Access to Healthcare and the Economic Crisis in Europe

Health in Economic Policies and the Case for Universalism

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Introduction

Policy responses to the economic crisis varied across the Member States of the European Union (EU), however, with very few exceptions, the quest for fiscal balance hinged on austerity.

The rationale behind these cuts was not always evidence based. For example, measures such as increased user charges for medical care and co-payments for prescription drugs have long been described as inefficient and counterproductive. Likewise, withdrawal of funding for public health programs has had some dire consequences, for example a dramatic and avoidable rise in HIV infections in Greece after needle exchange programmes were stopped.

When evidence for curtailment was purportedly offered, for instance in the case of denying access to healthcare to undocumented migrants on the basis of the financial burden they might impose on the system, it was often flawed and misleading. This was pointed out not only by *Médicins de Monde International Network*[1] but also in a Joint Open Letter to EU Health Ministers co-signed by EPHA.[2]

The purpose of this report is to **make a case for universal access to healthcare** with the objective of ensuring that policy makers are able to meet their commitments and can act on the recommendations put forward here. Improving access is not only relevant in Europe – in addition to the effects of the crisis, the implementation of the Cross-border Healthcare Directive (2011/24/EU) provides another relevant hook[3], in addition to the ongoing work on reducing health inequalities[4] - but globally, notably to **attain the Sustainable Development Goals (SDGs).** Goal 3.8 on health explicitly asks to 'Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all'. Moreover, universal access to healthcare is a key element of the World Health Organization's (WHO) Health 2020 framework.

In addition, it is **vital to ensure that a 'Health in All Policies' (HIAP) approach is taken** at EU level in order to safeguard policy coherence and warrant that health impacts are taken into

[1] Médecins du Monde (2014). Access to vaccination for groups facing multiple vulnerability factors in Europe. Available at: http://eiw.euro.who.int/profiles/blogs/access-to-vaccination-for-groups-facing-multiple-vulnerability
[2] http://www.epha.org/a/6378
[3] Article 4 confirms the values of universality, access to good quality care, equity, and solidarity which have also been held up by the EU institutions on many other occasions. See http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:en:PDF
[4] See for example the 2009 Communication on Solidarity in Health, http://ec.europa.eu/health/social_determinants/policy/commission_communication/index_en.htm

account across the board. For example, HIAP hinges on the correct balancing of health, social and fiscal measures in macro-economic policies such as the European Semester process. The country-specific recommendations (CSRs) issued as part of the latter tend to neglect the value of prevention, health promotion and access for all, the focus being rather on economic measures that have been translated into cuts to healthcare services. As a consequence, the **strengthening of the social dimension of the Economic and Monetary Union (EMU) is impeded**.

EPHA actively supports and endorses efforts to bring attention to the plight of minorities and vulnerable groups in accessing healthcare in Europe. Therefore, this report **highlights the need for a whole of the population approach.** This is becoming increasingly important as rights to healthcare for the entire population are being progressively eroded in recent years, be it through user fees, increased waiting lists or closures of healthcare facilities. What once were services available to everybody, such as child benefits, school meals or free access to healthcare at the point of delivery, are now means-tested, challenging the principle of universality upon which European welfare states are based. That principle is that the state, in this case through the healthcare system, constitutes an insurance system whereby all can benefit if they are ever in need. Its segmentation, accompanied by significant reductions in funding, is compromising the quality of the remaining services used by more affluent citizens, effectively nudging them to seek private options. As the more vocal and politically active middle classes leave the healthcare system, its quality is at risk of deterioration. As pioneering social scientist Richard Timus has stated, 'a service for the poor inevitably becomes a poor service'. **The impoverishment of health systems systematically undermines their societal benefits.**

A more specific objective of this document is to bring attention to two aspects of the impact of the current recession and accompanying economic and fiscal policies on access to healthcare. Firstly, EPHA's own research has shown that the declining trend in unmet need for healthcare was reversed at the onset of the crisis. While EPHA fully acknowledges that the most vulnerable groups show a higher risk of marginalisation from mainstream healthcare systems, this report emphasises the **barriers to access that cuts to healthcare and social protection budgets have posed for health seekers at large**. Secondly, by restricting healthcare coverage, the principles of universality upon which health systems in Europe have based themselves are being undermined. Restricting access to healthcare to certain groups or reducing entitlements in healthcare packages creates **systems of residual coverage catering to small subsets of the**

population. Such arrangements are also weakening political pressure for improvement from all layers of society.

EPHA thus make the case for universal coverage whilst recognising that healthcare systems alone cannot guarantee full access. Even where healthcare is free at the point of delivery other barriers such as increased transportation prices or loss of unemployment benefits pose additional challenges to access..**Access must work hand in hand with social protection and investment in the social determinants of health.**

The report is organised as follows: It begins with describing access in the EU in the post-2008 period, identifying which groups have been affected by the economic crisis and through what pathways. It proceeds to discuss some specific instances of loss of access and what lessons can be learned. Finally, it identifies potential ways forward, making an evidence based case for the universality of health coverage.

The Economic crisis and inequalities in access to healthcare

How is the current economic crisis affecting access to healthcare?

In response to the economic crisis, European national governments have largely opted to enact cost-cutting policies that led to a retrenchment of the welfare state. This was visible in the restrictions imposed on healthcare systems, which eventually led to curtailed access to healthcare[5] and social protection[6] to varying extents across the continent.

