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# Impacts of the Crisis on Access to Healthcare Services in the EU

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# Impacts of the Crisis on Access to Healthcare Services in the EU

## **Abstract**

[Excerpt] This report is the first output of Eurofound's research project on the impacts of the recent financial and economic crisis on access to publicly financed healthcare services in the EU. It aims to provide an overview of context and developments, setting the scene for the ongoing research project. A final overview report, incorporating findings from various country studies, will be published in 2014.

Following a description of the policy context, this report goes on to explore how the crisis has impacted demand for and supply of healthcare services. It characterises different dimensions of access and discusses how the crisis may have impacted on barriers to access. It highlights groups that have traditionally been in vulnerable situations with regard to access, as well as those that may have been particularly affected by the crisis. Examples of past initiatives that have sought to enhance access to healthcare are identified. The final section presents how this research project aims to improve understanding of the impacts of the crisis on access to healthcare and of the ways in which access may be maintained.

This report takes a broad perspective on access to healthcare services, referring to different understandings of access and various indicators. It draws on a review of the literature and primary data analysis. One key indicator concerns people's perceptions of difficulties they face in accessing a doctor; in this regard, data are analysed from Eurofound's 2007 and 2011 European Quality of Life Surveys (EQLS). A second key indicator concerns people's perceptions of not having received medical care when they felt they needed it. Here, the main source of data is the 'EU Statistics on Income and Living Conditions' (EU-SILC). These indicators are used to explore how access has changed since the onset of the crisis in autumn 2007. Other perspectives on access are also discussed, including for example legal entitlements and views on appropriate care provision by service providers. Sources of data include complaints to the Ombudsman and surveys of general practitioners (GPs).

The forthcoming overview report will expand on such sources, and will include more in-depth information from studies of specific countries.

## **Keywords**

financial crisis, healthcare services, European Union, access

## **Comments**

### **Suggested Citation**

Dubois, H., & Anderson, H. (2013). *Impacts of the crisis on access to healthcare services in the EU*. Dublin: European Foundation for the Improvement of Living and Working Conditions.



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# Impacts of the crisis on access to healthcare services in the EU

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When citing this report, please use the following wording: Eurofound (2013) *Impacts of the crisis on access to healthcare services in the EU*, Dublin.

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**Eurofound project:** Impacts of the crisis on access to healthcare services

The authors would like to thank the following for providing comments: Philipa Mladovsky, Sarah Thomson, Jonathan Cylus, Marina Karanikolos (LSE Health and European Observatory on Health Systems and Policies); Joana Madureira Lima (European Public Health Association); Maria Zafiropoulou (Hellenic Foundation for European and Foreign Policy); Uldis Mitlenbergs (Riga Stradins University); Eszter Kovacs (Semmelweis University); Sarah Burke (Trinity College Dublin); and Maria Hofmarcher and Ricardo Rodrigues (European Centre for Social Welfare Policy and Research). Sonia de Paz Cobo (King Juan Carlos University) and Rachel Kuenzi (Scripps College) contributed with background research.

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# Introduction

This report is the first output of Eurofound's research project on the impacts of the recent financial and economic crisis on access to publicly financed healthcare services in the EU.<sup>1</sup> It aims to provide an overview of context and developments, setting the scene for the ongoing research project. A final overview report, incorporating findings from various country studies, will be published in 2014.

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<sup>1</sup> See Eurofound webpage: <http://www.eurofound.europa.eu/areas/health/healthcareservices.htm>





# EU policy perspective

## Importance of access to quality healthcare

Access to high-quality ‘services of general interest’ is essential for good quality of life and ‘inclusive growth’, a main objective of the Europe 2020 strategy (European Commission, 2010). Healthcare is a key service of general interest. Along with effective prevention, access to and quality of healthcare are important factors in addressing health inequalities (European Commission, 2009; Council of the European Union, 2010, 2011). Good access to quality healthcare can contribute to addressing social exclusion and poverty (European Commission, 2010). It is a crucial element of social investment and contributes to maintaining a productive workforce and to reducing the costs of care in the longer run (European Commission, 2013a; European Parliament, 2013; FRA, forthcoming). ‘Access to good quality healthcare’ was also adopted as a ‘common value for EU healthcare systems’ by the Council of the European Union (Council of the European Union, 2006). Furthermore, ‘the right to benefit from medical treatment under the conditions established by national laws and practices’ was included in the 2000 Charter of Fundamental Rights of the European Union, which became legally binding with the entry into force of the Treaty of Lisbon, in December 2009.

## Need for policy action

Most Member States have universal coverage and systems in place to support vulnerable groups in accessing healthcare. However, in practice many people have problems in accessing healthcare services when they need them. There are large inequalities in this respect, both between and within Member States. Various groups have traditionally been at risk of experiencing problems in accessing healthcare services. They include ethnic minority groups, women, people who are unemployed, people who are homeless, people in inadequate or insecure housing, migrants (especially asylum seekers and undocumented migrants), poor people, people who live in remote areas, people with low education, and older people (European Commission, 2008; Sienkiewicz, 2010; Devaux and de Looper, 2012; Doctors of the World, 2012; Eurofound, 2012c; FRA, 2013a).

As explored below, some people in the EU report that they have not been able to meet medical needs. Nevertheless, considerably more people experience difficulties in accessing healthcare services. Even in countries with the highest proportion of people reporting having no problem at all in accessing healthcare services due to distance, cost, or waiting times on the day of the appointment or in making an appointment, over one-third do experience at least one of these problems: 35% in Sweden, 41% in the Netherlands, 43% in Finland, 44% in Spain and 45% in Denmark. Furthermore, ageing populations put pressure on healthcare systems, as do rising public expectations, and cross-border patient flows (Flear, 2009).

Many challenges in access to healthcare services are unrelated to the crisis. For example, waiting lists have been a longstanding problem. Nevertheless, while it can be difficult to separate its impact from other factors, the recent financial and economic crisis is likely to have affected healthcare services in two ways. First, it is likely to have increased demand for certain healthcare services. Second, financing has come under pressure, in particular as a result of reduced public budgets, in combination with decreased income levels among service users. Sustaining access to high quality healthcare in the context of the crisis is therefore particularly challenging for policymakers and service providers.

## EU policy regarding healthcare

While healthcare falls mostly within the realm of national policymaking, certain EU instruments can have an influence, specifically structural funds and the socio-economic governance systems such as the Open Method of Coordination (OMC) and the European Semester. Since the Lisbon Summit in 2000, the OMC can be used to provide guidelines and benchmarks with regard to social protection issues. These issues include access to healthcare services, along with the quality and sustainability of these services. Parallel to this voluntary governance mechanism, the European Semester

provides the framework for steering and monitoring EU countries' economic and social reforms so that they may reach the Europe 2020 targets. It covers a six month cycle, starting with the Annual Growth Survey and concluding with country-specific recommendations being issued. Since 2010, it has included healthcare in the context of sustainability of public finances. The 2013 Annual Growth Survey called for assessing the performance of health systems against the twin aims of a more efficient use of public resources and access to high quality care. However, in practice the country-specific recommendations mostly focused on the issue of efficiency, to reduce pharmaceutical expenditure and to move from hospital to outpatient care. Only some deal directly with guaranteeing access to quality healthcare. (See Box 1 for further detail.)

### **Box 1: Health in the European Commission's country-specific recommendations (2013)**

In 2013, Country-specific recommendations for Bulgaria, Romania and Spain included a recommendation regarding access to healthcare.

- Bulgaria: 'Ensure effective access to healthcare and improve the pricing of healthcare services by linking hospital financing to outcomes and developing outpatient care.'
- Romania: 'Pursue health sector reforms to increase its efficiency, quality and accessibility, in particular for disadvantaged people and remote and isolated communities.'
- Spain: 'Increase the cost-effectiveness of the healthcare sector, while maintaining accessibility for vulnerable groups, for example by reducing hospital pharmaceutical spending, strengthening coordination across types of care and improving incentives for an efficient use of resources.'

The recommendations of most countries, however, contain little mention of healthcare. For some countries no specific recommendations for 2013 were provided, because they were already subject to Economic Adjustment Plans (Cyprus, Greece, Ireland and Portugal). References to healthcare in these plans focus on efficiency, transparent administration and cost-reduction rather than access.

Source: *European Commission (2013b)*

The European Court of Justice's rulings on cross-border healthcare and the EU's free movement of persons and goods also have an impact. In addition, the European Commission is preparing a framework for the comparative analysis of health systems at EU level, including a list of indicators, to be used in a Joint Assessment Framework (JAF) exercise. These indicators will combine issues of sustainability, access and quality along with the OMC principles.

In its 'Voluntary European Quality Framework for Social Services', the Social Protection Committee (2010) sets out guidelines with regard to access to services more generally. It stresses the importance of guaranteeing equality of access, independent of wealth or income, across the territory. As an overarching quality principle, it also mentions that the service should be affordable, and that:

*Social services should be easy to access by all those who may require them. Information and impartial advice about the range of available services and providers should be accessible to all users. People with disabilities should be ensured access to the physical environment in which the service provision takes place, to adequate transport to and from the place of service provision, as well as to information and communication (including information and communication technologies).*

This voluntary framework states that healthcare venues should be designed ‘for all’ and emphasises the need for clear, accurate and accessible information. This information should be adapted to the specificities of each target group, notably the type, availability, extent and limitations of the service provided, and should address complaint procedures.

The WHO’s ‘Health 2020’ policy framework for the European region (2012) also mentions access to high quality and affordable healthcare services in its priorities.



# Impacts of the crisis on healthcare demand and supply

The autumn of 2007 marked the onset of an economic and financial crisis in the EU. This crisis has affected EU Member States and regions to differing extents and over different periods of time, with varying consequences. Out of the 28 Member States, Poland is the only country that has not experienced a decline in annual real gross domestic product (GDP) in any year between 2007 and the 2013 forecast (Eurostat, 2013). All the other Member States have experienced at least one year of decline in real GDP of between 2.8% (Belgium and Malta in 2009) and 17.7% (Latvia in 2009) since 2007. Decline has been most pronounced and prolonged in Cyprus, Croatia, Greece, Ireland, Italy, Spain, Latvia, Portugal and Slovenia. Five of these countries (Cyprus, Greece, Ireland, Portugal and Spain) have received financial support from the European Union, conditional on compliance with reforms aiming to balance public budgets and stimulate long-term growth.

## Increased demand

Impacts on health data are not as rapidly available as economic data, so it is difficult to give a clear and exhaustive assessment of the impact of the crisis on health. For example, mortality data usually has about a two year time lag, and information on the cause of death and the socio-economic status of the deceased is not always available.

