many other European countries, the wealthiest can skip the waiting queues in the public system by buying private healthcare, or can afford VHI (see Sections 1.4.5 and 1.3).

Distance to healthcare and regional disparities

As discussed in Section 1.4.3, geographical disparities in provision of healthcare may be quite considerable in some countries. Figure 16 clearly shows that there are significant differences between countries in terms of travelling time. In general, the problem is most acute in Central and Eastern European countries, while respondents in the Western Europe and Nordic countries barely mention this factor (except for Iceland 0.3%, Denmark 0.1% and Italy 0.1%). There is a substantial match between the countries for which people report unmet needs for medical examination due to travelling time, and the countries for

which ESPN experts highlighted important disparities in the supply of health services across urban and rural areas (e.g. BG, CZ, EL, HR, HU, LT, LV, RO, RS, TR).

Figure 16: Self-reported unmet needs for medical examination due to travelling time (2016)



Source: Eurostat [hlth_silc_08]; * ESPN countries not included in the dataset: LI; ** Data for IS and TR refer to 2015, no data available for 2016.

Regional differences in access to care may be particularly high in countries where competences for the organisation of healthcare have been (partially) devolved to the regions.

For instance, in an Italian national survey, the share of individuals declaring unmet healthcare needs in Southern Italy is twice as high as in Northern Italy: 9.4% versus 4.7%. There are also wide gaps between the share of Italians accessing dental care by macro-region: around 52% in Northern Italy and around 36% in Southern Italy. Waiting lists and problems linked to travel distances to healthcare centres are also more widespread in Southern (and Central) Italy than in Northern Italy. According to the Italian ESPN experts, it is hard to provide an explanation for this gap. It is not simply related to regional differences in public healthcare per-capita spending. The North-South difference in performance of the system also seems to be due to differences in administrative and organisational capacities, and the ability of regional and local administrations to manage healthcare efficiently and effectively.

In Sweden, successful access levels differ between the regions, in particular between the Northern region and the Stockholm region, regarding specialist care. The success rate for getting an appointment with a specialist within 90 days was 67% in the Northern region and 94% in the Stockholm region, and the likelihood of having an intervention within 90 days of a decision to operate was only around 60% in the Northern region and 87% in the Stockholm region.

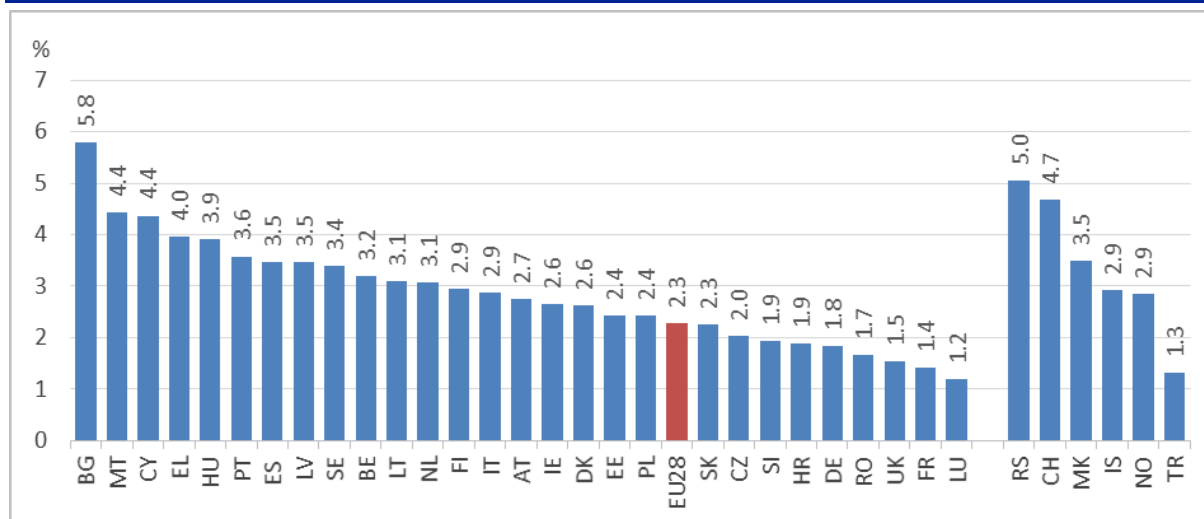
In Spain, while in Madrid patients had to wait 46 days on average for a non-urgent hospital surgical intervention in June 2017, patients in the Canary Islands had to wait 169 days. Waiting times for neurosurgical interventions can be as much as 317 days in the Canary Islands, 229 days in Castile-La Mancha, 114 days in Valencia, compared to 52 days in Madrid.

Out-of-pocket payments

The issue of affordability of healthcare has already been partially discussed in Section 2.1.1, in relation to low income groups. It is, however, worth examining out-of-pocket payments (OOP) as a share of household expenditure in more detail: 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 figures

(almost) double the EU average of 2.3%. As for the non-EU countries, those with the highest percentages of OOP are Serbia, Switzerland, FYR of Macedonia, Iceland and Norway. Of the 35 countries under scrutiny, Luxembourg (1.2%), Turkey (1.3%), France (1.4%), the UK (1.5%), Germany (1.8%) and Romania (1.7%) have the lowest scores in this respect (see Figure 17).