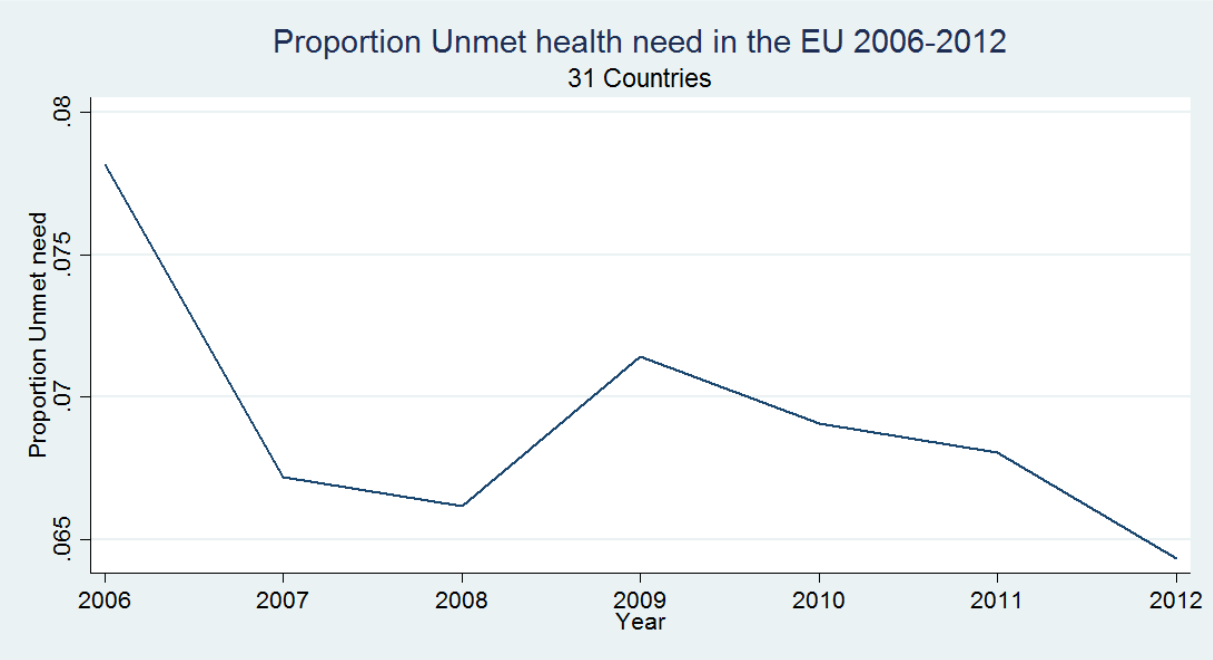
A preliminary analysis of the evolution of unmet health need[7] in 31 European countries over the last decade shows an initial period of decline, followed by a deceleration in the rate of decline ending in outright increase in unmet need in 2008. The level of unmet need then took several years to recover to pre-crisis levels (however, this does not take into account that perceptions of 'unmet health needs' may have changed profoundly as pre- and post-crisis expectations differ).

[5] Reeves et al. (2015). Financing universal health coverage--effects of alternative tax structures on public health systems: cross-national modelling in 89 low-income and middle-income countries. Lancet. 2015 Jul 18;386(9990):274-80

[6] Ferrarini, T. et al. (2014), Unemployment insurance and deteriorating self-rated health in 23 European countries, J Epidemiol Community Health, http://jech.bmj.com/content/early/2014/03/10/jech-2013-203721.full?g=widget_default

[7] There appears to be no agreed definition of 'unmet health need', Eurostat includes two main categories linked to reasons, namely 'Too expensive or too far to travel or waiting list', and 'Other reasons'.

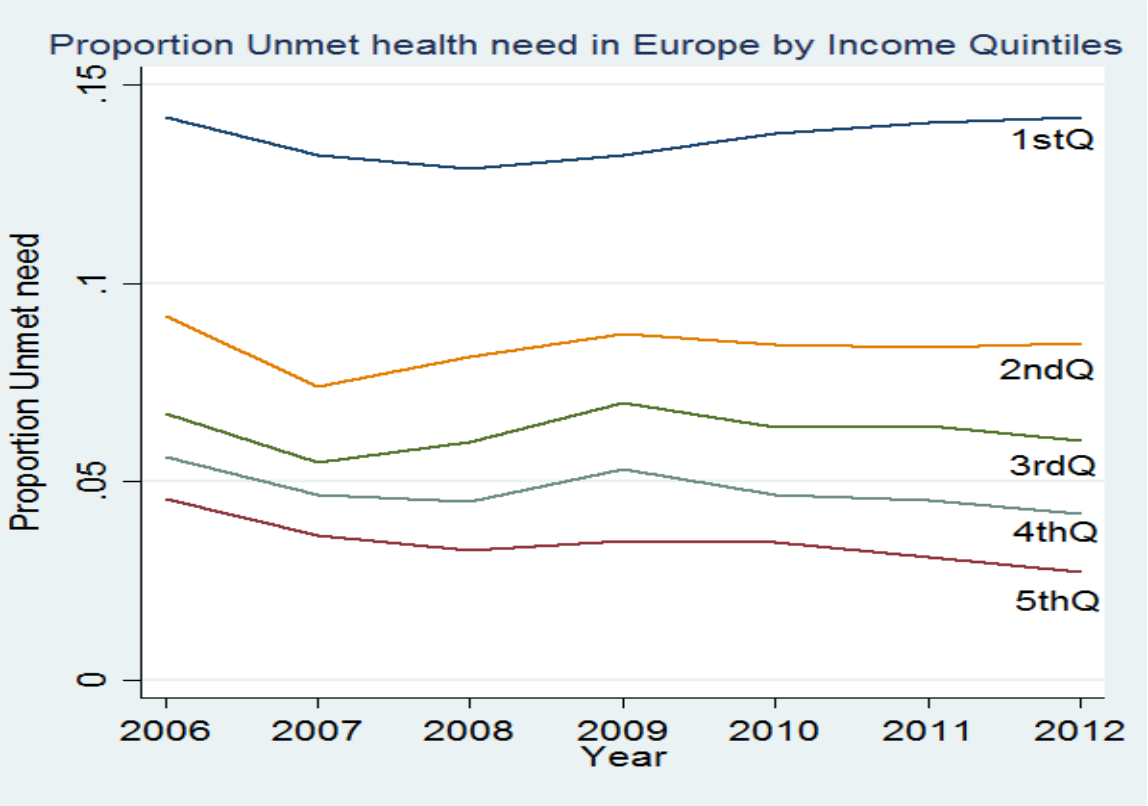
Figure 1: Evolution of unmet health need in 31 European Countries



Source: Own analysis – Eurostat data 2015

These trends beg the question of whether this increase is a direct result of the curtailed budgets for investing in healthcare and social protection observed at the onset of the crisis. Furthermore, they raise concerns about who was hit hardest by access constraints: were these the people who relied most on the universality of the system and who have no other means to seek care when it is no longer available? To answer this question, it is necessary to take a closer look at the composition of those who have lost access.