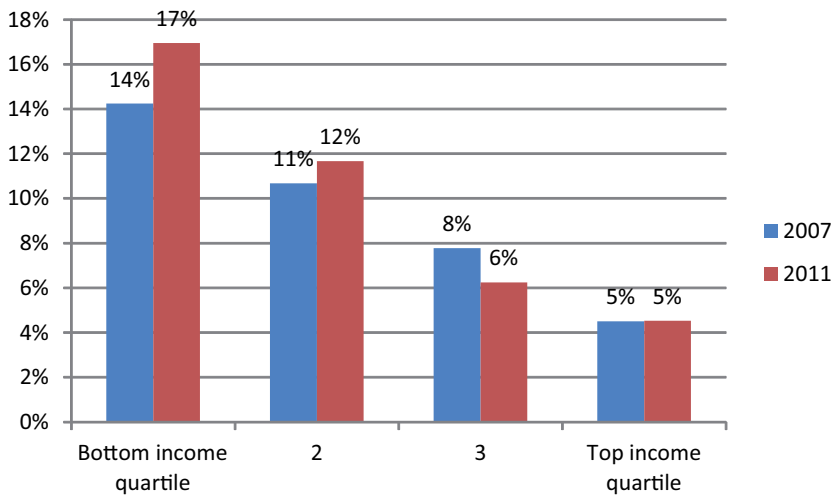
Karanikolos et al (2013) compare the health impact of this recent crisis with that of previous crises. As in previous crises, suicide rates have risen, while the number of road traffic deaths has fallen. In contrast to previous crises, certain communicable diseases have become more common in the current crisis. Such diseases include tuberculosis, influenza and sexually transmitted diseases, whose control largely depends on prevention and infection control measures, especially among population groups in vulnerable situations (Rechel et al, 2011). Indeed countries that saw drastic cuts to relevant services also experienced an increase in the prevalence of these communicable diseases, particularly in the case of Greece, where there was an increase in cases of HIV and malaria re-emerged.

Analysis of EQLS data reveals that while health satisfaction appears to have stayed rather constant in the EU28, at 7.3, the proportion of people reporting that they are in good or very good health decreased from 67% to 64%. There are large differences between Member States, but in the majority of them (n. 15), the proportion of people reporting bad or very bad health increased between 2007 and 2011.

There are large differences both between and within countries, for example between age groups. In some countries a decline in self-reported health has been most marked among people aged 50 and over (Estonia, Luxembourg and Romania). In other countries, the decline has been greatest among people aged between 35 and 49 (France and Lithuania). Elsewhere, worsening self-reported health has been spread equally across age groups (the Netherlands).

One remarkable development is the increase in the proportion of people in the bottom income quartile who report bad health. This confirms Karanikolos et al's suggestion that while the health of some groups may be unaffected or even improved during the crisis, other population groups suffer disproportionately. This is demonstrated in Figure 1, which shows that an increased proportion of people in lower income quartiles experienced bad health, in contrast to those in higher income quartiles which showed an improvement or remained stable. People in higher income quartiles may be financially worse off than before, but still earn enough to stay in the higher income range in their country. They may be more cautious with their expenditure, for example when they have large mortgage debts. They may thus have less to spend on unhealthy behaviour, such as smoking and drinking, and subsequently have better health outcomes. This may outweigh the negative impact of the crisis on their health. For lower income groups, the negative impact of relatively large increases in job insecurity and unemployment, as well as housing insecurity (Eurofound, 2012a and b), may dominate. Regardless of the reasons, this illustrates that aggregate data conceal inequalities in health, as adverse effects on groups in vulnerable situations may be masked by improvement in other groups.

Figure 1: Poor health status and income in the EU28, 2007 and 2011



Note: Based on responses to Question 42: ‘In general, would you say your health is very good, good, fair, bad or very bad?’ (Other responses included ‘don’t know’ or refusal to answer.) The figures refer to the proportion of people who reported ‘bad’ or ‘very bad’ health.

Source: Eurofound’s analysis of EQLS micro-data.

This increase in the proportion of people in the bottom income quartiles reporting bad health has been particularly marked in some Member States. Increases of over five percentage points were observed in some countries that have generally had low proportions of people in low income groups reporting bad health (Germany, France and the Netherlands), but also in countries where self-reported bad health is very common among low income earners (Romania, Slovakia and the UK).

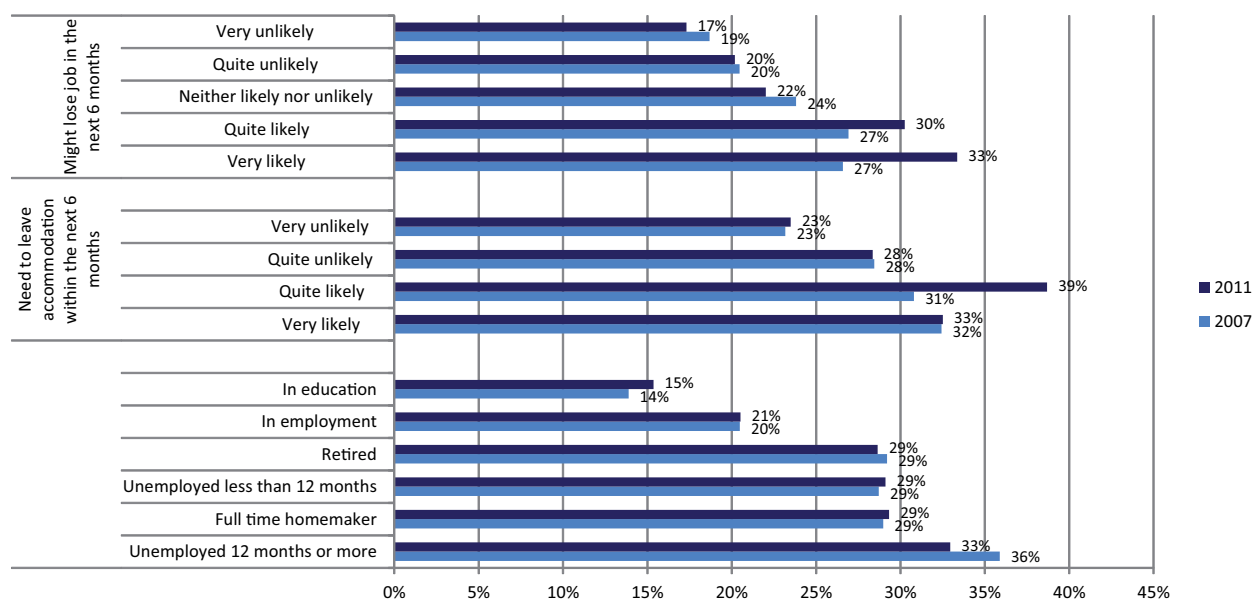
Mental well-being in the EU28, measured by the WHO-5 Index,<sup>2</sup> has increased from 62 in 2007 to 63 in 2011. This average masks larger differences between and within countries, as well as an increase in the proportion of people with particularly low mental well-being. People with a WHO-5 Index below 48 are considered to be at risk of poor mental health. The proportion of people who are at risk of poor mental health has increased from 24% in 2007 to 25% in 2011, by over 3 million persons in the EU28. The largest increases occurred in Netherlands, Greece, Ireland, the UK and Sweden (by 6 percentage points), but important increases are observed also in Hungary, France (by 4 percentage points), Belgium and Slovenia (by 3 percentage points).

Figure 2 shows that the proportion of people at risk of poor mental health has decreased among the long-term unemployed (from 36% to 33%). In contrast, the proportion of people in employment at risk of poor mental health has increased (from 20% to 21%). Nevertheless, the unemployed are still more likely to be at risk of poor mental health than people in employment. Much of the increase in the proportion of people at risk of poor mental health can thus be attributed to the increase in unemployment.

<sup>2</sup> The WHO-5 Index is calculated from the overall average score from responses to five statements in Q45: ‘I have felt cheerful and in good spirits’, ‘I have felt calm and relaxed’, ‘I have felt active and vigorous’, ‘I woke up feeling fresh and rested’, and ‘My daily life has been filled with things that interest me’. Responses are scored on a 0–5 scale, where 0 = ‘At no time’ and 5 = ‘All of the time’. These five scores are aggregated and multiplied by four to a maximum of 100.

The proportion of people at risk of poor mental health among those suffering from housing insecurity or fear of job loss has increased. As their numbers have increased as well because of the crisis, housing and job insecurity have particularly contributed to an increase in the proportion of people at risk of poor mental health.

Figure 2: Proportion of people at risk of poor mental health in the EU28, according to activity status and housing and job insecurity, 2007 and 2011



Note: Based on responses to Question 20. ‘How likely or unlikely do you think it is that you will need to leave your accommodation within the next 6 months because you can no longer afford it?’ Is it... 1) Very likely, 2) Quite likely, 3) Quite unlikely, 4) Very unlikely. Q15. How likely or unlikely do you think is it that you might lose your job in the next 6 months? 1) Very likely, 2) Quite likely, 3) Neither likely nor unlikely, 4) Quite unlikely, 5) Very unlikely.

Source: Eurofound’s analysis of EQLS micro-data.

Mental health problems caused by job loss, fear of job loss, and loss in income are among the clearest consequences of the crisis (Karanikolos et al, 2013). Insecure working arrangements and long working hours are associated with higher stress and anxiety, and countries with higher unemployment rates tend to have higher suicide rates. Figure 2 shows that similar observations can be made for mental health more generally. People who find it likely they may lose their jobs have worse mental health than those who find it unlikely, and this difference has increased. The proportion of people who find it likely they may lose their jobs has increased during the crisis (Eurofound, 2012a). The increase in housing insecurity also plays a role (Eurofound 2013, forthcoming; Eurofound, 2012a and b). People who think they are likely to need to leave their accommodation because they can no longer afford it are more often at risk of poor mental health than people who feel secure in their accommodation, and this difference increased between 2007 and 2011. The crisis has led in particular to an increase in the proportion of people who have reported feelings of insecurity, especially among people who own their own accommodation with a mortgage. Furthermore, debt problems are associated with low mental well-being, particularly among people in the bottom income quartile. A Spanish study (Gili et al, 2012) of patients in primary healthcare services showed that one-third of the overall risk of attending with mental health disorders could be attributed to the combined risks of household unemployment and mortgage payment difficulties.

It is important to note that these conditions are not only more prevalent, they often have different causes and characteristics as a result of the crisis, which, in turn, require different healthcare responses.