Figure 17: Out-of-pocket medical spending as a share of final household consumption, 2014 (or nearest year)

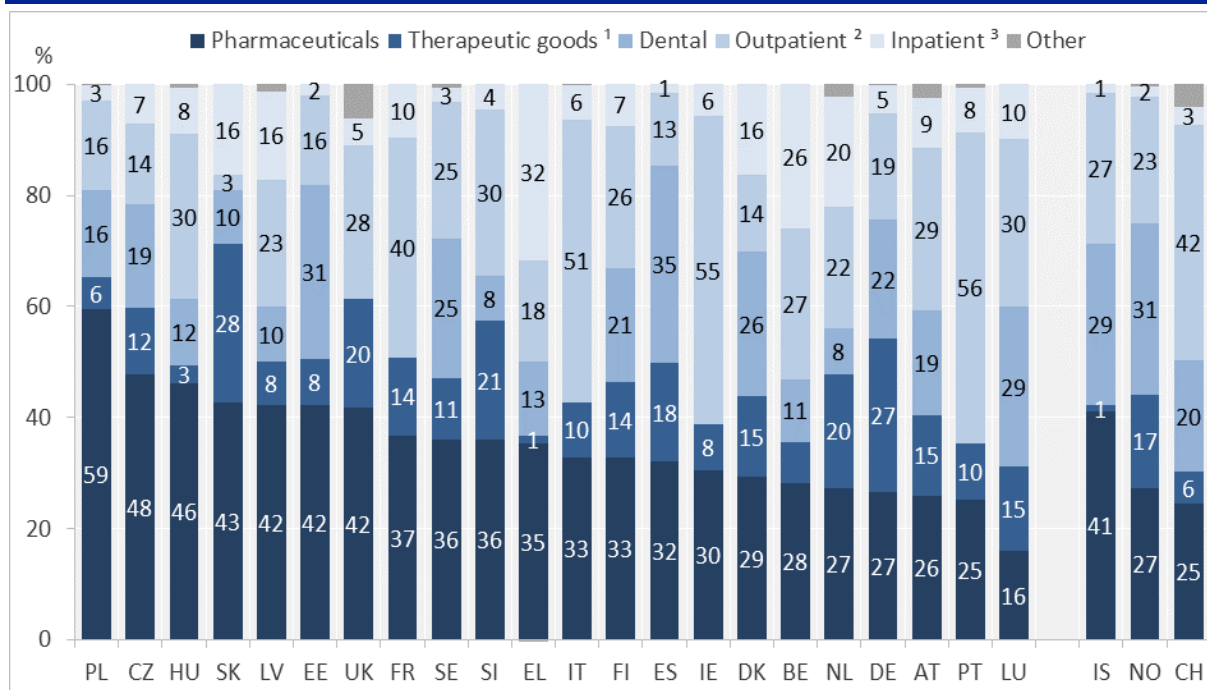


Source: OECD/EU (2016), *Health at a Glance: Europe 2016*; * ESPN countries not included in the dataset: LI.

In general, the share of OOP spent on pharmaceuticals is among the most significant (see Figure 18). This is especially true for Central and Eastern European countries (e.g. CZ, EE, HR, HU, PL, RO, LV, SK), Greece and Iceland. In Romania, pharmaceuticals account for 75% of total out-of-pocket medical spending on services and goods, although this relates to a very low level of OOP as a share of household consumption (see Figure 17). The share of OOP for curative care is high in Austria, Belgium, Greece and Switzerland. The share of OOP is highest for dental care in some Nordic countries (e.g. DK, IS, NO) and Southern countries (e.g. ES). In these countries, dental care (for adults) is not included in the healthcare basket (see Section 1.2.3).

The low coverage of some services and products, and in particular the high user charges for medicines, but also dental care and mental healthcare, are a cause of concern in most European countries (e.g. AT, BE, EE, EL, ES, FI, HR, HU, IE, IS, IT, LI, LT, LV, MT, NO, PL, PT, RO, SE, SK). In particular, the fact that in many countries vulnerable groups are not protected from high user charges for pharmaceuticals, and that pharmaceuticals are often exempted from annual caps on user charges, may have an important impact on the effectiveness of the healthcare provided. If a patient has access to a medical doctor but cannot afford to pay for the prescribed medication, the care provided may be ineffective. It should be noted that access to pharmaceutical products is not measured in the EU-SILC data on self-reported unmet needs.

Figure 18: Shares of out-of-pocket medical spending by services and goods, 2015 (or nearest year)



Source: OECD (2017), *Health at a Glance 2017*. Note: This indicator relates to current health spending excluding long-term care (health expenditure). ¹Including eye care products, hearing aids, wheelchairs, etc. ²Includes home care and ancillary services (and dental if not shown separately). ³Including day care. * ESPN countries not included in the dataset: BG, CY, HR, LI, LT, MK, MT, RO, RS, TR.

Several ESPN experts point to the issue of “catastrophic” health expenditure (e.g. CY, EL, HU, LV, PT), in relation to the existence of high OOPs. The “catastrophic” label mainly refers to the fact that falling ill can induce often sizeable and unpredictable shocks to a household’s living standards, pushing many of them into poverty³¹. Moreover, these are particularly problematic for low-income groups (e.g. CY, HR) and other vulnerable categories, such as pensioners. For some examples, see Box 12.

Box 12: OOPs and catastrophic health expenditure: poor access to healthcare for poorer population groups

Out-of-pocket payments in Cyprus are heavily skewed towards the lowest income group (poorest 20% of the population). In addition, the proportion of households experiencing catastrophic payments was higher for those having only public coverage than for households having other types of coverage (i.e. combination of public and private coverage or only private). The predominant determining factor for this is the limited access to public health services due to long waiting lists, which results in catastrophic expenditure for a significant proportion of low-income households as they are forced to seek health services in the private sector.