Figure 2: Proportion of unmet health need in 31 European countries by income quintile



Source: Own analysis - Eurostat data 2015

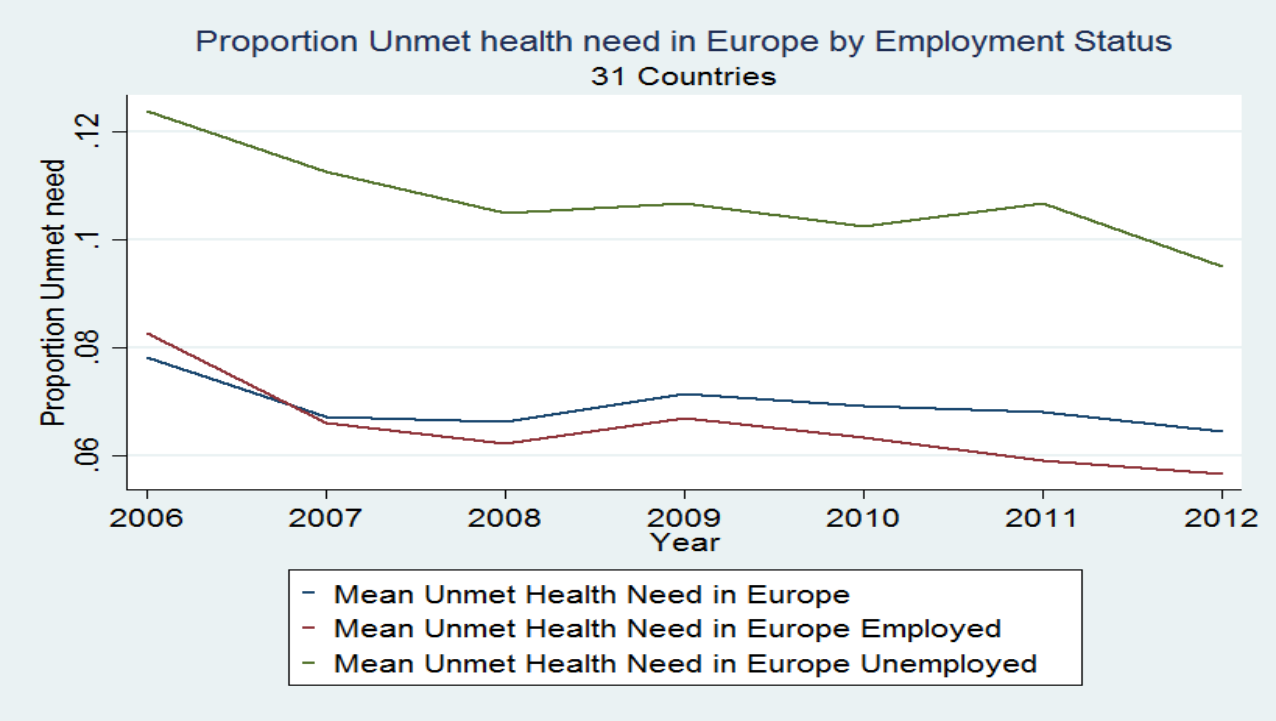
A first glance at the trend in self-reported unmet health need according to income reveals that all groups, except for the top 20% of earners, experienced a rise in 2008-2009. This means that not only the poor suffered from the effects of the recession: with the exception of the richest quintile, all layers of society saw their access to healthcare reduced, albeit to different extents.

However, a closer look shows that the proportion of unmet health need is higher among the lowest earners by a large margin - the 1st income quintile – and in addition, the levels of unmet need never returned to pre-crisis levels as it did in the other income groups where it either plateaued or decreased after the initial rise. The increase in unmet health need is almost imperceptible among the highest earners, i.e. those in the 5th income quintile.

Since the economic crisis led to substantial rises in unemployment - and in many EU countries, access to healthcare is tied to employment – it is pertinent to pay special attention to access to healthcare for those who have lost their jobs.

Thus, looking at the distribution of unmet need according to employment status, we see that the unemployed not only display the highest proportion of unmet health need but they also show a different trend evolution during the recession and the subsequent austerity period (Figure 3); only the unemployed experienced a second peak in 2011.

Figure 3: Proportion of unmet health need in 31 European countries by employment status



Source: Own analysis– Eurostat data 2015

This preliminary analysis demonstrates that, although there is an important socio-economic gradient when it comes to accessing healthcare, there is a case to be made for large-scale population-wide interventions to improve the coverage of health systems.

In the following sections, this report will examine what factors determine loss of access, and identify which of these can be targeted to buffer the effects of the crisis in this area.

What do we know about the effects of recessions on access to healthcare?

The current recession has led to substantial rises in unemployment even in countries where it has traditionally been high (e.g. Spain). Unemployment is an important social determinant of

health to the extent that diminished financial resources may be displaced away from health into needs which are perceived as more pressing like utility bills or purchasing food. It is also a direct determinant of access since in many health systems, health insurance is tied to employment status.