Not all changes in demand for healthcare observed since the onset of the crisis are necessarily related to the crisis. Some trends clearly began before the crisis – such as population ageing and availability of new technologies. Others, like the flu epidemic, may have coincided with the crisis. These developments may affect the prevalence of medical conditions, and the likelihood of people contacting a service provider. Even though they are not caused by the crisis, their impact on demand for and access to healthcare services is relevant in this context.

### Impacts beyond health

An increase in demand for public healthcare services is not only caused by increases in the prevalence of certain crisis-related conditions. In several Member States, patients frequently make use of private healthcare services. However, the decreased disposable income of potential users as a result of the crisis may lead them to opt for publicly financed services instead, to avoid out-of-pocket payments or voluntary health insurance premiums. In Greece, for instance, between 2009 and 2011 there were increases in public hospital admissions (but a decline in outpatient services and GP visits) and a clear decrease in private hospitals admissions (Kentikelenis et al, 2011). In Cyprus a recent increase in the demand for public health services (Social Protection Committee, 2011) may also be partly explained by a shift away from private services. Aggregate data showing apparent shifts from private to public healthcare may obscure a more complex picture. Some people may actually have shifted to the private sector because of the crisis. Decreased budgets are likely to be available for public healthcare provision. As a consequence, if they can afford it, people may have reverted to the private sector if they expect to find higher quality healthcare there.

Lastly, as discussed in this working paper, the crisis may have had a negative impact on access to several services for certain population groups. As a consequence, while ‘latent demand’ may have increased for some services, actually observed demand may have fallen.

### Decreased supply

Several EU governments have sought to balance public budgets. Mladovsky et al (2012b) present an extensive overview and analysis of the impact on health policy. First, some governments have decreased the budget for publicly financed care by decreasing the size of the budget assigned, the public contribution to social health insurance, or the part of service cost that is covered publicly. Second, some reduced the volume of publicly financed care. Measures that fall in this category include a reduction in services covered by the statutory benefits package, reduced population coverage as well as non-price rationing such as extending allowed waiting times. Third, governments have sought to reduce the cost of publicly financed care. This includes reduced payments to providers, reduction of staff and reconfiguration or coordination of care. In addition to such explicit measures, supply may also be impacted in other ways such as by reduced job opportunities in home countries leading to an outflow of medical staff in affected countries (Eurofound, 2013), resulting in reduced availability of qualified staff.

A longstanding general trend of increases in public expenditure on health in the EU has come to a halt. Public expenditure on health has even decreased in one or more years since 2007 in 18 of the 28 Member States. In countries with high public expenditure on health, there may have been room to cushion such decreases and avoid a detrimental impact on access to healthcare services. Decreases have occurred in countries with low and high public expenditure on health, but most countries that have shown no decreases in public expenditure on health in this period are in the top quartile of expenditure and have had relatively favourable GDP development (Table 1). The fact that countries with tight budgets have been particularly affected makes concern for decreasing access and quality of healthcare in the EU all the more valid.



Table 1: *Decreases in public expenditure on health in high- and low-expenditure countries*

Country	Public expenditure on health per capita, € PPP current prices, 2011	Public expenditure on health decreased compared to previous year
<b>Bottom quartile</b>		
Bulgaria	449*	2009 (-7%) <sup>2</sup>
Latvia	472*	2008 (-2%), 2009 (-15%) and 2010 (-3%) <sup>2</sup>
Romania	523	2009 (-5%) and 2011 (-4%)
Cyprus	758*	None <sup>2</sup>
Lithuania	782	2009 (-3%) and 2010 (-2%)
Poland	783	None
Estonia	793	2009 (-4%) and 2010 (-1%)
<b>Second quartile</b>		
Croatia <sup>1</sup>	838	2009 (-5%) <sup>5</sup>
Hungary	843	2009 (-3%)
Slovakia	1,042	None
Greece	1,179	2010 (-12%) and 2011 (-14%)
Czech Republic	1,270	2008 (-1%) and 2010 (-6%)
Malta	1,274*	None <sup>4</sup>
Portugal	1,307	2008 (-1%) and 2011 (-7%)
<b>Third quartile</b>		
Slovenia	1,369	2009 (-2%) and 2010 (-2%)
Spain	1,722	2011 (-1%)
Italy	1,799	2009 (-1%), 2011 (-1%)
Ireland	1,901	2009 (-2%), 2010 (-9%) and 2011 (-6%)
Finland	1,953	2011 (-2%)
United Kingdom	2,165	2011 (-2%)
Belgium <sup>1</sup>	2,366	None
<b>Top quartile</b>		
France	2,425	None
Sweden	2,458	2009 (-2%)
Germany	2,637	None
Austria	2,660	None
Denmark	2,943*	None <sup>2</sup>
Luxembourg	3,020**	2008 (-5%) <sup>3</sup>
Netherlands <sup>1</sup>	3,112	None

Notes: \*2010, \*\*2009. <sup>1</sup>Data refers to Current Health Expenditure. Missing data for <sup>2</sup> 2011, <sup>3</sup> 2010 and 2011, <sup>4</sup> 2007–2009 and 2011. <sup>5</sup> 2007–2010 includes current spending by social security only. PPP = purchasing power parity.

Source: *Analysis of OECD/Eurostat/WHO harmonised data. OECD Stat, Joint Health Accounts Questionnaire 2013, Eurostat Database.*

As with changes in demand, changes in public expenditure on health cannot be wholly attributed to the crisis. Examples of other causes include longer-standing efforts to shift spending to the private sector (Montanari and Nelson, 2013) and specific events such as the bulk purchases of influenza vaccines by some governments in 2009 with a consequent decrease in expenditure in 2010 (Morgan and Astolfi, 2013).

Not all impacts of the crisis on health expenditure may be relevant to this study. For example, while they may free up resources to improve access to healthcare services, policies to reduce the price of medical goods (pharmaceuticals, medical devices and equipment) or improve the rational use of drugs are not directly relevant, as they are less likely to have a direct impact on access to healthcare services. Cuts in the salaries of healthcare providers may also not appear to impact access to healthcare services for users directly, but they may do so through reduced work motivation of healthcare personnel, for example.

### **Challenge for service providers and governments**

Increased demand in combination with decreased funding not only provides a challenge at government level, in terms of guaranteeing access to quality healthcare services, it also generates challenges for service providers faced with reduced budgets and reduced personnel. At the same time, service providers may be experiencing increased demand for their services, due to the reasons discussed and to the closure of other local service providers.

Rationing may not always be explicit in terms of policies; implicit rationing may happen at the level of the service provider (Thomson et al, 2009). For example, Hungary introduced volume limits to inpatient services, but left it to the hospitals and doctors themselves to ration care implicitly or explicitly (Mladovsky et al, 2012b). Service users may also face increased user charges (Mladovsky et al, 2012b) in addition to reduced incomes. In this environment, providing access to healthcare is likely to be a challenge.

# Access to healthcare services for individuals

Eurostat, through the EU-SILC, asks Member States to collect yearly data on perceptions of unmet healthcare needs. Most people in the EU (93.3% in the EU27, 89% in Croatia) reported no unmet healthcare needs in 2011.

At EU level, changes seem small and it is hard to observe clear trends, but such aggregate data can mask important differences among Member States. In some countries the proportion of people reporting unmet needs has increased. In particular, Greece experienced a 50% increase in the reporting of unmet medical need between 2007 and 2011, after adjusting for people’s age, sex, marital status, level of education and urban or rural residence (Kentikelenis et al, submitted for publication). In many countries, unmet medical needs increased among both unemployed and employed people. In some countries, this increase has been concentrated among unemployed people (Table 2).

Table 2: *Countries with an increase in unmet healthcare needs*

Categories of employment	Countries
Unemployed people only	Austria, Czech Republic, Latvia, Sweden, UK
Unemployed and employed people	Belgium, Denmark, Finland, France, Greece, Malta, Spain
Employed people only	Slovakia

Note: This table lists EU Member States that saw an increased proportion of people reporting an occasion when they needed examination or treatment but did not receive it in the past year. An increased proportion is measured as over a one percentage point reduction in the proportion of people who said that there was no occasion when they really needed examination or treatment but did not receive it in the past year.

Source: *Eurofound’s analysis of EU-SILC macro-data, compiled from Eurostat (2013)*.

It is much more common for people to experience difficulties in accessing healthcare, than to report unmet needs. An increase in difficulties accessing healthcare does not always imply an increase in reported unmet healthcare needs, as people may still receive healthcare services, even if it is difficult to do so. For example, in Estonia access became more difficult across several dimensions (Tables 3–5), but the data do not show an increased proportion of people reporting unmet needs in the same period.

Data sources other than surveys also show that reforms are felt on the ground. For example, the number of complaints to the Spanish Ombudsman tripled from 595 in 2011 to 1,674 in 2012 (El Mundo, 2013). Prior to 2012, such complaints were mainly concerned with quality of care, but in 2012 the number of complaints related to access issues increased.

In the next section, a range of access issues will be discussed. Various barriers to healthcare services have been identified in the literature; the aim here is to provide a comprehensive picture, drawing on this previous research. Furthermore, for each access issue, some assessment will be provided of the impact of the crisis for various population groups, providing empirical evidence where available, but also discussing potential impacts that are still to be investigated. Issues relating to legally covered access (population and benefit package coverage), affordable access, physical access, informed access and timely access are discussed. Even if healthcare services are accessible in all these respects, people may still not receive the care they need; other barriers to access will be discussed as well.

## Legally covered access

Most EU28 Member States provide ‘universal’ population coverage for basic healthcare services, but eligibility can depend on residency status. In countries with a social health insurance system, an insurance policy is required, usually through work, but special funds are available for those who are not employed. Cyprus, for example, has no universal coverage. While arrangements are in place for vulnerable groups, coverage is more accessible for those who are in formal employment as it is often provided through work (ILO, 2011; Theodorou et al, 2012). In countries where people actively need to choose a basic package of health insurance rather than being automatically covered through the tax system, being employed may facilitate insurance.

In most Member States, documentation is required for people to access healthcare. Only in seven of the 27 countries (there are no data for Croatia) do undocumented migrants have access to publicly financed healthcare services, either in full (France, Portugal and the Netherlands) or partially (Belgium, Italy, Sweden and the UK). In all other 20 EU Member States, undocumented migrants only have access to emergency services, and may have to pay for this, depending on how rigidly invoices are handled. These data concern 2013, and include the latest reforms in Spain and Sweden (Center for Health and Migration Vienna, 2013, cited in ASEF, 2013). EU citizens who have lost their legal residency status due to lack of financial resources and/or health insurance also face barriers to legal entitlements, in particular in Munich and across Spain (Chauvin and Simonnot, 2013).