In Hungary, OOPs and catastrophic payments are often linked to informal payments and are estimated to make up at least 2.1% of total health expenditure — a much higher share than in most EU countries. They are often used to gain quicker access to healthcare and better-quality care. In 2014, catastrophic medical expenditure affected 21.6% of households, and especially those in the lowest income quintiles: 92.1% in the lowest, 9.0% in the second lowest and 1.7% in the top income quintile. Between 2011-2014 both the proportion of OOPs and those affected by catastrophic medical expenditure increased, while state support for prescription medicine decreased.

³¹ Catastrophic health expenditure is defined in relation to a households’ capacity to pay. K. Xu *et al.* (2003), defined expenditure as being “catastrophic” if a household’s financial contributions to the health system exceed 40% of income remaining after subsistence needs have been met (the threshold at which health spending has been defined as “catastrophic” varies from 5% to 20% of total family income in other studies).

In Latvia, nearly 27% of the poorest fifth of households experienced catastrophic out-of-pocket payments, compared to 4% of the richest fifth. Out-of-pocket payments for outpatient medicines and medical products are the single largest cause of financial hardship, accounting for 75% of catastrophic out-of-pocket payments on average in 2013 and rising to over 80% of catastrophic out-of-pocket payments among the poorest half of the population.

In Poland, out-of-pocket (OOP) payments create a considerable burden for families and individuals on low incomes. Catastrophic OOP health expenses, estimated as 10% of total income, were experienced by every fifth household in Poland in 2010 (20.3%) and 8.8% of households experienced expenditures amounting to 40% of their total capacity to pay. About 60% of OOP payments are for pharmaceuticals, 11-12% are used for paying for private doctors' consultations and 14-16% for dental care.

Source: ESPN country reports

2.1.4 Wrapping up: strengths and weaknesses of healthcare systems in ensuring access to healthcare

Most countries whose system is described by their national ESPN experts as underfunded (e.g. BG, CY, EE, EL, HR, HU, IE, IT, LT, LV, PL, RO, RS) score less 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 A3 in Annex 1). In underfunded systems, important shares of the cost of services must be paid by the patient or the insured person, and there are large variations in the availability and quality of services, which may lead to long waiting lists.

However, even between countries spending similar amounts of public money, the outcome with regard to access to healthcare can be quite different. Some countries with below EU average public spending on healthcare as a proportion of GDP perform rather well with regard to access to healthcare and inequalities in access to healthcare among income groups, based on the data on self-reported unmet needs for medical examination (e.g. CZ, ES, UK). Although the qualitative data in the national reports do not allow us to draw robust conclusions explaining why this is the case, the relatively low user charges for health services (as discussed in Section 1.2.3) seem to play an important role here. This hypothesis is supported by the country scores on unmet needs for dental care, where the picture is quite different from that relating to unmet needs for medical examination, and this in turn correlates with the level of user charges in the respective countries.

Moreover, inequalities in access to healthcare do not seem to be linked to the model of health system funding. Well-performing countries can be found among all three models: for example, Austria and Luxemburg among the countries with a Social Health Insurance (SHI) system; the Netherlands with a compulsory Private Health Insurance (PHI) system; and Spain and Norway with a National Health Service (NHS). This suggests that the success of systems in terms of access is related, rather, to the country-specific details of financing and organisation of healthcare provision and funding, and the way in which vulnerable groups are protected from user charges within each of the systems.

Many ESPN experts warned that the (growth of) voluntary and occupational health insurance could exacerbate inequalities in access to healthcare, in particular when the schemes are used to "jump the queue" by those who can afford it, usually those in better employment situations. VHI schemes risk reducing public support for measures aimed at improving affordability of healthcare or improving waiting times for the whole population. The schemes furthermore provide an incentive for health professionals to leave the contracting system and to freely set their tariffs.

The unequal distribution of health services between urban and rural areas has been highlighted for most countries (see Section 1.4.3) and cuts across health systems and countries in Europe. The reasons for this geographical divide are multiple. Some of the

factors behind these inequalities are not specific to health services but are typical for services of general interest. Access to these services has to be guaranteed by the public authorities, even in areas and circumstances where they cannot be financially viable, due to long distances and low numbers of clients/patients. Other factors are specific to healthcare. In particular and increasingly, quality of healthcare provision requires a certain concentration of knowledge and experience, which is hard to guarantee in remote and sparsely populated areas. For highly specialised care, high investment costs may be a further challenging factor. Several ESPN country reports highlighted the resistance to plans to close hospitals in remote areas, as part of policies to concentrate human and technological resources (e.g. BE, LT, RO, SI).

2.2 Recent and planned reforms

Five countries recently implemented or plan a comprehensive reform, involving an important overhaul of their health system: Cyprus, Greece, Finland, Ireland and Latvia (see Box 13). These are the countries for which ESPN country experts highlighted that the health system is fragmented, with different insurance coverage for different population groups, serious gaps in health coverage and important inequalities in access to healthcare. The main features of the reforms in these countries are:

- a **move towards universal population coverage** (e.g. CY, EL);
- an **extension of the benefit package** to a comprehensive range of services (e.g. IE, LV);
- generation of additional resources by **shifting from a state-funded system to a contribution-based compulsory social health insurance system** (e.g. CY, LV);
- a **reduction** in fragmentation in **health funding bodies** (e.g. EL, FI);
- greater **integration between social and health services**, in particular in ambulatory settings (e.g. EL, FI, IE);
- an **increased role for private providers** in healthcare delivery (e.g. FI).

Box 13: Comprehensive system reforms in some countries

In Cyprus, a new National Health Service (NHS) will be implemented by 2020, after the country has sought to implement a universal health system for nearly 30 years. The scheme will provide universal population coverage and will be financed by state revenues and compulsory contributions levied on wages, incomes and pensions. User charges will apply, with an annual ceiling. The new system is expected to resolve the majority of the deficiencies of the current system.