Employment status as a key health determinant

During the recent crisis, an analysis of the relationship between unemployment and 51 indicators of health in OECD countries over time looked at all-cause mortality, as well as five specific mortality causes, revealing that although mortality rates remained largely unaffected by the crisis, suicide rates appeared to increase.[8] When looking at maternal and child health indicators, however, the same study found that obstetric trauma increases with rising levels of unemployment. This positive association could be an indication of worsening quality of healthcare if resource constraints inhibit professionals from providing optimum care. It may also be explained by the additional financial pressure faced by expectant mothers, preventing them from seeking adequate pre-natal care and therefore incurring higher risks during childbirth. In Greece, an increase in stillbirths has been linked to the economic crisis: the rate increased from 3.31 per 1,000 live births in 2008 to 4.36 in 2010, a reversal of a longstanding decline9. The largest stillbirth risk factor – foetal growth restriction- can be detected in prenatal care consultation10, hinting at the role of shortcomings in access to prenatal care in producing these outcomes. Another study found that a 1% increase in unemployment was associated with a 0.79% increase in suicides and a 1.79% decrease in road traffic accidents.[11]

Poor mental health is an immediate outcome of losing a job. Longitudinal studies suggest that becoming unemployed precedes the onset of psychiatric disease[12], i.e. poor mental health is more often a consequence rather than a cause of unemployment. As for mortality, a Swedish study investigating workers displaced due to establishment closures between 1987 and 1989

[8] Gool, K. Van & Pearson, M. (2014). *Health , Austerity and Economic Crisis: Assessing the Short Term Impact in OECD Countries*, Paris
[9] Vlachadis, N. & Kornarou, E. (2013). Increase in stillbirths in Greece is linked to the economic crisis. Bmj, 346(feb19 2), pp.f1061–f1061. Available at: http://www.bmj.com/cgi/doi/10.1136/bmj.f1061
[10] Gardosi, J. et al. (2013). Maternal and fetal risk factors for stillbirth: population based study. BMJ (Clinical research ed.), 346(January), p.f108. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3554866&tool=pmcentrez&rendertype=abstract
[11] Stuckler, D. et al. (2009). The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. Lancet, 374(9686), pp.315–23. Available at: http://www.ncbi.nlm.nih.gov/pubmed/19589588
[12] Murphy, G.C. & Athanasou, J. (1999). The effect of unemployment on mental health. Journal of Occupational and Organizational Psychology, 72, pp.83–99. Available at: http://search.proquest.com/docview/199367134?accountid=14777

saw the overall mortality risk increase by 44% among men in the four-year period subsequent to the closure.. For both sexes there was a twofold increase in probability of suicide and alcohol abuse.[13] Similar effects were found in the US, e.g. the impact of losing employment near retirement age on the increased risk of strokes[14] and of the impact of job insecurity on short-term risk of non-fatal myocardial infarction among nurses.[15]

Other somatic effects have been described, calling for a broad strategy for safeguarding healthcare access during times of economic strain. For example, contracting labour markets may impede women with disease symptoms from getting proper medical attention or distract them from detecting them. African American women appear to be at greatest risk of having a tumour undetected by virtue of labour market performance.[16] In a similar vein, risk factors for sudden infant death increase among black families during periods of economic contraction.[17]

Effects of the recession on access to healthcare

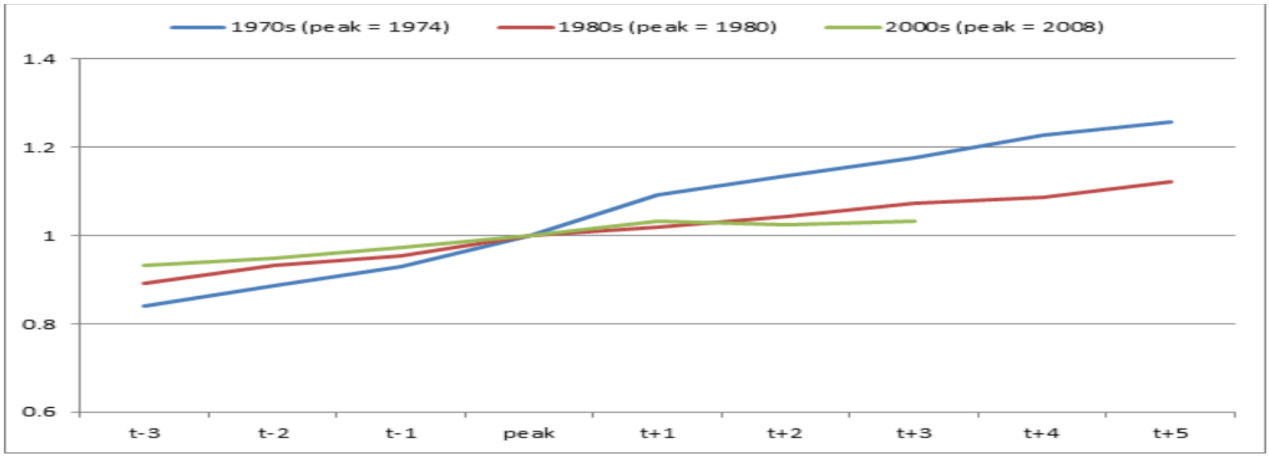
Access to healthcare is not a health indicator per se but it is highly correlated with health indicators. For instance, it has been associated with breast cancer early diagnosis[18]. Decreased access is associated with higher rates of hospitalisation[19] and increased mortality rates.[20]

The study of access during the current economic crisis deserves particular attention as it has been severely compromised by unprecedented limitations on health expenditure. Whereas Figure 4 does not show an outright decrease in expenditure, it shows a clear stagnation of its growth. As this stagnation coincides with an ageing population and the increasing health demands that this entails, as well as increased demand among the working population, this is tantamount to a significant cut in real expenditures. Understanding the mechanisms

[13] Eliason, M. & Storrie, D. (2009). Does Job Loss Shorten Life? *Journal of Human Resources*, 44(2), pp.277–302
[14] Gallo, W.T. et al., 2004. Involuntary job loss as a risk factor for subsequent myocardial infarction and stroke: ndings from the health and retirement survey. *American Journal of Industrial Medicine*, 45(5), pp.408–416
[15] Lee, S. et al. (2004). Prospective study of job insecurity and coronary heart disease in US women. *Annals of Epidemiology*, 14(1), pp.24–30
[16] Catalano, R. a, Satariano, W. a & Ciemins, E.L. (2003). Unemployment and the detection of early stage breast tumors among African Americans and non-Hispanic whites. , 13(1), pp.8–15
[17] Bruckner, T. (2008). Economic antecedents of prone infant sleep placement among black mothers. Annals of epidemiology, 18(9), pp.678–81. Available at: http://www.ncbi.nlm.nih.gov/pubmed/18794008
[18] Ayanian, J. et al. (1993). The relation between health insurance coverage and clinical outcomes among women with breast cancer. *The New England Journal of Medicine*, 329(5)
[19] Trivedi, A.N., Moloo, H. & Mor, V. (2010). Increased ambulatory care copayments and hospitalizations among the elderly. *The New England journal of medicine*, 362(4), pp.320–8. Available at: http://www.ncbi.nlm.nih.gov/pubmed/20107218
[20] Franks, P., Clancy, C. & Gold, M. (2003). Health Insurance and Mortality. *Journal of the American Medical Association*, 270, pp.737–741

underpinning decreased access will help target the causal steps susceptible to public policy intervention.