### Impacts of the crisis on legally covered access

A clear impact of the crisis with regard to population coverage is the removal of coverage of non-emergency care for non-pregnant undocumented migrants in Spain in 2012 (but not all regions endorsed this reform) and removal of a dental care benefit for people below 64 in Estonia in 2009.

With regard to healthcare services that are included in the benefit package, coverage reductions included lower reimbursement rates for: IVF, physiotherapy, mental health services and coverage of care outside the EU (the Netherlands); cosmetic surgery (Portugal); non-acute spa treatment, certain medicines, non-urgent ambulance services, dental prostheses and some ophthalmologic appliances (Slovenia) (Mladovsky et al, 2012b). Voluntary health insurance may cover services not included in basic benefit packages, but it may not always be accessible especially in the context of the crisis due to the unaffordability of premiums (see below), age limits, benefit caps or the exclusion of treatment for pre-existing conditions (Thomson and Mossialos, 2009; Social Platform/SPC, 2012).

### Affordable access

Barriers to affordable access can include the high cost of healthcare and low income/household means.

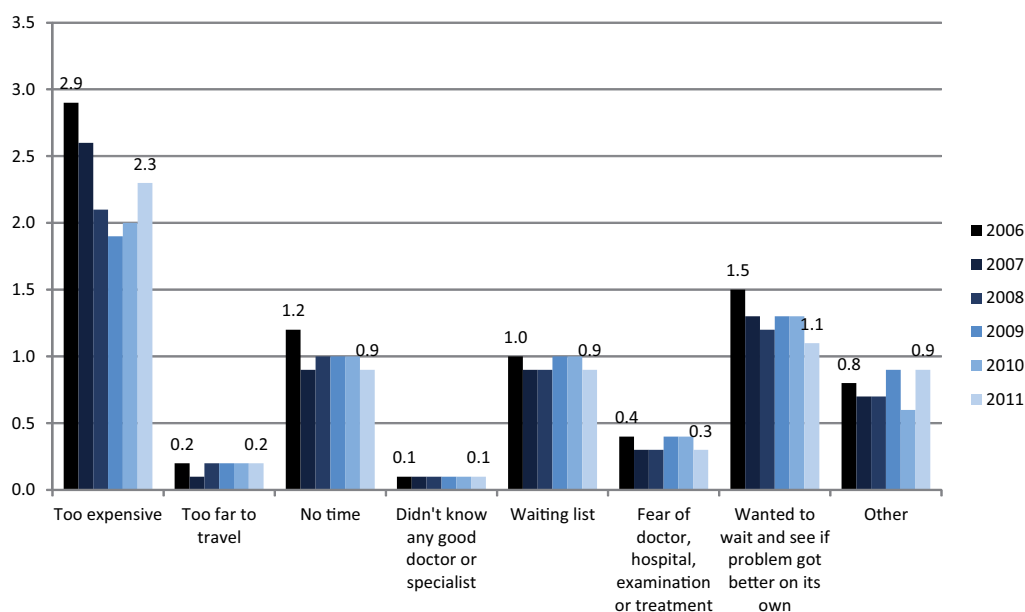
Private payments may be required in the form of a fixed fee, a proportion of a healthcare cost being borne by the service user, or payments required up to a certain threshold. Such cost-sharing arrangements can constitute a barrier to access (Busse et al, 2011). In particular, in Member States with a health insurance system, some people may further find it difficult to pay for an insurance policy.

Private payments do not only include such formal arrangements. They may also concern under-the-table payments required by some healthcare workers (European Commission, 2011). They may concern cash payments, 'gifts' or 'favours' (European Commission, 2012), and may be necessary to ensure prompt access, for example by jumping queues (Kentikelenis et al, 2011), or to receive good quality care, or any care at all. Even though the magnitude of requested or expected under-the-table payments may differ depending on the patient's financial situation, poorer patients may nevertheless be inhibited from accessing healthcare.

The need to make even apparently small payments can have a large impact on people with low incomes and people with relatively frequent healthcare needs, such as those who are chronically ill or who have a disability. If payments are restricted to non-emergency care, some may revert to using emergency units for non-emergency care, even if they are further away and involve longer waiting times (Mas et al, 2011).

In the EU, the most commonly reported reason for 'unmet medical needs' is that the usage of healthcare services was considered too expensive (Figure 3).

Figure 3: Reasons for reporting unmet medical needs in the EU27, 2006–2011 (%)



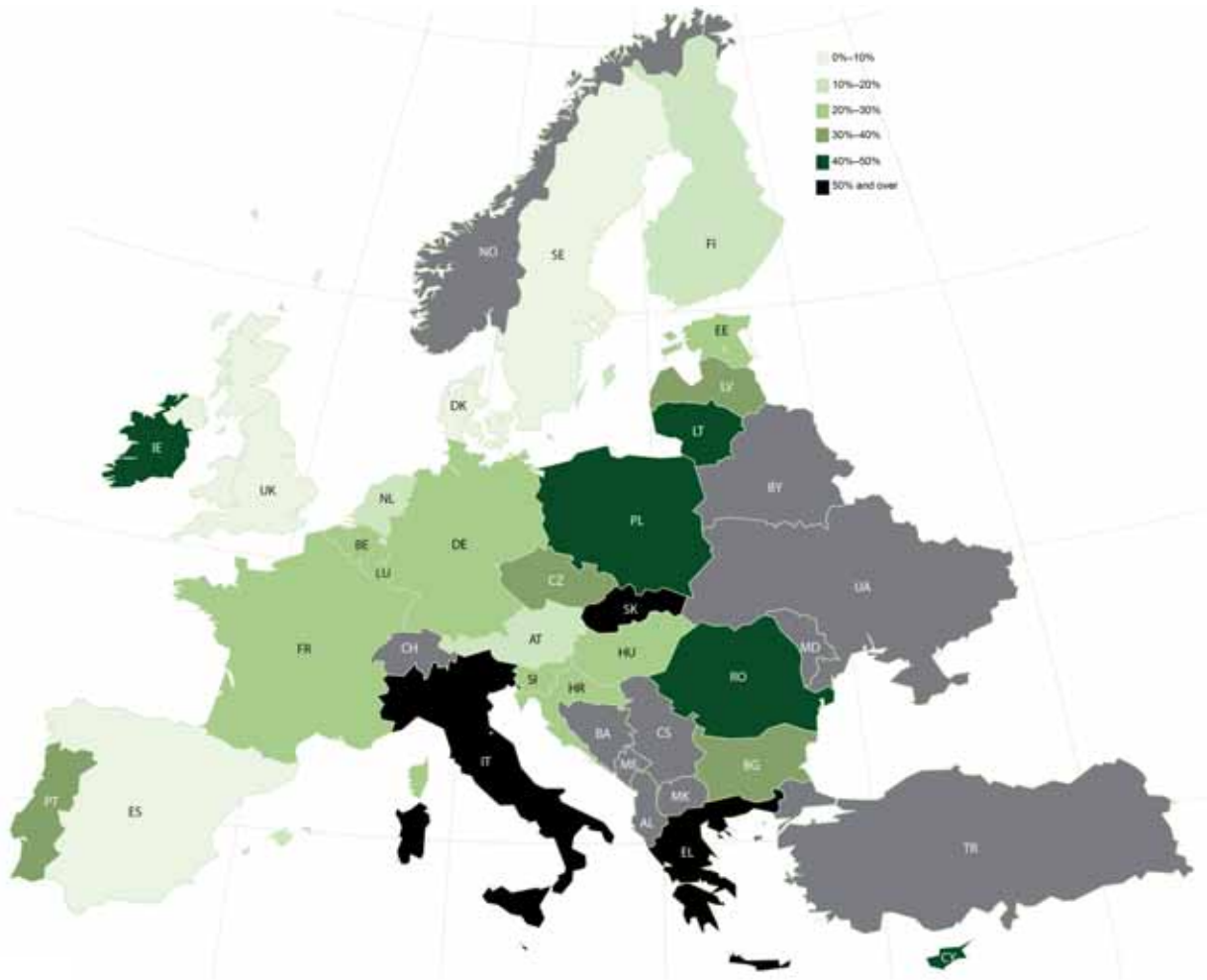
Note: Comparable data for Croatia were not available.  
 Source: EU-SILC data, compiled from Eurostat (2013).

While cost is the most common reason for ‘unmet medical needs’, it makes it difficult for 30% for EU28 residents to use healthcare services, less often than waiting times to see a doctor on the day of an appointment (42%) and delays in getting an appointment (39%). Nevertheless, there are large country differences (Figure 4), with cost making it more often difficult for people to see a doctor than waiting times in Cyprus and Ireland, and equally frequently in Lithuania and Romania (see Appendix Table A2). In terms of reported intensity of the difficulties experienced (see Appendix Table A1), the proportion of people reporting cost as a barrier is highest in Greece (31%), Cyprus (28%), Italy (23%) and Poland (21%).

Countries with a higher share of out-of-pocket private expenditure, paid directly by the household, generally have significantly higher proportions of people reporting difficulties due to cost in the EQLS. Overall, the proportion of people reporting difficulties in access due to cost is 1% higher for every one percentage point increase in the proportion of expenditure on health that is out-of-pocket.<sup>3</sup> Nevertheless, a country with lower out-of-pocket expenditure does not always have a lower proportion reporting difficulties with access than a country with higher out-of-pocket expenditure. For example, in 2011, out-of-pocket expenditure in the UK comprised a higher share of total expenditure on health (9%) than in the Netherlands (5%), but the proportion of people reporting cost as a barrier to visiting the doctor was higher in the Netherlands (16%) than in the UK (5%). Similarly, out-of-pocket expenditure was 16% in Austria, and 15% in Croatia, but in Austria a smaller proportion of people (18%) reported difficulties due to cost than in Croatia (24%).

<sup>3</sup> According to 2011 data from the WHO Health for All database (out-of-pocket expenditure) & EQLS (difficulties in access). Ordinary Least Squares,  $R^2 = 0.32$ , coefficient's (out-of-pocket expenditure)  $p=0.002$ .

Figure 4: Proportion of people reporting cost makes it difficult to access healthcare services, by country, 2011



Note: This refers to the proportion of respondents reporting that cost makes it very or a little difficult to access a doctor or medical specialist. Based on responses to Question 47 (Cost of seeing the doctor): ‘On the last occasion you needed to see a doctor or medical specialist, to what extent did each of the following factors make it difficult or not for you to do so?’

Source: Eurofound’s analysis of EQLS micro-data (2011).