In Finland, the planned social and healthcare reform (SOTE) will: a) restrict the national health insurance, one of the three historical legacies; b) increase the role of private players vis-à-vis public providers in healthcare delivery; and c) shift powers for health provision from municipalities towards new counties/regions, with a view to creating seamless service chains for the provision of key social welfare and health services. However, rather surprisingly, the occupational health insurance scheme, which was considered to be the major cause of differences in access to healthcare, will remain intact. The ambition is to have SOTE implemented by 2020. While, according to the Finnish ESPN expert, the SOTE reform has much potential to create more equal access to healthcare, there are many risks as well. It may create new inequalities between urban and rural areas and between high- and low-resource groups, between those in the labour market and those who are inactive.

In Greece, since 2011, the newly created National Organisation for the Provision of Health Services (EOPYY) has brought together all the health branches of most social insurance funds. Since 2016 it has also covered the uninsured segment of the population, which is considered an important step towards universal health coverage. The whole (previously extremely fragmented) system for the provision of health services is now underpinned by a unified regulation (Unified Healthcare Regulation-EKPY). Furthermore, a reform of the Greek primary health system, which is currently underway, includes the establishment of "local health units", consisting of a multidisciplinary team of social and health workers. It is considered a positive

development which has long been awaited. However, the progress of implementation is rather slow, while understaffing continues to be a serious obstacle to the proper functioning of the whole primary health system in Greece.

In Ireland there has been broad agreement for some time that the health system needs to be reformed and the direction of travel is towards universal healthcare. However, proposals to this effect failed for many reasons: these include the potential costs associated with the reform, under-specification of key mechanisms and opposition from many interest groups. In 2017, an all-party parliamentary committee provided a blue-print for universal healthcare, that would give all residents access to a comprehensive range of services. Other recommendations include the introduction of a new model of integrated and coordinated health and social care. While the Irish government welcomed the report at the time, little has happened in the interim to implement it.

Latvia will shift from a state-funded system to a compulsory health insurance system in 2019. The reform aims to address the underfinancing problems of the system and to increase access to state-funded health services. Persons who pay social contributions and groups of the population for whom health insurance contributions will be paid by the state will have access to a broad basket of benefits. According to the Latvian national ESPN experts, there is, however, considerable uncertainty about the reform. It is feared that the new approach may jeopardize accessibility of healthcare for those who are not insured. The law will furthermore not resolve the issue of the high ratio of out-of-pocket payments made by the population.

Source: ESPN country reports

Other specific reforms were recently implemented or planned in many European countries. These include:

- **Increase of the overall budget for the health system**, in particular to improve the attractiveness of the health professions and reduce waiting times (e.g. CZ, EE, LV, PL)³². Additionally, the systemic reforms in Cyprus and Latvia discussed above – transforming the state-funded health system into a contribution-based compulsory social health insurance system – also primarily aim to generate additional resources. The additional resources in these two countries aim primarily to ensure universal population coverage and to broaden the benefit package. In Liechtenstein, however, the state contribution to the compulsory PHI fell steadily until 2018.
- **Improved availability of health professionals** (e.g. CZ, DE, LT, LV, PL, RO, SI) by increasing wages; by providing incentives to work in outpatient care, general medicine and in poorly-serviced areas; through incentives to re-enter the labour force and through additional financing of rural health centres.
- **Improved availability of specific health services** (e.g. BE, BG, HU, IS, PL, PT): this includes, in particular, investment in mental health services and dental care. Furthermore, measures have been taken to improve hospital funding mechanisms, intra-hospital referrals, and the transition from hospital care to outpatient care. In Turkey, additional hospitals have been opening since 2015.
- **Improved access to primary care** (e.g. EL, IT, PL, RO, UK), in particular in remote areas, through: financial incentives; initiatives to shift from inpatient care to outpatient and primary care; and the setting up of multidisciplinary integrated primary care centres.
- **Improved waiting list management** (e.g. BG, DE, HU, LT, LV, MK, PT, SI, TR) through the introduction of official waiting lists and maximum waiting time guarantees, in particular for cancer patients.
- In addition to the countries mentioned above, which have enacted major reforms aimed at providing universal population coverage (e.g. EL, LV, CY), other countries

³² This is also the case in Spain, under the new government (June 2018).

improved population coverage for specific groups (e.g. EE, RO)³³. By contrast, in Bulgaria, citizens' disrupted health insurance will in the future be restored only subject to payment of arrears for the previous five years, instead of the 3 years applicable until the end of 2015.

- **Limits on specific user charges** (e.g. BE, EE, IS, IT, LT, LU, RS, SK, PL, PT)³⁴: this includes reduced user charges for specific medical devices and pharmaceuticals and exemptions from co-payments for the elderly. Initiatives have also been taken to tackle informal payments and increase transparency (e.g. LT, RS), and up-front payments for outpatient medical care have been abolished for lower income groups (e.g. LU). Measures were taken (e.g. BE) to identify beneficiaries and to invite them to apply for exemptions from user charges. Some of the measures taken reverse increases in user charges enacted during the crisis years. However, in SK, the maximum limit for co-payments has been increased while the groups of patients subject to these maximum limits have been extended.
- Fostering prevention and health promotion (e.g. AT, BG, IT, HU, RO), by new **specific screening programmes and vaccinations**. By contrast, in the UK, despite strong advocacy of prevention, the public health budget has been severely cut since 2015 and more spending cuts are planned.
- In France, **coverage of voluntary health insurance was extended** to nearly the whole population, to cover the high user charges in the statutory system.
- **Improved access for ethnic minorities** (e.g. BE, MK, RO, SI). This includes community nurses providing basic healthcare and intercultural mediators.
- **Improved monitoring of access to healthcare** and waiting lists (e.g. IT, SI, UK).