Figure 4:. Growth in health expenditure during the economic crisis

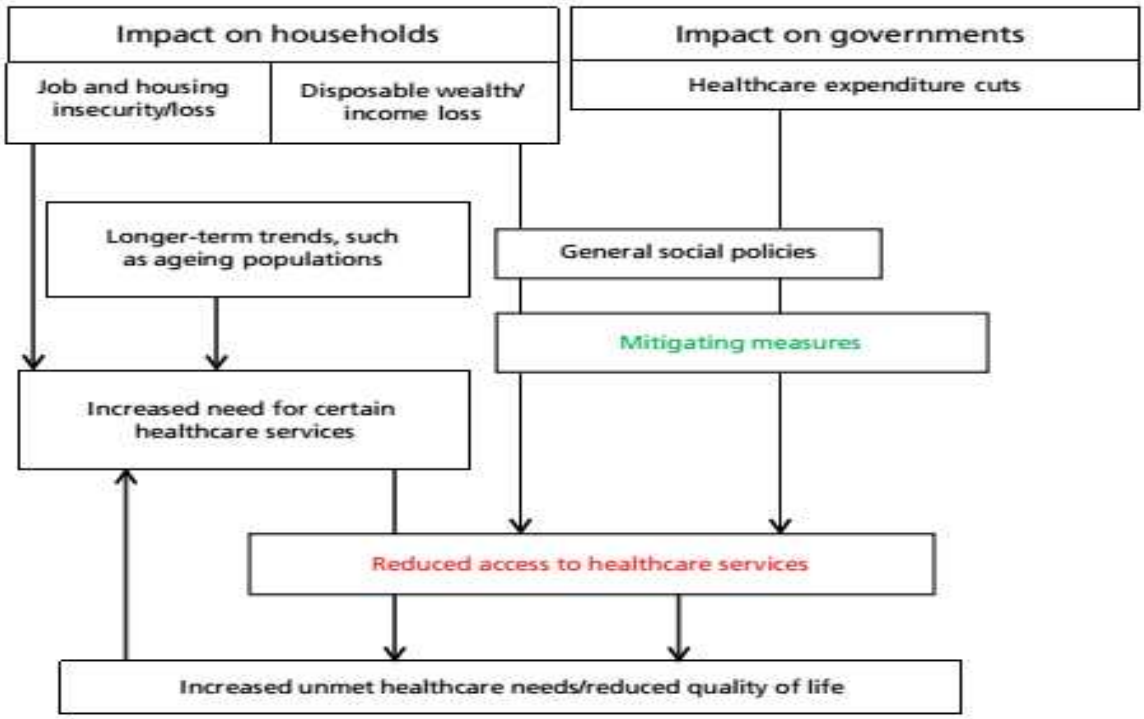


Source: OECD, OECD "Health, Austerity and Economic Crisis: Assessing the Short-term Impact in OECD countries", OECD Health Working Papers, No. 76, OECD Publishing.

Access to healthcare for the population in general and the unemployed in particular, can be compromised during a recession through mechanisms of demand and/or supply for healthcare. In the former, individuals and households decrease their demand for healthcare, sometimes despite increased need, because the cost of living may increase. For example, mortgage payments may go up, child benefits may decrease, or, in the case of unemployment, benefits may not be sufficient to cover household expenses leading people to postpone seeking healthcare. Arguably, in healthcare regimes that provide care free at the point of delivery, the reallocation of resources within the household budget should not impede seeking care; however, households still incur transportation and prescription drugs costs which may be prohibitive.

On the supply side, governments who have a reduced tax base and, in many cases, voluminous debt servicing obligations, may cut health budgets, a frequent target as they traditionally account for a relatively large share of GDP. Figure 5 illustrates these pathways.

Figure 5: Effects of the current recession on access to healthcare



Source: Adapted from Hou et al. 2013 p.10 by EUROFUND (2015)

Impact of the recession on access to healthcare: the role of governments

Governments across the EU have not only reduced overall spending on health but have simultaneously enacted policies to curb the consumption of health services. It is difficult to ascertain whether these policies reduce both necessary and superfluous health consumption to the same extent. According to a survey of policy instruments used to implement healthcare reform, healthcare policy responses to the economic crisis can be grouped in the following way[21]:

1. Changes to public finance (e.g. increase revenue through taxes/levies/premiums)
2. Reducing coverage (e.g. eligibility criteria for population groups , changes to the benefit basket or increases in co-payments);
3. Cutting the prices paid for publicly financed health care (e.g. cuts to the price of medical goods and salaries).

[21] Mladovsky, P. et al. (2012), Health policy responses to the financial crisis in Europe, Copenhagen: WHO/European Observatory on Health Systems and Policies.

4. Reducing the supply of services, through cuts in the number of facilities, beds or personnel.
5. Structural reforms aimed at changing the incentives in the system or price negotiations

It is beyond the scope of this report to provide an anthology of health reforms, therefore only a few illustrative examples of each type will be highlighted.