There are various possible reasons behind the fact that countries with high out-of-pocket expenditure do not always show relatively high proportions of people reporting difficulties in access due to cost. Richer people may choose to spend more on private sector healthcare (cost being no burden for them). Support for vulnerable groups may be well-targeted or private incomes could be relatively high. Expenditure on health could come from general tax rather than insurance fees, which may make service users less likely to feel that they spend a lot on healthcare. There may be no under-the-table payments.

Among population groups within countries, there are also large differences to be found. People who live in households with higher per capita income experience fewer access problems than people in lower income quartiles in almost all Member States. The UK, Spain, Cyprus and Ireland are exceptions. Living in a rural or urban area often became insignificant in most Member States after controlling for other factors. Nevertheless, in some countries, the problems were larger in urban areas (Bulgaria and Latvia), while in others (Czech Republic and Slovenia) the opposite was true. In some countries (Austria, Bulgaria, Poland and Slovakia), women reported more problems than men. In most countries, older people reported fewer or equal access problems as young people, but in the Czech Republic, Bulgaria, Croatia, Poland, Lithuania, Latvia and Slovakia, older people reported more problems. While in many other aspects, the comparisons

between ‘old’ and ‘new’ Member States seem to have become outdated, with regard to ‘age’ this comparison still makes sense, with older people being clearly disadvantaged in countries that have joined the EU since 2004.<sup>4</sup>

### Impacts of the crisis on affordable access

Many people have experienced a decrease in their income. In addition, the cost of basic goods has increased in some countries, due for example to VAT increases. Furthermore, low income earners reported health problems more frequently in 2011 than at the onset of the crisis (Figure 1), the very group that can be expected to experience most difficulties in accessing healthcare services because of cost.

The EQLS investigates whether cost makes it difficult for people to see a doctor or medical specialist, regardless of the reasons. It could be due to low income as well as high formal and informal costs. In the EU28, the proportion of people for whom cost made it ‘very’ or ‘a little’ difficult to access a doctor went from 32% in 2007 to 30% in 2011. Although this appears to be a positive development, the improvement was small compared to rates of improvement for other factors – distance, delay in getting an appointment and waiting time. Furthermore, the proportion of people who reported that cost made access ‘very difficult’ remained unchanged, at 9%.

Importantly, these average figures for the EU28 mask important differences between countries and population groups. Increases in the proportion of people reporting difficulties in access due to cost can be observed in various Member States. This is the case for some countries where difficulties are relatively rare (Estonia, Luxembourg, Netherlands, Slovenia and Sweden), but mostly in countries where the situation was already unfavourable. In most of these countries, access has either become more difficult due to cost for all income groups, or the impact of cost has concentrated on the bottom half of income earners, who already experienced difficulties in this regard, or households which previously had larger incomes. In a few countries where the situation was already relatively unfavourable, the top income group have been most affected (Table 3).

Table 3: *Countries with an increase in cost-related difficulties 2007–2011, by income group*

Affected income groups	Countries
Bottom half income earners	Cyprus, Czech Republic, Lithuania, Slovenia, Sweden
Bottom and top half income earners	Estonia, Greece, Luxembourg, Malta, the Netherlands
Top half income earners	Ireland, Poland, Slovakia

Note: Based on responses to Question 47, ‘Cost of seeing the doctor’: ‘On the last occasion you needed to see a doctor or medical specialist, to what extent did each of the following factors make it difficult or not for you to do so?’ An increase was measured as over a four percentage point increase in the proportion of people responding ‘very’ or ‘a little’ difficult.

Source: based on Eurofound’s analysis of EQLS micro-data.

The share of people reporting unmet needs due to financial constraints has increased in the EU overall, but only since 2009 (Figure 3). A significant increase occurred in the proportion of unemployed people, migrants and urban populations experiencing unmet need due to financial reasons, waiting lists or transport-related costs in the majority of the EU Member States that were the most affected by the financial crisis (Rodrigues et al, forthcoming).

Analysis of unmet need in Greece showed a statistically significant rise, of 43%, in the proportion of respondents reporting unmet medical need due to financial reasons (could not afford) (Kentikelenis et al, submitted for publication), after adjusting for people’s age, sex, marital status, level of education and urban or rural residence.

<sup>4</sup> Results of an ordinal logit regression (dependent variable: cost made access 2= very difficult, 1=little difficult, 0= not difficult). Variables included: year (2007 & 2011), age, education, gender, income quartile, urban or rural location and employment status.

In Estonia, Lithuania, Luxembourg, Malta, the Netherlands, Slovakia and Sweden, cost was a greater barrier to access in 2007 than in 2011, even after controlling for age, education, gender, income quartile, urban or rural location and employment status. This finding separates the impact of the crisis from demographic changes between 2007 and 2011. The fact that employment status is controlled for enables a better understanding of whether increases in access difficulties are caused by increased unemployment or by other factors. Unemployed people face the greatest barriers to accessing healthcare in Bulgaria, Estonia and Finland, but after controlling for the other variables as well, it was found that between 2007 and 2011, this situation only worsened in Estonia. Moreover, the other two countries did not show a decline in accessibility, even without controlling for unemployment. In other countries where the data suggest an improvement (most notably Spain), any significance to such changes disappears when controlling for demographic factors.

Another piece of evidence of reduced access due to cost comes from the Netherlands. This country has a ‘gatekeeping system’, where people are required to access healthcare services through their general practitioner (GP). The country also has an ‘own risk’ system: people pay all medical expenses themselves up to €350 per year (up from €220 in 2012), except GP services, which can be accessed without any cost for the patient. As a consequence, GPs see patients who might at a later stage opt not to proceed in the medical system as they will need to pay a fee after that first stage. The national GP association in the Netherlands recently conducted a survey of over 1,000 GPs – 12% of all GPs in the Netherlands. Almost all GPs (94%) reported that some of the patients they saw do not follow their advice for financial reasons (LHV, 2013). Most GPs (91%) reported they noticed a strong or moderate increase of this problem. The patients concerned do not attend the healthcare provider to whom they are referred by their GP, do not attend follow-up consultations (such as x-rays) or lab tests, or do not purchase certain medicines. Most GPs (72%) say they began noticing this during the year the survey was conducted or the previous year. A further 16% said they began noticing it more than two years previously, and 7% reported that this had always been the case. Of all respondents, 62% noticed that at least once a week, patients did not follow their advice; most of these patients were single or had a low level of education.

In several Member States that have been impacted by the crisis, the EQLS and EU-SILC data do not show a clear decline in access to affordable healthcare between 2007 and 2011. Previous analyses suggest that economic shocks often affect health spending a few years afterwards (Cylus et al, 2012). Several cuts only took effect in 2012 (Social Protection Committee, 2011). For example, in 2012 Hungary increased co-payments for day care for long-term hospitalised patients, from HUF 400 to HUF 800 per day. In the same year, Portugal increased co-payments for primary care appointments from €2.25 to €5, for emergency visits from €3.80 to €10, and secondary care emergency visits from €9.6 to €20 (capped at €50 and with exceptions for those on low incomes, disabled people and people with chronic illnesses). The effects of the crisis may not appear for some time. Furthermore, unemployment benefits are usually relatively high directly after becoming unemployed but then gradually decrease causing a lagged impact of the recession on disposable incomes.

### Physical access

Physical access can be made difficult because of issues related to reachability of the service provider or to the accessibility of the service provider’s venue.

Reachability may be a problem especially in areas with low population density. For example, travel time to the nearest hospital can vary a lot within one country even when hospitals are distributed across regions and districts. For example, the time it takes to reach a hospital ranges from 70 minutes travel time by car for people in the north eastern part of Del-Alfold in Hungary, more than 60 minutes for those in the northern part of the Polish region Mazowsze and in the northern part of Navarre in Spain, and over 30 minutes in the northern part of Eastern Austria (Breuer et al, 2013). This only provides part of the picture; sometimes helicopter emergency services are well developed, and public transport matters especially when few people have cars.



Analysis of EQLS data reveals that in the EU28, distance from the doctor’s office, hospital or medical centre makes it either a little or very difficult to access a doctor or medical specialist for 27% of people living in a village or in the countryside, compared to 21% in more urban areas. Access difficulties are common among people who report having great or some difficulty accessing public transport (but who do use it), regardless of whether they live in a rural (41%) or urban (40%) area. People who report no access problems with regard to public transport are least likely to experience difficulties in accessing healthcare services because of distance, especially if they live in urban areas (15%). (The figure is 20% for those living in rural areas.) This suggests public transport can facilitate access to healthcare. Problems are not confined to rural areas, but are also found in urban areas with little access to public transport. People who report that they don’t use public transport are also more likely to report distance-related access problems, especially in rural areas (24%) but also in urban areas (21%). So part of the difference between urban and rural settings can be explained by people reporting limited access to public transport more often in rural (26%) than in urban areas (11%), as well as by the high proportion of people not using public transport in rural (17%) compared to urban (10%) areas.

Physical barriers can also relate to the architecture of a healthcare venue. One example is poor access for disabled people, including inaccessible parking areas, uneven access to buildings, poor signage, narrow doorways, internal steps and inadequate bathroom facilities (WHO and World Bank, 2011). Design limitations may also limit transport options for people wishing to access healthcare services.

### Impacts of the crisis on physical access

The crisis may have made distance-related access problems more of an issue, because of increased public transport costs for users (reduced public funding), reduced incomes (and thus reduced resources for using private or public transport) and closure of healthcare services. In most countries the poorest people and people living in rural areas seem to have suffered most in this respect (Table 4). In some countries, people reported difficulties in accessing medical services because of distance more often in 2011 than they did in 2007 (Greece and Malta), regardless of their income group and whether they lived in a rural or urban area. Again, the EU28 average figures mask these developments, as a considerable improvement was observed overall, with 27% reporting that distance made access very or a little more difficult in 2007, compared to 22% in 2011.

Table 4: Countries with an increase in distance-related difficulties in accessing healthcare services 2007-2011, by income and urban/rural

Category	Countries
Living in rural areas	Germany, Slovakia
Bottom half of the income range	France, the Netherlands
Bottom half of the income range in rural areas	Luxembourg
Top half of the income range in rural areas	Latvia, Poland
Rural areas and bottom half of the income range in urban areas	Estonia, Slovenia
Rural and urban areas, on both the bottom and top halves of the income range	Greece, Malta

Note: Based on responses to Question 47, Distance to doctor’s office / hospital / medical centre: ‘On the last occasion you needed to see a doctor or medical specialist, to what extent did each of the following factors make it difficult or not for you to do so?’ An increase is measured as over a four percentage point increase in the proportion of people responding ‘very difficult’ or ‘a little difficult’ to this question.