³³ And in Spain since the new government has been in power (June 2018).

³⁴ And in Spain since the new government has been in power.

3 The measurement of inequalities in access to healthcare

This final section provides a brief discussion of the measurement of inequalities in access to healthcare. Measuring the accessibility of healthcare requires consideration of various factors, related both to the health system and to the patients (Allin and Masseria 2009). From that perspective, factors such as the design of statutory healthcare, coverage and the public benefits packages, human resources, waiting times, continuity of care, the quality of healthcare, as well as socio-economic status, the age of the patients and the level of health literacy should be taken into consideration (Ibid).

Different approaches and indicators are available to measure the accessibility of healthcare and to assess the extent of inequality in access to services. As illustrated above, 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. The main source in Europe is the *EU Statistics on Income and Living Conditions (EU-SILC)*. Although this indicator, commonly used in the EU³⁵, has the undeniable advantage of facilitating cross-country comparisons and providing a first indication of inequalities and problems regarding affordability and accessibility, many ESPN experts have pointed to its limitations and emphasised the need for caution in interpreting the results (e.g. AT, BE, BG, CY, DE, EE, EL, ES, HR, IT, LV, PT, MT, NL, NO, SE, SI, SK) (see also EXPH 2016; European Commission 2017).

ESPN experts primarily express concerns regarding the variation in the results between surveys, wording issues, and the lack of consistency with national data on accessibility of health services. However, major progress has already been made regarding the harmonisation of health-related questions between countries (notably based on collaboration between the EU-SILC and EHIS teams). Some changes in the guidelines and model questions in the EU-SILC survey were notably introduced in 2015 (European Commission 2017). But there is still some room for improvement. For example, the Swedish ESPN expert raises the issue of the falling response rate, in general and for disadvantaged groups, of most national health surveys. In relation to variables that are associated with non-response, such as unmet needs, the overall figure for the population may be seriously underestimated. The “report on the comparative assessment of the accessibility of healthcare services” focused mainly on translation issues as a potential cause of comparability issues for the EU-SILC data on unmet needs for medical examination or treatment across Member States. It also raised the need to further investigate cultural aspects, since responses vary according to cultural differences in the perception of health (European Commission 2017).

Alongside the indicator on unmet needs for medical care, which is primarily a broad proxy indicator on the issue, complementary indicators are useful and needed in order to paint a subtler and more comprehensive picture of the situation (e.g. AT, CY, FI, HR, HU, IE, MK, NO). ESPN experts emphasise the existence of a wide range of indicators (covering, among others, the three main domains of access – coverage, availability and affordability) already available in Europe and internationally and refer to their valuable insights. Some examples have been reported by ESPN experts. OECD measures, such as the OECD Horizontal inequity index³⁶, can be of great value; this index examines the extent to which the use of health services, based on standardised needs, differs among different income groups in various countries. ESPN experts also referred to data available in the European Social

³⁵ Various surveys include questions on self-reported unmet need for medical care: the EU Statistics on Income and Living Conditions (EU-SILC), the European Health Interview Survey (EHIS), the Eurofound Quality of Life Survey (EQLS), the Survey of Health, Ageing and Retirement in Europe (SHARE) and the European Social Survey (ESS).

³⁶ Estimates are based on national health interview surveys/ European Health Interview Survey. See [OECD \(2013\)](#), and [Devaux and de Loooper \(2012\)](#) for complementary information. Data is compiled on an ad-hoc basis and is based on 2009 data. Covers selected OECD countries.

Survey³⁷, in the EU-SILC special ad-hoc module³⁸, and WHO indicators on health inequities³⁹, which make it possible to directly measure inequalities in access to healthcare, from a comparative perspective. Access to healthcare can also be evaluated indirectly by considering outcomes related to healthcare (see also EXPH 2017). Existing data comprise various health outcome indicators (child mortality, amenable mortality, preventable mortality, external causes of death excluding transport accidents, etc.) (see European Commission 2015, p.16-19). Data related to inputs, process and outcomes are notably available in the regular "Health at a glance" reports produced by the OECD and the EU (OECD/EU 2016; OECD 2017).

For additional information on some international standardised indicators, see Boxes 14a, 14b and 14c.

**Box 14a: Additional information on international standardised indicators
(2016 and 2017 EU-SILC ad hoc modules)**

EU-SILC ad hoc module on access to services (2016)

Persons using healthcare services by household type, income group and level of difficulty to afford care services (ilc_ats12)

Three questions are used to assess access to healthcare (available [here](#)):

- *Has the household used any healthcare services during the last 12 months (e.g. consultations, treatment and prescribed medication) (at the household level)? (HC160) Yes / No. If "No", go to question HC190*
- *Has the household paid or contributed to the cost of healthcare services during the last 12 months? (HC170) Yes / No.*
- *Level of difficulty experienced by the household in covering the total healthcare services costs (costs of consultations, treatment and prescribed medication; dental examination or treatment) for all the household members (including former members) (HC180). Answers: great difficulty, difficulty, some difficulty, fairly easily, easily, very easily.*

It should be noted that households that were not able to use healthcare services during the last 12 months (e.g. due to financial problems, waiting lists, etc.) are not taken into account in this indicator.