For the first category, an example would be the increase in VAT for medicines from 5% to 9% in Estonia, and by 1% in the Czech Republic, Finland, Portugal and Poland. The UK increased VAT on over-the-counter medication to 20%.[22]

Coverage reforms deserve special attention as preliminary evidence suggests they are hindering access in parts of the EU. For instance, the Czech Republic and Spain reduced public entitlements for undocumented migrants. In Spain, this led to public outcry and the decision to leave coverage for this group to the autonomous regional governments.[23] The same Royal Decree stipulated that coverage would be dropped for young people under 26 who have never entered the job market[24], which is particularly worrying in a country where youth unemployment reaches 50% in some regions. Similarly, post-financial crisis Greek health reform was rife with coverage changes, the most conspicuous of which being the reduction of access to healthcare for individuals who lost unemployment entitlements after the 12-month limit. This resulted in an estimated 100,000 persons losing coverage in 2013[25] and led to a surge of Greek citizens seeking care in free clinics operated by humanitarian organisations.[26]

Co-payments were the most contentious measure likely to have a direct effect on access. In some EU countries they were instated or increased for pharmaceuticals, in others for doctors' visits, while some did both. For pharmaceuticals, Austria and Belgium introduced automatic annual increases in co-payments, France decreased its reimbursement level from 35% to 30% in 2012, and Iceland increased co-payments for prescription drugs in 2010 and 2011.[27] Estonia introduced a 15% co-payment for inpatient nursing care[28], and Spain introduced income-

[22] Vogler, S. et al., (2011). Pharmaceutical policies in European countries in response to the global financial crisis. *Southern med review*, 4(2), pp.69–79. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3471176&tool=pmcentrez&rendertype=abstract
[23] Médecins du Monde (2012). *Access to Health Care for Vulnerable Groups in the European Union in 2012: An overview of the condition of persons excluded*, Brussels.
[24] Boletin Oficial del Estado (2012). *Real Decreto-ley 16/2012*, Madrid: JEFATURA DEL ESTADO. Available at: http://boe.es/boe/dias/2012/04/24/pdfs/BOE-A-2012-5403.pdf
[25] Gool, K. Van & Pearson, (2014)
[26] Andrew, J. & Hope, K. (2012). Greek crisis gets under skin of vulnerable. *The Financial Times*. Available at: http://www.ft.com/cms/s/0/d1cc3256-78c3-11e1-9f49-00144feab49a.html#axzz2BMGlIXV8
[27] Vogler, S. et al., (2011). pp.22–32
[28] Eurofound (2014) Access to healthcare in times of crisis, Dublin.

dependent co-payments for medicines, including for most pensioners albeit with limits depending on pension levels.[29] In Portugal, increased co-payments were prescribed in the Memorandum of Understanding with the so called Troika. The new rates had the explicit goal of deterring the 'abuse' of emergency care and nudging patients towards using primary care. However, the magnitude of the increase has made them potentially prohibitive.

Table 1: Evolution of co-payments for emergency and outpatient care in Portugal

	2007	2011	2012	2013	2014
Emergency care					
Central hospital	8.75	9.60	20.00	20.60	20.65
Primary care facility	3.40	3.80	10.00	10.30	10.35
Outpatient care					
Central hospital	4.30	4.60	7.50	7.75	7.75
Primary care facility	2.10	2.25	5.00	5.00	5.00

Source: (Rodrigues & Schulman 2014), page 4

The evidence on the effects of co-payments on health-seeking behaviour in Portugal is still inconclusive; while they did not pose a barrier to accessing the health system, they also did not affect utilisation of emergency services in tertiary care as had been originally intended.[30] Any decreases of usage, for both emergency and primary care, were similar among both exempt and non-exempt users.[31] This highlights the need for examining how the introduction of exemptions per se may not guarantee access if the accompanying deterioration of social conditions is not addressed. Even in countries where healthcare is free at the point of delivery, a recession and accompanying hardship may pose a cost challenge in terms of physically reaching providers and maintaining care thereafter.

Evidence from Portugal also suggests that despite the implementation of greater exemptions, there is a possibility that access remains problematic for the unemployed. In the pre-Troika era, the unemployed and beneficiaries of income support (*Rendimento Social de Inserção)* were automatically exempt. This exemption has now become means-tested and the overall number of exempted unemployed people has fallen from 207,438 in 2006 to 92,426 in 2014.[32] This raises concerns not only because unemployment rates have gone up substantially, but also because

[29] Gallo, P. & Gené-Badia, J. (2013). Cuts drive health system reforms in Spain. *Health Policy*, 113(1-2), pp.1–7. Available at: http://dx.doi.org/10.1016/j.healthpol.2013.06.016
[30] Pita Barros, P. et al., 2013. *Impacto das taxas moderadoras na utilização de serviços de saúde*, Lisbon
[31] Rodrigues, R. & Schulman, K., 2014. *Impacts of the crisis on access to healthcare services: Country Report on Portugal*, Vienna
[32] Rodrigues, R. & Schulman, K., 2014. *Impacts of the crisis on access to healthcare services: Country Report on Portugal*, Vienna

evidence from the period 2000-2005 found that even when the unemployed were exempted from paying co-payments, they were at higher risk of catastrophic healthcare expenditure, i.e. households forced into poverty as significant shares of their income go towards healthcare.[33] Ministry of Health data illustrates a decrease in primary healthcare consultations between 2012-2013, which has been attributed to the deteriorating financial condition of households; the greatest decrease occurred among those who, although exempted from co-payments, were unable to spend more on transportation and other costs.[34]

Reductions in availability of services also contribute to limiting access. Still in Portugal, growing numbers of people who could afford private insurance in the past are now returning to the national health service. This has the double disadvantage of delaying care for the individual due to longer waiting times, but also for others as the public system has to cope with a higher patient volume.[35] This has also been observed in Spain[36], Greece and in Cyprus[37]. In Portugal, another pernicious effect of public coverage retrenchment is that, following co-payment increases, private insurers can compete with the national health service on price.[38] As the number of cancellations of private health insurance plans goes up - a 17% decline was recorded in the first half of 2012 - there was also an increase in the uptake of new policies offering basic insurance packages with reduced coverage at lower premiums.[39] These may cost the same as those offered by the NHS but they do not include the same range of care options. A similar dynamic has also been described in Italy.[40]