Source: Eurofound’s analysis of EQLS micro-data.

The crisis not only seems to have made it more often difficult for people to access healthcare services due to distance; there is also evidence that it has led to unmet medical need. In particular, the proportion of people in Greece reporting unmet medical need due to geographical distance almost tripled between 2007 and 2011 (Kentikelenis et al, submitted for publication), after adjusting for people’s age, sex, marital status, level of education and urban or rural residence.

Furthermore, during a crisis it is less likely that funds are available to remove such barriers related to the architecture of healthcare service venues and design of public transport.

### Informed access

One may be entitled to certain types of healthcare services, but not know about this entitlement, or not know how to access the relevant care. Support may be available, but people may not know about it or may not be aware of how to apply for it. System complexity and limited or ill-targeted information may play a role, combined with low assertiveness among service users, and literacy and language problems. Lack of familiarity with the system may also play a role, with newcomers being in a disadvantaged situation, whether they are internal EU migrants or come from outside of the EU (Mladovsky et al, 2012a).

In a survey of over 8,000 patients of Doctors of the World clinics in 14 cities in seven Member States, lack of knowledge of one's rights or understanding of the health system (21%), as well as administrative problems (20%), were the most frequently cited barriers to accessing healthcare (Chauvin and Simonnot, 2013).

A survey of the Roma population in 11 EU Member States found that Roma were generally less likely to say they were covered for healthcare than were non-Roma (FRA and UNDP, 2012). In three of the 11 countries, the difference was more pronounced: in Bulgaria, Greece and Romania, around 45% of Roma reported having medical insurance compared to around 85% for the non-Roma population. This difference may partly be explained by coverage. In addition, Roma may be less likely than others to know about their entitlements. This difference was relatively small in some other countries. In France, Hungary, Poland, Portugal, Slovakia and Spain, reported coverage for both groups was around 90% or more. It was around 80% in the Czech Republic and Italy.

'Informed access' may also be caused by lack of awareness among healthcare providers. For example, in the Netherlands there is a fund that healthcare providers can draw upon when people in vulnerable situations seek to access services to which they are not entitled and which they cannot afford. Nevertheless, as potential users of this fund, healthcare providers are not always aware of its existence or of how to access it. This is reflected in the low level of use since it came into existence (Karl-Trummer, 2013).

### Impacts of the crisis on informed access

The impacts of the crisis are hard to predict with regard to informed access. On the one hand, fewer resources may be available for investment in information provision, outreach centres and language services. On the other hand, there may be an additional incentive to reduce cost in complex administrative systems by simplifying them, and problems for groups in vulnerable situations may become more visible, with the result that additional help is provided for access to relevant services.

### Timely access

One might be covered for healthcare, know about the service, be able to access it easily physically, have no problem paying for it and still face problems in accessing it, due to waiting times to make an appointment, waiting periods at the location of the healthcare provider, waiting times for referrals and opening hours of the service.

Waiting lists are a key complaint in the EU, especially for appointments with specialists (European Commission, 2012). Waiting lists differ considerably across Member States, and are even present in countries that are generally known for not having waiting lists (Figuera et al, 2004). After controlling for age, education, gender, income quartile and employment status (see below), EQLS data show that in some countries rural areas are particularly disadvantaged in

terms of delays to get an appointment (Croatia, France, Luxembourg, Slovenia and Sweden), while in other countries, urban areas are more disadvantaged (Belgium, Bulgaria, Estonia, Greece, Latvia, Lithuania and Poland).

People in low socioeconomic groups are least likely to be able to circumvent waiting lists (for example by going to the private sector or travelling abroad) because of lack of confidence, resources and knowledge, and because of less developed language skills (Flear, 2009). Waiting times may vary by service. In a recent qualitative study, patients in several of the Member States that joined the EU since 2004 spoke of limited access to diagnostic tests, GPs and specialists due to waiting times (European Commission, 2012). This was most common in rural areas.

EQLS data reveal that there seems to be some trade-off in the EU28 between delays in getting an appointment and affordable access. Some countries, like the Netherlands and Sweden, do very well, while others, like Italy and Greece, do very badly on both accounts. Others do well in affordable access, but delays in getting an appointment often make access difficult (Croatia, Estonia, Hungary and Slovenia). Finally, Cyprus, Ireland, Lithuania and Romania do well in terms of timely access, but not in cost (see Appendix Table A1).

Whether such issues are a problem for the user depends, to some extent, on individual characteristics. For example, care and employment responsibilities may make it difficult to access healthcare providers during opening hours, and even small delays may cause difficulties for people who cannot be long away from home or work. Waiting at the location of the healthcare service may be more of a barrier for people with certain disabilities. This is confirmed by EQLS 2011 data analysis. The waiting time required to see a doctor on the day of an appointment made it very difficult for 11% of all people in the EU28. Those who were limited in their daily activities by a chronic physical or mental health problem or disability more often (14%) reported waiting time making it very difficult for them than other people (9%). This difference is observed across age groups.

The extent to which waiting times, both at the venue and to make an appointment, is a barrier also depends on medical conditions. Analysis of data from the Survey of Health, Ageing and Retirement in Europe (SHARE) of older people in nine EU Member States shows that people with low incomes and low education generally experience relatively long waiting times for non-emergency surgery and specialist consultation (Siciliani and Verzulli, 2009). This has partly been explained by differences in degree of assertiveness in searching and complaining, but it may also be due to a geographical concentration of low-income groups in areas with poor local services, such as deprived rural or urban areas.

### **Impacts of the crisis on timely access**

The increased demand for certain healthcare services in combination with limited supply may have led to increased waiting lists to receive medical care. Sometimes an increase in waiting times can be marked by an explicit rationing policy (Thompson and Mossialos, 2009). Estonia is one example of this, where the official maximum waiting time for outpatient specialists' visits increased in March 2009 from four to six weeks (Habicht, 2012).

Delays in getting an appointment with a doctor was cited as a barrier less frequently in 2011 (39%) than in 2007 (42%). The same holds true for waiting times on the day of an appointment, down from 46% in 2007 to 42% in 2011. Nevertheless, in several countries delays in getting an appointment were often greater in 2011 than in 2007. In Cyprus, Finland, France, Greece, Malta and Poland, delays in getting an appointment made it more difficult in 2011 than in 2007 for people to see a doctor. This persists even after controlling for age, education, gender, income quartile, urban/rural, and employment status.<sup>5</sup> Waiting time on the day of the appointment also made access more difficult in a smaller number of Member States. This was not limited (except in the UK) to low income groups (Table 5).

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<sup>5</sup> Results of an ordinal logit regression (dependent variable: delay in getting an appointment made access 2= very difficult, 1=little difficult, 0= not difficult), alpha = 0.1.

Table 5: Countries with an increase in waiting time-related difficulties in accessing healthcare services 2007-2011, by income

Category	Difficulty caused by delay in getting an appointment	Difficulty caused by time waiting on the day of the appointment
Both bottom and top half of the income range	Cyprus, Estonia, Finland, Greece, Malta	Greece, Malta
Bottom half of the income range	UK	UK
Top half of the income range	France, Poland, Slovakia	Denmark, France

Note: This presents data from Question 47, ‘Waiting time to see doctor on day of appointment and Delay in getting appointment’: ‘On the last occasion you needed to see a doctor or medical specialist, to what extent did each of the following factors make it difficult or not for you to do so?’ An increase is measured as over a four percentage point increase in the proportion of people responding ‘very difficult’ or ‘a little difficult’.

Source: based on Eurofound’s analysis of EQLS micro-data.

In Spain the sharpest increase in waiting lists, since centralised data collection started in 2004, took place between mid-2012 and mid-2013. The number of people waiting for surgery increased by 6.4% and the average duration of this waiting period grew from 76 to 100 days, with many people waiting more than the legal maximum that applies to some procedures (El Pais, 2013).

As a consequence of the crisis, the proportion of people who are not in employment has increased in most Member States. Lack of time, either to wait for healthcare or to reach the provider within opening hours, can thus be expected to be less of a problem. Indeed, in Spain the proportion of people who report unmet medical needs because they did not have the time to go to the doctor has decreased, from 2.0% in 2009 (when it was at its highest level) to 1.3% in 2011 (Eurostat, 2013). As well as not receiving treatment, access may be made difficult because it is hard to find the time required. EQLS only includes a question about ‘lack of time due to employment or caring responsibilities’ in 2011 for the first time, but results do reveal something about the potential impact of the crisis. Among people in employment, in the EU28 as a whole, 10% reported that finding time made it very difficult to access healthcare services while another 27% said it made it a little difficult. Unemployed people experience this difficulty less often: 3% reported finding time made it very difficult, while 14% reported it made it a little difficult. This difference was consistent across all Member States, except Finland. The length of time required, both to get an appointment and, in particular, to wait on the day of the appointment, may also have become less of an issue due to other barriers in accessing healthcare.

## Other barriers to access

Good quality healthcare services may be available, but in practice may not be sought or offered. This can occur for a range of reasons.

### Not seeking care

Various reasons may exist for not seeking the healthcare services to which one is entitled. Preferences (Busse et al, 2011) and habits in healthcare usage (sometimes personal, sometimes engrained in culture) play a role, as do attitudes towards healthcare. Many people in the EU report unmet needs because they wanted to wait and see if the problem got better on its own, in particular in Hungary (3.9%) and Sweden (5.3% in 2011) (Eurostat, 2013). Anticipated low quality care, a lack of trust in or fear of service providers and a lack of trust in the ability of medicine to provide an effective treatment can also be barriers to seeking healthcare services, as can anticipated negative interactions with the service provider. Relevant factors for the potential service user can include the language or dialect spoken, migrant or minority ethnic status, having a physical or intellectual disability, gender (for example, expecting to be attended by a medical professional of the opposite sex), religion, and not having a fixed address. Cultural differences also play a role (EUGATE, 2009), including country and cultural norms regarding health, intercultural communication, dress code, attitudes to nudity, dietary requirements, and gender roles.

One barrier for undocumented migrants may be fear of deportation. In Germany, undocumented immigrants have the right to publicly funded healthcare services, but the healthcare providers have to ask for funding at the social security office. This social security office, in turn, has the obligation to report the undocumented migrants to the police. Anticipating this, undocumented migrants are unlikely to seek non-emergency care.

The fear of being stigmatised is another possible reason for not seeking care. This might be a particular issue for people suffering from particular health conditions and belonging to specific demographic groups. An example includes people with mental health problems (McDaid, 2008). Stigma surrounding mental health may be more pronounced for people living in some rural areas, minority ethnic communities and young people (Jenull et al, 2012; McDaid, 2008), and this may be equally true for other medical conditions.