EU-SILC ad hoc module on health and children's health (2017)

This module includes the following questions related to access to healthcare for households with children:

Information on financial burden (refers to the household)

- *To what extent were the costs of medical examinations or treatments a financial burden to your household during the past 12 months (excluding dental examinations or treatments)? (HS200)*
- *To what extent were the costs of dental examinations or treatments a financial burden to your household during the past 12 months? (HS210)*
- *To what extent were the costs of medicines (prescribed and non-prescribed) a financial burden to your household during the past 12 months? (HS220)*

³⁷ [European Social Survey](#): the core module takes place every two years (2002-2016). Geographical coverage varies over time: see [the list of participating countries](#) for each round (year). Rotating modules are dedicated to specific themes and are collected on an ad-hoc basis. See for example: [Social inequalities in health](#) (2014) – data available for EU countries (AT, BE, CZ, DK, EE, FI, FR, DE, HU, IE, LV, LT, NL, PL, PT, SI, ES, SE, UK) and non-EU countries (Israel (IL), NO, CH) – and: [Health and care seeking](#) (2004).

³⁸ [2016 EU-SILC ad hoc module on access to services](#). Countries covered: EU Member States and IS, NO, CH and TR.

³⁹ [WHO indicators](#): see for example: [List of 100 core health indicators \(2015\)](#), [Health systems data](#), [Universal health coverage data](#), [Health equity monitor](#) and [European Health Information Gateway: Health for All explorer: 1503 indicators](#). Periodicity and geographical coverage vary according to the indicator and the data set.

Information on health (provided for each household member)

- *During the past 12 months, how many times did you visit a dentist or orthodontist on your own behalf (PH080)?*
- *During the past 12 months, how many times did you consult a GP (general practitioner) or family doctor on your own behalf? (PH090)*
- *During the past 12 months, how many times did you consult a medical or surgical specialist on your own behalf? (PH100)*

Information on unmet need (refers to children aged 0-15 living in the household)

- *Was there any time during the past 12 months when [any of] your child[ren] really needed medical examination or treatment (excluding dental examination or treatment)? (HC010 Q1). If "Yes", go to question HC010 Q2. If "No", go to question HC030*
- *Did your child[ren] have a medical examination or treatment each time it was really needed? (HC010 Q2). If "Yes", go to question HC030. If "No", go to question HC020.*
- *What was the main reason for not having a medical examination or treatment? Answers: could not afford to (too expensive), waiting list or the time needed to obtain an appointment was too long, could not take the time, because of work, care of other children or of other persons, too far to travel or no means of transportation, other reason (HC020)*
- *Was there any time during the past 12 months when [any of] your child[ren] really needed dental examination or treatments (HC030_Q1). If "Yes", go to question HC030_Q2. If "No", go to question HC040*
- *Did your child[ren] have a dental examination or treatment each time it was really needed? (HC030_Q2)*
- *What was the main reason for not having a dental examination or treatment? Answers: could not afford to (too expensive), waiting list or the time needed to obtain an appointment was too long, could not take the time, because of work, care of other children or of other persons, too far to travel or no means of transportation, other reason (HC040)*

Source: authors' own elaboration

**Box 14b: Additional information on international standardised indicators
(OECD Horizontal inequity index)**

OECD Horizontal inequity index

This indicator compares the observed distribution of healthcare by income with the distribution of need (Devaux and de Looper, 2012).

"Inequalities in the probability and the number of doctor consultations across different socio-economic groups must take into account differences in need, because health problems are more frequent and more severe among lower socio-economic groups. The adjustment for need provides a better measure of inequity" (OECD, 2013, p. 144)

Based on different variables (see Devaux and de Looper, 2012):

- *Doctor (specialist/GP) visits in the past 12 months*
- *Dentist visits in the past 12 months*
- *Need for healthcare*
- *Individual characteristics*
- *Income level of the household*

Source: authors' own elaboration

**Box 14c: Additional information on international standardised indicators
(European Social Survey and WHO Health Equity Monitor)**

European Social Survey

Core module

- Please say what you think overall about the state of health services in [country] nowadays?
- How is your health in general?
- Are you hampered in your daily activities in any way by any longstanding illness, or disability, infirmity or mental health problem?

Rotating module (2014 social inequalities in health)

Use of primary, secondary and alternative healthcare:

- Discussed health, last 12 months with general practitioner, medical specialist, none of these (E13)
- Unable to get medical consultation or treatment, last 12 months (E14)
- Reason for no medical consultation or treatment: could not pay, could not take time off work, other commitments, not available where you live, waiting list too long, no appointments available (E15)
- Never able to get medical consultation or treatment, reason, last 12 months (E16)
- Treatments used for own health, last 12 months: acupuncture, acupressure, Chinese medicine, chiropractic, osteopathy, homeopathy, herbal treatment, hypnotherapy, massage therapy, physiotherapy, reflexology, spiritual healing (E19)

See [here](#) for complementary information

WHO Health Equity Monitor

Inequality in reproductive, maternal, new-born and child health (RMNCH) interventions, combined: composite coverage index of RMNCH interventions capturing both the provision and use of key RMNCH interventions

Source: authors' own elaboration

ESPN national reports also reflect the data available (on coverage, availability and affordability) at national level. This information enables us to understand some country specificities and enriches the standardised indicators (see Box 15). For instance, the Dutch experts highlight that in the case of the Netherlands, the structure of financing needs to be considered (especially the arrangements for deductibles, although this aspect is not included in international indicators). Some countries (e.g. CH, CZ, DK, SE) have a strong history of developing indicators that can be broken down into sub-areas (regional, municipalities...). So far, however, regional discrepancies are barely revealed in international indicators. In Denmark, the National Action Plan has about 30 indicators which make it possible to compare health inequities across regions and municipalities. In Sweden, the "Open Comparisons" produced by the Swedish Association of Local Authorities and Regions (SALAR) and the National Board of Health and Welfare (NBHW) provide comparisons between municipalities and counties.