In addition to the introduction of co-payments for services, reforms were also introduced for medicines. An extensive mapping of pharmaceutical policies enacted in response to the economic crisis found that changes were reported in 23 European countries.[41] Measures that can be implemented rather swiftly (e.g. price cuts, changes in co-payments and VAT rates on

[33] Kronenberg, C. & Barros, P.P. (2014). Catastrophic healthcare expenditure - Drivers and protection: The Portuguese case. *Health Policy*, 115(1), pp.44–51. Available at: http://dx.doi.org/10.1016/j.healthpol.2013.10.001
[34] Rodrigues, R. & Schulman (2014).
[35] Campos, A. (2012). Doentes esperam cada vez mais tempo por consultas nos hospitais. *Público*. Available at: http://www.publico.pt/sociedade/noticia/hospitais-publicos-estao-a-demorar-mais-tempo-nas-consultas-e-cirurgias-1552065
[36] OECD (2014). *Health at a Glance: Europe 2014*, Paris: OECD Publishing. Available at: http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2014_health_glance_eur-2014-en
[37] Dubois, H. & Molinuevo, D. (2013). *Impacts of the crisis on access to healthcare services in the EU*, Dublin
[38] Campos, A. (2015). Seguros são mais baratos do que ADSE para funcionários públicos solteiros e jovens. *Publico*. Available at: http://www.publico.pt/sociedade/noticia/descontos-dos-funcionarios-publicos-para-a-adse-duplicaram-em-cinco-anos-1689488
[39] Santos Gomes, A. (2012). Cartões ampliam acesso a saúde privada. *Vida Economica*. Available at: http://basededados.vidaeconomica.pt/users/0/39/Seguros_0914640a08faec3c4e4e5c7293f57ee5.pdf
[40] Eurofound (2014). *Access to healthcare in times of crisis*, Dublin
[41] Vogler, S. et al. (2011), pp.22–32

medicines) were most frequently used. While the 'crisis countries' (e.g. Baltic states, Greece, Spain) reacted with bundles of measures, reforms in other countries (e.g. Poland, Germany) were not directly linked to the crisis but still aimed at containing public spending. Despite the calls for close monitoring of the health and healthcare access effects of these policies, few studies have been conducted. One exception looked into the impacts of changes in pharmaceutical policies in psychotropic medicines in Finland and Portugal. Both countries successfully increased the market share of generics for a number of drugs used to treat mental health problems but, in some cases and despite the price reduction, there was a decrease in sales. This is being attributed to a possible decrease in access to needed treatment.[42]

Given the scarcity of health impact assessments of changes to pharmaceutical policies during the economic crisis, it is of relevance to examine the evidence gathered elsewhere.

It appears that the effects of prescription drug charges on access to healthcare differ according to whether these charges have the explicit goal to encourage the purchase of generic medicines or just to shift the cost to the patient. Information asymmetries in the purchase of health services lead to market failures in healthcare. The implication is that patients do not have the knowledge to make rational choices and consequently they may delay or outright forego treatment, thereby potentially damaging their health and incurring greater long-term expenditure, or even turning to free but more resource-intensive forms of care to avoid co-payments. Unless user chargers exempt high users of healthcare, they represent a de facto tax on people in poor health.[43]

A comprehensive review undertaken by the London School of Economics (LSE) examined whether prescription drug charges result in cost shifting from privately or publicly pooled pre-treatment to the consumer, concluding that there is a shift from third party payers onto patients. The review also looked found that, with very few exceptions, prescription drug charges are not only unlikely to lower overall health expenditure but they are also more likely to increase the use of highly resource-intensive services which substitute prescription drugs. Charges also lowered the use of essential and non-essential drugs indiscriminately, and poorer people are more likely to reduce medicines use when faced with higher prices. Finally there seem to be health effects

[42] Leopold, C. et al. (2014). Impact of pharmaceutical policy interventions on utilization of antipsychotic medicines in Finland and Portugal in times of economic recession: interrupted time series analyses. *International journal for equity in health*, 13(1), p.53. Available at: http://www.ncbi.nlm.nih.gov/pubmed/25062657

[43] Gemmill, M.C., Thomson, S. & Mossialos, E. (2008). What impact do prescription drug charges have on efficiency and equity? Evidence from high-income countries. International journal for equity in health, 7, p.12.

that reduced coverage leads to worsening of health indicators and even higher mortality in some groups of patients, more hospitalisations and lower treatment adherence.[44]

On the subject of cuts to the prices paid for publicly financed healthcare, some governments have introduced cuts to health workforce salaries: Greece, Ireland, Iceland and Estonia reduced wages of nurses and salaried GPs in response to the crisis. Portuguese overtime wage rates were cut in half. Greek health workers' salaries benefits were cut by €568 million. In Ireland, professional fees were reduced by 8% in 2009 and by a further 5% in 2010 and 2011. In Spain, salaries were cut by 5-7% for all civil servants in 2010, including most healthcare personnel.[45,46] Concerns about large scale migration of qualified health workers are widespread[47,48,49] especially in Southern and Eastern European Member States where their migration can be viewed as the equivalent of a subsidy to richer countries employing workers whose training has been paid for by governments elsewhere.[50] More importantly it leads to delays or unavailability of care altogether.

There is room to believe that the policy measures adopted to reduce costs in healthcare services and pharmaceuticals during the economic crisis compromise health systems' stated goals of equity. While total public health expenditure in health has decreased steadily since the onset of the crisis, out of pocket expenditure has increased just as steadily. Concerns about deteriorating health access and the creation of new vulnerable groups are not misplaced. The evidence suggests that public finance sources tend to have small positive redistributive effects and less differential treatment while private financing sources generally have larger negative redistributive effects which are to a substantial degree caused by differential treatment.[51] Two consecutive studies undertaken in the 1990s found that out-of-pocket payments are a highly regressive means of revenue, though the extent varies across countries based on differences in exemptions.[52] Furthermore, a study of inequalities in access to healthcare in OECD countries