### **Impacts of the crisis on seeking needed care**

The prevalence of certain medical conditions for which such problems are generally more pronounced (e.g. mental health problems) has risen because of the crisis. As a consequence, not seeking care is expected to be a barrier to accessing healthcare for a larger proportion of the population. One strong example is the rise in mental health problems. Furthermore, some reasons for not seeking care may have increased. An example is that of pregnant women who may be less likely to access healthcare for fear of losing their job (WHO, 2013).

#### **Not being offered appropriate care**

Even when healthcare is sought, services may not be offered appropriately. At the system level, there may be theoretical equality, but in day-to-day dealings with clients, service providers have discretion. This does not always need to imply a barrier to access, however. For example, undocumented migrants may not be entitled to certain basic healthcare services in some countries, but in practice healthcare providers may still offer them these services free of charge.

Other barriers may include outright discrimination, by barring access or providing better care to some than to others. This can relate to the medical condition concerned, but also, for instance, to someone's ethnicity, gender, sexual orientation or disability status. A recent study found that patients with chronic illnesses and conditions tended to be more critical of their country's healthcare systems than others. Some reported that their involvement in healthcare was inhibited by doctors' lack of empathy and consideration, and by insufficient explanation of treatments (European Commission, 2012). With regard to immigrants, another study (EUGATE, 2009) points to negative attitudes among staff and patients, including discrimination and lack of trust. One in ten lesbians, gays, bisexuals and transgender persons who had accessed healthcare services in the 12 months before they participated in a recent survey reported they felt personally discriminated against by healthcare personnel, with particularly high rates for transgender respondents (19%) (FRA, 2013b). Discrimination was considered more common in healthcare services than in social services.

These barriers are not always due to the service provider, or to the interaction between service provider and patient. They may also be caused by technology. Medical equipment is, for example, not always designed for people with certain characteristics or disabilities (WHO and World Bank, 2011).

#### **Impacts of the crisis on care being offered**

The crisis may lead to increased xenophobia (Chauvin and Simonnot, 2013), increased selectiveness by healthcare workers due to decreased resources, lack of funds for 'facilitating measures' (such as translators), increased stress levels and eroded motivation among healthcare professionals due to cuts in staff and worsening working conditions. It can also lead to increased demand among certain groups that were already subject to discrimination or that have become so.

Lastly, in several Member States the proportion of people reporting unmet medical needs for ‘other reasons’, not captured by EU-SILC’s answering categories, has increased (Germany, Portugal, Slovakia, Spain, UK). This suggests that it is important to realise that new barriers may have appeared during the crisis, which may not have been considered yet.

# Maintaining access in the face of economic crisis

Previous research has identified initiatives aimed at enhancing access to healthcare for groups in vulnerable situations. Most of them concern longer-standing initiatives that existed before the crisis. An overview of relevant initiatives is given here, followed by a discussion of the impact of the crisis on them.

## Initiatives that enhance access

Some measures have been based on facilitating entitlement to healthcare access among groups in vulnerable situations. National initiatives frequently exempt such groups from cost-sharing requirements, in particular low income groups, unemployed people, those who are chronically ill and older people. Initiatives aimed at reducing cost for the patient may also be initiated less formally and systematically at the service provider level. In the Dutch GP survey mentioned above (LHV, 2013), GPs reported searching for alternatives (76%), such as cheaper medicine or a repeat visit rather than a referral to the hospital (the latter is subject to payment by the patient, while the GP visit is not). Many (62%) also responded by telling the patient about the health consequences of not following their advice, thus trying to encourage the patient to prioritise this expenditure.

Other initiatives are aimed at reducing the barriers to ‘informed access’. The ‘Guide to Healthcare’ for immigrants in Spain provides information about the healthcare system in Arabic and English, as well as Spanish (European Commission, 2008). Improving communication, for instance by graphical illustrations, can also improve access (Karamitri et al, 2013). The ‘Thalis’ project in Greece is another example of removing barriers to informed access. It aims at establishing a website and information kiosks (in public, but protected, places in Athens and Thessaloniki), where people can access information about publicly funded services, in English and other languages, as well as about the rights of immigrants with regard to access to healthcare services, co-payments, and the identification of symptoms of the most frequent or dangerous infectious diseases. In the UK, several small-scale programmes have produced documents mapping local health and social services, such as maps for homeless clients. In the Netherlands there are websites, such as ‘KiesBeter’, which are designed to help people making choices in the healthcare system, including choices between social health insurers and services (European Commission, 2008).

Other initiatives aim to remove barriers to ‘informed access’ and ‘physical access’, bringing care closer to the community. They include, for example, initiatives targeted at older people such as community centres for older people and programmes aimed at joined-up working to improve access to a range of health, social care and community services; examples include KAPI in Greece, LinkAgePlus and Partnerships for Older People in the UK (European Commission, 2008) and ‘care-friendly districts’ in the Netherlands (Saltman et al, 2006). It has been demonstrated that older people like to have common entry points for services, which makes access easier, including having complex needs assessments done in a uniform way. They also prefer to see a practitioner with whom they are familiar (European Commission, 2008). This may also be the case for the general population. In relation to people with mental health problems, outreach centres, 24-hour helplines, and the coordination of ‘gateway workers’ were found to enhance access in the UK (European Commission, 2008).

Simplifying the system can also improve healthcare accessibility. This can entail single entry points in the community, and enhanced systems that require little action by users. In systems where people must choose a basic health insurance package (such as the Netherlands and Germany), it can help to standardise packages for comparison purposes and to develop proactive approaches in cases where people do not understand or take the time to select an insurance package. In tax-based systems such as Denmark, the UK and Spain, this is less relevant as people are automatically covered by the basic package, although they may not be aware of this.

Stability is another issue. It is important to understand the impact of changes to the system on people who may not be directly aware of them.

Some initiatives are aimed at achieving access among people who might not seek healthcare services, even though they need them and are entitled to them. For example, the ‘anti-stigma’ campaign ‘Open Doors’ in Germany is specifically for people with mental health problems (European Commission, 2008). There is also a role for the media in addressing stigma (McDaid, 2008). Training people from groups in vulnerable situations themselves to serve as cultural mediators can further enhance accessibility, particularly in addressing cultural barriers (Karamitri et al, 2013). For example, ‘Roma health mediators’ in Finland and Romania are persons of Roma origin who mediate between doctors and Roma patients during medical consultation and communicate with the Roma community on behalf of the public health system. In Germany, ‘scout services’ for migrant patients by migrants, represent another example (European Commission 2008). There are also programmes that target specific conditions among minority groups. For example, ‘the bridge’ programme in the Netherlands focuses on migrant women with psychological symptoms, providing culturally sensitive information, counselling in the migrant’s native language, and liaising with health services via migrant health educators (European Commission, 2008).

Other initiatives are aimed at reducing the possibility that care, once sought, was not offered, or not correctly offered. For example, staff training was identified in several studies with regard to migrants as playing a crucial role in preventing healthcare workers from appearing discriminatory and culturally inappropriate (EUGATE, 2009; Karamitri et al, 2013). Through initiatives involving mediators, such as the Roma project mentioned above, health mediators can accompany vulnerable people during a medical consultation. Anti-discrimination legislation and effective implementation also help, as does the exchange of information on the use of legal instruments to tackle discrimination (McDaid, 2008). For migrants, the use of medical and cultural mediators, transcultural education and stronger linkages among medical facilities are all important in reducing accessibility problems (Karamitri et al, 2013).

### Promoting initiatives during the crisis

Public funding for initiatives to enhance access may be less readily available in the context of funding cuts. One can expect three challenges with regard to such initiatives.

**Existing initiatives may have lost financial support.** This is expected to have an adverse impact on access to healthcare services.

**Little support for new initiatives and adjustment of existing ones to the demands of the crisis.** This is due to new groups finding themselves in vulnerable situations, while other groups in vulnerable situations become larger and their situation more vulnerable and with different needs. Reduced funding opportunities may make such responsiveness to the context challenging.

**Few resources for adjustment to certain longer-term trends in healthcare service provision.** For example, there is a move away from inpatient care and towards outpatient care. Independent living is facilitated not only for people with chronic health problems, but also for people with disabilities, and there is a drive to support care in the community. If well managed, these trends can both improve quality of life and reduce costs, and may therefore be accelerated during an economic crisis. Nevertheless, it is a challenge to make investments in these measures with limited resources and without reducing access.

Those responsible for developing and implementing initiatives that seek to limit the negative impact of the crisis on access to healthcare may include professional organisations, interest groups, local governments, regional governments, national governments and services providers. If successful, both users and healthcare service providers will notice their impact, but there is a need for more documentation and evaluation of these initiatives.



# Conclusions

The crisis has clearly had an impact on access to healthcare services. The nature of this impact is complex. Much relevant research has been conducted, and further research is ongoing, but there are still important gaps to fill to inform policymakers and service providers.

## What has been done and what can be added?

Research has revealed access-related problems in the past (see for example European Commission, 2008; ILO, 2011). The health impacts of the crisis have also been examined (see for example Rechel et al, 2011; Karanikolos et al, 2013). Nevertheless, evidence is more limited on how access to healthcare services has been affected by the recent crisis. The impacts of the crisis on access to healthcare can be expected to be multiple and complex. As outlined above, the crisis can be expected to have affected the various dimensions of access in different ways. Furthermore, in some Member States there has been a particularly stark increase in ‘other reasons’ for unmet care, not captured by the answer categories in the EU-SILC survey, suggesting that new types of access problems have emerged.

Recent research has identified groups in vulnerable situations with regard to accessing healthcare (European Commission, 2008; Doctors of the World, 2012; FRA, 2013a). Less is known about the impacts of the crisis on these groups, which new groups may have emerged, and which groups in vulnerable situations have maintained access to healthcare. Research has tended to focus on specific groups in vulnerable situations, on specific access problems (frequently limited to formal entitlements), on specific medical conditions, in specific countries. There is less cross-national EU research available that has a broader perspective on access and groups in vulnerable situations. As discussed above, the impact of the crisis on different groups can be expected to vary, in terms of the degree to which access has been affected, along which dimensions, and the mechanism through which this occurred.

Health system reforms triggered by the crisis have been mapped (Mladovsky et al, 2012b), but less attention has been placed on the implementation of these measures, the impact they are having on the ground and the responses of affected service providers. As shown here, the impact of the crisis goes beyond cuts alone. Little is known about what lies behind indications, in macro-level data from surveys and other sources, of worsening access for some and more stable access for other groups in vulnerable situations in various Member States.