With regard to the indicators available to measure health coverage, which range from administrative data at national level to international standardised indicators (such as the OECD indicators), some ESPN experts point to the lack of information on group differences (e.g. EL, ES), especially for those which are excluded from the system (e.g. ES). Some experts also emphasise that national and Eurostat measures are not always the same. In Denmark, national and Eurostat measures of private health insurance coverage differ. Indicators to assess the *availability* of health services are usually split into two distinct topics – geographical distribution of doctors and waiting times/waiting lists (e.g. DE, ES, FR). Some ESPN experts highlight issues when it comes to measuring affordability. For

example, in Greece, out-of-pocket payments are underestimated, since the extensive use of informal payments for healthcare is not taken into account.

The challenge of measuring inequalities in access to healthcare is also linked to the lack of indicators and access to reliable and quality data at national level. Some countries are still facing difficulties in gathering regular, quality data (e.g. BG, CY, EL, LI, LV).

Box 15: Examples of national initiatives to produce data related to inequality in access to healthcare

In Finland, the different registers (on income, education, socio-economic status, language, diagnoses, the utilisation of health services and the use of medicine), besides providing rich data, make it possible to directly evaluate the state of health and the utilisation of services.

In France, an indicator of disparities in healthcare availability or "localised potential accessibility" has been developed. This indicator combines a measurement of the distance to the closest health professional with the level of the practitioner's activity, using full-time equivalents and healthcare requests that consider different needs depending on age.

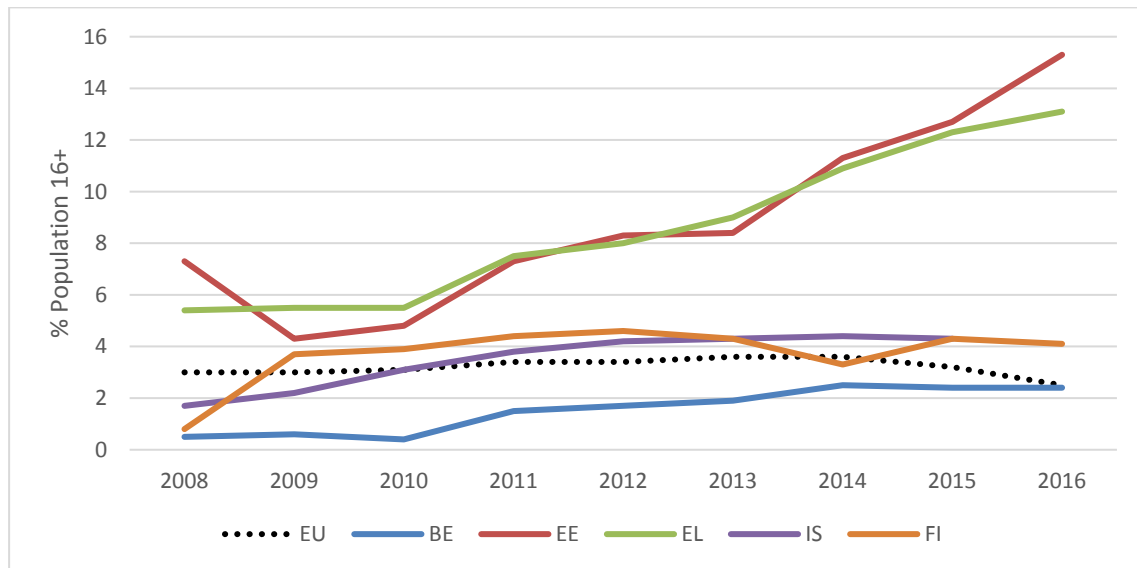
Ireland has developed a number of initiatives to produce analyses related to health inequalities: the Irish Health Poverty Index of the Institute of Public Health in Ireland; the Health Atlas Ireland, and the Pobal maps — a free geographical information system (GIS) which provides local area deprivation and service profiling.

In Lithuania, following the impetus of the project "Development of the Model for the Strengthening of the Capacities to reduce Health Inequalities", a system for monitoring healthcare inequalities has been developed. There are various types of indicators: demographic, economic, social indicators; indicators on mortality, morbidity and access to health services and indicators based on data from population surveys.

Source: ESPN country reports

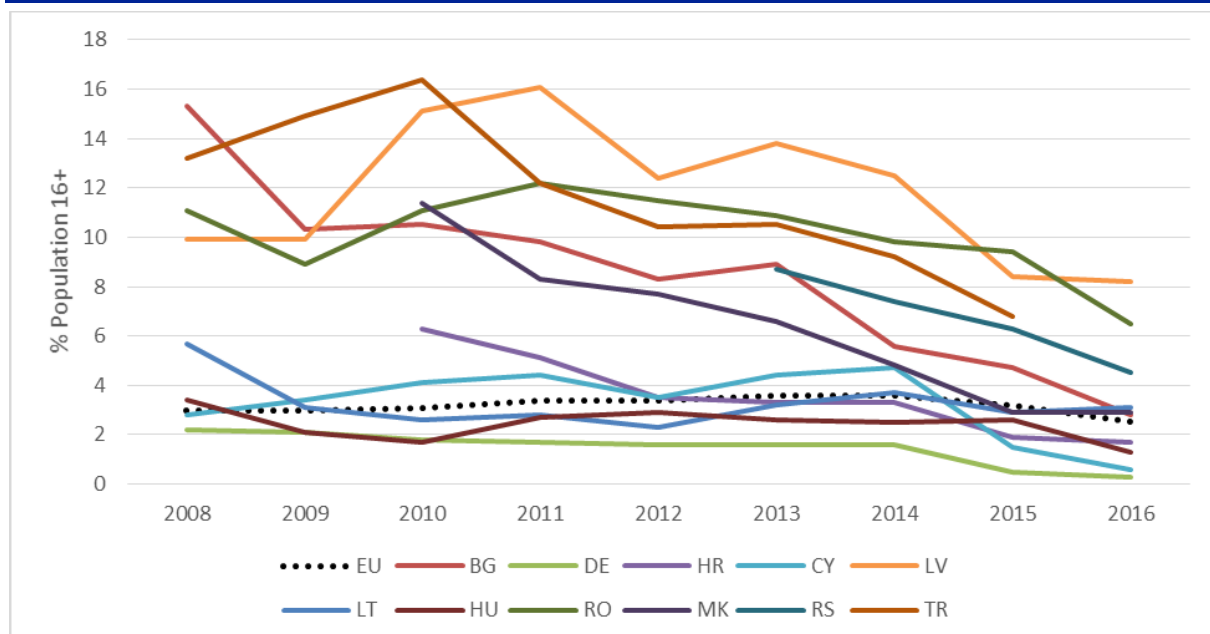
ANNEX 1: FIGURES

Figure A1: Self-reported unmet needs for medical examination: trends in selected countries with increasing trends (2008-2016)



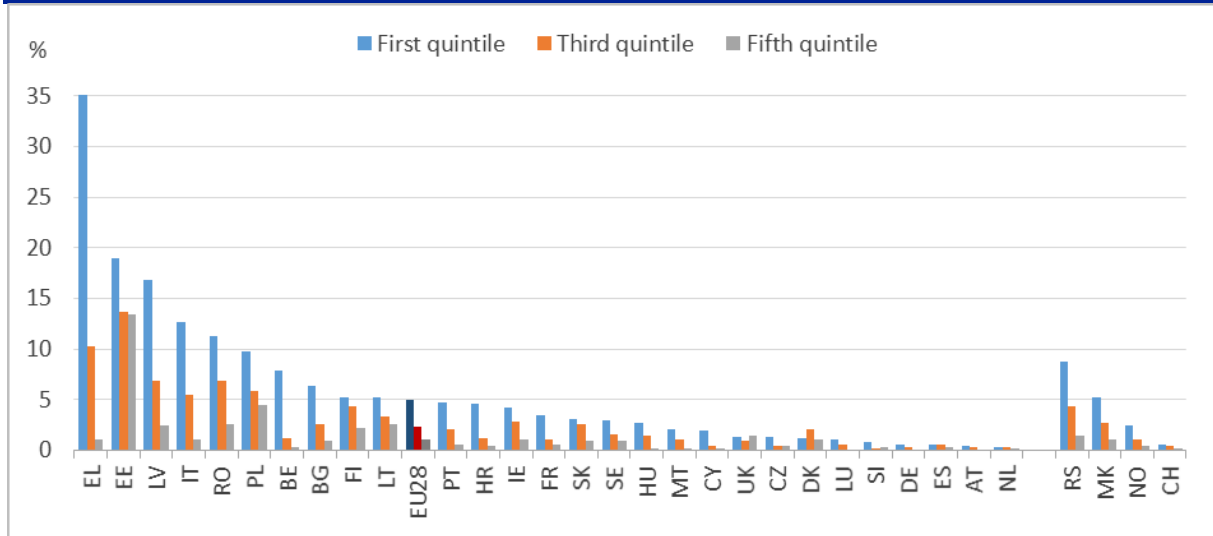
Source: Eurostat [hlth_silc_08].

Figure A2: Self-reported unmet needs for medical examination: trends in selected countries with decreasing trends (2008-2016)



Source: Eurostat [hlth_silc_08].

Figure A3: Self-reported unmet needs for medical examination due to cost, waiting time and travelling distance by income quintile (2016)



Source: Eurostat [hlth_silc_08]; * ESPN countries not included in the dataset: LI; ** ESPN countries with no data for the year considered in the graph: IS, TR.

ANNEX 2: OFFICIAL COUNTRY ABBREVIATIONS

A. EU countries

| EU countries prior to 2004, 2007 and 2013 Enlargements (EU-15) | | EU countries that joined in 2004, 2007 or 2013 | |
|--|-----------------|--|----------------|
| BE | Belgium | 2004 Enlargement | |
| DK | Denmark | CZ | Czech Republic |
| DE | Germany | EE | Estonia |
| IE | Ireland | CY | Cyprus |
| EL | Greece | LV | Latvia |
| ES | Spain | LT | Lithuania |
| FR | France | HU | Hungary |
| IT | Italy | MT | Malta |
| LU | Luxembourg | PL | Poland |
| NL | The Netherlands | SI | Slovenia |
| AT | Austria | SK | Slovakia |
| PT | Portugal | 2007 Enlargement | |
| FI | Finland | BG | Bulgaria |
| SE | Sweden | RO | Romania |
| UK | United Kingdom | 2013 Enlargement | |
| | | HR | Croatia |

In EU averages, countries are weighted by their population sizes.

B. Non-EU countries covered by the ESPN

Former Yugoslav Republic of Macedonia (MK), Iceland (IS), Liechtenstein (LI), Norway (NO), Serbia (RS), Switzerland (CH) and Turkey (TR).

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ANNEX 5: PRESENTATION OF THE EUROPEAN SOCIAL POLICY NETWORK (ESPN), July 2018

A. ESPN Network Management Team and Network Core Team

The European Social Policy Network (ESPN) is managed jointly by the Luxembourg Institute of Socio-Economic Research (LISER) and the independent research company APPLICA, in close association with the European Social Observatory.

The ESPN Network Management Team is responsible for the overall supervision and coordination of the ESPN. It consists of five members:

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