Research has identified what can be done to improve access; see for example, European Commission (2008) and Karamitri et al (2013). Less is known about whether, amidst all the crisis-related measures, such initiatives have diversified or narrowed in scope, strengthened or weakened, changed target group or not. Some service providers and governments may have taken measures to limit the negative impact of the crisis on access to healthcare services, or they may have developed initiatives to mitigate the negative impact on access for some groups in vulnerable situations.

## Next steps

Eurofound’s work on healthcare in the context of the crisis has three broad objectives. It aims to develop a better understanding of how access to healthcare services has been affected by the crisis, and to identify groups that have been particularly affected by the crisis in terms of reduced access to healthcare services. In order to achieve these first two objectives, Eurofound draws on a review of the literature and analysis of European-level datasets. Some findings have been presented in this report, but further reviews and analyses will be presented in the forthcoming overview report.

In addition, Eurofound will draw on country studies, which will include a general overview of the available data and literature at the national level, as well as interviews with key stakeholders. The country studies will concern EU Member States that have been most adversely affected by the crisis, as well as wealthier Member States that have experienced economic decline as well as cuts in health expenditure.

In order to illustrate the impact of the crisis, studies of various healthcare service providers will be conducted. This will provide an insight into some of the macro-level data, and anticipated developments among people delivering services.

It is important to acknowledge the limitations of this research plan. These include the short amount of time that has passed since the measures were implemented, the lack of data (Karanikolos et al, 2013), and the limited scope of this project.

As a third objective, Eurofound aims to identify initiatives that have reduced or mitigated the negative impact of austerity measures on access to healthcare services. In order to achieve this, this research project aims to identify groups in vulnerable situations for whom access may not have worsened as much as expected. Case studies will be a key source here, specifically those of healthcare measures that appear to have mitigated, or decreased, the negative impact of the crisis on healthcare access. Case studies may also deal with national or regional government measures, or other stakeholder initiatives. The case study then serves to illustrate the impact of these measures in practice on the ground.

Limitations also arise regarding this stage of the research. It may not be realistic to expect initiatives to fully offset the impact of the crisis on access to healthcare services. Furthermore, any successful model that is identified may not be transferable to other regions, countries, service providers or population groups.

The analysis will also draw on expert input, through reviews of analysis and workshops.

The overall aim of this project is to inform the healthcare policy debate. By addressing these three objectives, it seeks to enable policymakers, service providers and social partners to learn from different experiences and to consider various methods for maintaining and improving access to healthcare in a challenging environment.

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Table A1: *Difficulties in access, 2011*

	Country average indicator of the difficulty posed by each factor to see a doctor (1=very difficult, 2=a little difficult, 3=not difficult at all)					No difficulties because of any of the five factors	Factors making it 'very difficult' to see a doctor				
	Delay appointment	Distance	Waiting time	Cost	Time		Delay appointment	Distance	Waiting time	Cost	Time
<b>Sweden</b>	2.72	2.89	2.82	2.89	2.82	59%	5%	2%	3%	2%	2%
<b>Netherlands</b>	2.79	2.83	2.71	2.79	2.80	53%	4%	3%	5%	5%	2%
<b>Spain</b>	2.63	2.83	2.57	2.89	2.80	52%	8%	3%	7%	2%	3%
<b>Finland</b>	2.64	2.85	2.75	2.86	2.85	52%	7%	2%	4%	2%	2%
<b>Belgium</b>	2.75	2.85	2.73	2.72	2.73	49%	4%	3%	3%	4%	4%
<b>Austria</b>	2.65	2.81	2.65	2.79	2.77	49%	5%	2%	4%	3%	4%
<b>Denmark</b>	26.3	2.83	2.77	2.93	2.77	49%	7%	3%	4%	1%	4%
<b>Luxembourg</b>	2.72	2.89	2.71	2.71	2.76	45%	5%	2%	3%	4%	5%
<b>Slovenia</b>	2.35	2.59	2.35	2.73	2.82	43%	19%	7%	17%	6%	3%
<b>Croatia</b>	2.39	2.74	2.40	2.7	2.74	43%	16%	4%	14%	6%	6%
<b>United Kingdom</b>	2.53	2.81	2.62	2.94	2.64	41%	11%	4%	7%	1%	8%
<b>France</b>	2.63	2.85	2.62	2.7	2.67	40%	8%	3%	8%	4%	7%
<b>Bulgaria</b>	2.67	2.63	2.38	2.5	2.72	40%	6%	8%	14%	13%	6%
<b>Latvia</b>	2.61	2.69	2.61	2.51	2.66	39%	9%	6%	7%	11%	9%
<b>EU28</b>	<b>2.48</b>	<b>2.73</b>	<b>2.47</b>	<b>2.6</b>	<b>2.66</b>	<b>37%</b>	<b>13%</b>	<b>5%</b>	<b>11%</b>	<b>9%</b>	<b>7%</b>
<b>Ireland</b>	2.77	2.83	2.59	2.41	2.69	36%	5%	4%	8%	16%	6%
<b>Estonia</b>	2.33	2.61	2.51	2.68	2.72	35%	16%	8%	9%	6%	5%
<b>Romania</b>	2.56	2.63	2.41	2.4	2.64	34%	11%	9%	15%	16%	8%
<b>Lithuania</b>	2.58	2.77	2.48	2.43	2.73	33%	10%	5%	11%	15%	5%
<b>Portugal</b>	2.4	2.62	2.36	2.56	2.64	31%	15%	7%	15%	9%	6%
<b>Cyprus</b>	2.58	2.74	2.47	2.24	2.72	30%	12%	7%	16%	28%	8%
<b>Poland</b>	2.11	2.59	2.37	2.33	2.64	30%	30%	8%	16%	21%	7%
<b>Slovakia</b>	2.52	2.58	2.16	2.27	2.63	29%	11%	7%	23%	16%	6%
<b>Czech Republic</b>	2.48	2.65	2.25	2.57	2.57	25%	9%	6%	16%	9%	9%
<b>Italy</b>	2.17	2.55	2.17	2.20	2.5	22%	23%	6%	19%	23%	9%
<b>Greece</b>	1.98	2.41	2.06	2.05	2.47	16%	35%	14%	28%	31%	14%

Note: Based on responses to the following question: 'On the last occasion you needed to see a doctor or medical specialist, to what extent did each of the following factors make it difficult or not for you to do so? 1) Very difficult; 2) A little difficult; 3) Not difficult at all (Not applicable/ never needed to see doctor)'. Countries are presented by the proportion of people reporting no difficulties with any of the five factors.

Source: Eurofound's analysis of EQLS micro-data.

Table A2: Difficulties in access, 2011 and 2007

	Distance			Delay appointment			Waiting time			Cost		
	2007	2011	Change	2007	2011	Change	2007	2011	Change	2007	2011	Change
Greece	24%	45%	21%	43%	67%	24%	47%	66%	19%	45%	64%	19%
Malta	14%	19%	5%	31%	41%	10%	41%	61%	20%	44%	58%	14%
Netherlands	12%	14%	2%	22%	17%	-5%	29%	24%	-5%	8%	16%	8%
Estonia	23%	31%	7%	42%	50%	8%	36%	40%	3%	18%	26%	8%
Slovakia	33%	35%	3%	33%	37%	4%	62%	60%	-2%	49%	57%	7%
Cyprus	22%	19%	-3%	26%	30%	3%	39%	37%	-2%	42%	48%	6%
Luxembourg	13%	9%	-4%	25%	23%	-2%	30%	26%	-4%	20%	25%	5%
Czech Republic	36%	29%	-7%	48%	43%	-5%	66%	59%	-7%	29%	34%	5%
Lithuania	24%	18%	-5%	40%	32%	-8%	51%	42%	-10%	37%	42%	4%
Poland	33%	32%	-1%	53%	58%	5%	46%	47%	1%	42%	46%	4%
Ireland	14%	14%	0%	24%	19%	-5%	35%	32%	-2%	39%	43%	4%
Sweden	11%	9%	-2%	30%	23%	-8%	21%	15%	-6%	6%	9%	3%
France	11%	12%	1%	24%	29%	5%	27%	31%	4%	25%	26%	1%
Denmark	12%	14%	2%	32%	30%	-2%	19%	19%	0%	6%	6%	-1%
Slovenia	32%	34%	2%	53%	47%	-6%	54%	48%	-6%	22%	21%	-1%
Finland	15%	13%	-2%	25%	29%	3%	22%	20%	-2%	13%	12%	-1%
<b>EU28</b>	<b>27%</b>	<b>22%</b>	<b>-5%</b>	<b>42%</b>	<b>39%</b>	<b>-3%</b>	<b>46%</b>	<b>42%</b>	<b>-4%</b>	<b>32%</b>	<b>30%</b>	<b>-2%</b>
UK	16%	15%	-1%	36%	36%	1%	31%	31%	1%	7%	5%	-2%
Latvia	33%	25%	-8%	42%	30%	-12%	52%	32%	-20%	39%	37%	-2%
Bulgaria	36%	29%	-7%	35%	27%	-8%	54%	47%	-7%	39%	37%	-2%
Romania	33%	28%	-5%	38%	33%	-5%	51%	44%	-7%	47%	44%	-2%
Germany	20%	21%	1%	38%	39%	1%	46%	48%	2%	31%	25%	-5%
Spain	39%	14%	-26%	54%	29%	-25%	58%	35%	-23%	15%	8%	-6%
Belgium	15%	12%	-3%	27%	21%	-6%	29%	24%	-5%	33%	24%	-9%
Austria	28%	17%	-11%	40%	30%	-10%	44%	31%	-13%	28%	18%	-10%
Italy	52%	39%	-13%	68%	60%	-8%	72%	64%	-8%	67%	57%	-10%
Portugal	36%	31%	-5%	65%	45%	-20%	70%	48%	-21%	49%	34%	-14%
Croatia	35%	22%	-14%	48%	45%	-4%	52%	46%	-6%	39%	24%	-15%
Hungary	38%	29%	-10%	46%	46%	0%	55%	48%	-8%	52%	28%	-24%

Note: These data relate to the following question: 'On the last occasion you needed to see a doctor or medical specialist, to what extent did each of the following factors make it difficult or not for you to do so? 1) Very difficult; 2) A little difficult; 3) Not difficult at all (Not applicable/ never needed to see doctor)'. Figures represent the proportions of people who report 'very difficult' or 'a little difficult'. Some figures have been rounded up.

Source: Eurofound's analysis of EQLS micro-data.