[44] Ibid.
[45] European Federation of Nurses Associations (2012). Caring in Crisis: a Comparative Overview of 34 Countries European, Brussels.
[46] Gool, K. Van & Pearson, M. (2014). *Health , Austerity and Economic Crisis: Assessing the Short Term IMpact in OECD Countries*, Paris
[47] Sevillano, E. & Sahuquillo, M.R. (2013). Entre la precariedad y la emigración. *El Pais*. Available at: http://sociedad.elpais.com/sociedad/2013/06/01/actualidad/1370110531_661956.html
[48] OPSS (2012). *Relatorio de Primavera 2012*, Lisbon.
[49] See also the 'Health Workers for All' (HW4All) project and Call to Action, www.healthworkers4all.eu/
[50] Rimmer, A. (2014). Shortage of doctors across Europe may be caused by migration to UK. *British Medical Journal*. Available at: http://careers.bmj.com/careers/advice/view-article.html?id=20019362
[51] Van Doorslaer, E. et al. (1999). The redistributive effect of health care finance in twelve OECD countries. *Journal of Health Economics*, 18(3), pp.291–313.
[52] Wagstaff, A. et al. (1999). Equity in the finance of health care: some further international comparisons. *Journal of health economics*, 18(3), pp.263–90. Available at:

found that, although general practitioner care is distributed fairly equally, the pro-rich distribution of specialist care impacts on total doctor utilisation; this is reinforced when private insurance or care options are offered.[53]

Impact of the recession on access to healthcare: the role of households and individuals

As highlighted above, retrenchment of public expenditure on healthcare is only one pathway through which access to healthcare can be reduced during an economic crisis. The remainder of this section will be dedicated to exploring the second pathway, that of reduced individual and household resources for health.

Eurofound, the European Foundation for the Improvement of Living and Working Conditions, collected case studies from crisis affected countries documenting the increased financial barriers families and individuals are facing when accessing healthcare. They call for a systematic analysis of the role played by financial hardship, and more importantly for a study of the buffering effect of social protection mechanisms. Even where the nearest healthcare service remained open without budget cuts, people have experienced reduced accessibility due to decreased public investment in transportation – resulting in reduced frequency and increased prices of both public and private services, and reduced transport subsidies for chronic patients and the disabled.[54] Where healthcare institutions were closed, like in Romania where 67 public hospitals (about 15% of the country's public hospitals) in rural areas were shut down in 2011, people with reduced mobility and unable to pay for travelling the additional distance became more vulnerable to poor healthcare access.[55] Another important factor is reduced disposable income in order to purchase health insurance, particularly in countries with social health insurance systems. In Romania, Greece and Slovenia, unemployment led to a loss of insurance coverage for certain groups not entitled to free insurance under exemption rules. In Romania, where insurance coverage is triggered by receipt of certain social benefits, loss of benefits has left many uninsured including Roma communities. In Greece and Slovenia, those with debts owed to public bodies or health insurers are not eligible for insurance protection. In Bulgaria, the number of the uninsured has increased during the crisis due to a combination of increased

http://www.sciencedirect.com/science/article/pii/S0167629698000447\nhttp://www.ncbi.nlm.nih.gov/pubmed/10537896

[53] Van Doorslaer, E., Masseria, C. & Koolman, X. (2006). Inequalities in access to medical care by income in developed countries. *Cmaj*, 174(2), pp.177–183

[54] Dubois & Molinuevo (2013).

[55] Eurofound (2014)

unemployment and reduced disposable income for insurance payments among those not entitled to free premiums.[56]

In the peer reviewed literature there is also increased work illustrating the effects of the current crisis on health, as well as on the role of financial strain in the relationship between unemployment and losing access to healthcare.

In Greece, individuals who became unemployed following the introduction of austerity measures were 1.61 times more likely to experience a health decline than those remaining in employment.[57] This begs the question of what social and economic determinants are involved in the pathway connecting unemployment and ill health. The Greek context is particularly illustrative as both unemployment protection *and* health coverage have suffered as a consequence of public expenditure cuts.

Still on the subject of factors triggering loss of access, a recent Portuguese study found that adherence to treatment is being compromised by financial constraints. More than one fifth of chronic medication users reported failing to purchase prescribed medicines (22.8 %) and more than 50 % reported purchasing them but not taking them as prescribed. The existence of spare medicines and financial constraints were the two most frequent reasons cited for non-adherence.[58] A Greek study found that, while there is no decrease yet in immunization among the uninsured, and poor adherence to immunization plans of children is mainly associated with parents' socio-economic status, the evolution of healthcare coverage may compromise vaccination in the near future.[59] Médecins du Monde already vaccinated thousands of children of uninsured parents in their free clinics.[60] The fact that coverage in Greece is tied to employment re-emphasises the need for a systematic study of the effects of unemployment on access.

Studying financial barriers to accessing other determinants of health may also shed some light on their role in deterring care. In the US, unemployment has been associated with reduced

[56] Ibid.
[57] Barlow et al (2015), Austerity, precariousness, and the health status of Greek labour market participants: Retrospective cohort analysis of employed and unemployed persons in 2008–2009 and 2010–2011. Available at: http://dx.doi.org/10.1057/jphp.2015.25
[58] Costa, F.A. da et al. (2015). Primary non-adherence in Portugal: findings and implications. International Journal of Clinical Pharmacy.
[59] Vassiliki, P. et al. (2014). Determinants of vaccination coverage and adherence to the Greek national immunization program among infants aged 2-24 months at the beginning of the economic crisis (2009-2011). BMC public health, 14(1), p.1192. Available at: http://www.biomedcentral.com/1471-2458/14/1192
[60] Médecins du Monde (2014). Access to vaccination for groups facing multiple vulnerability factors in Europe. Available at: http://eiw.euro.who.int/profiles/blogs/access-to-vaccination-for-groups-facing-multiple-vulnerability

consumption of fruits and vegetables and increased intake of snacks and fast food. Among people at highest risk of unemployment, a 1% increase in the resident state's unemployment rate is associated with a 3 to 6% reduction in consumption of fruits and vegetables. Reduced family income and adverse mental health were cited as significant channels underlying the procyclical nature of healthy food consumption.[61] In the UK, the unprecedented rise in the number of local authorities with food banks (from 29 in 2009-10 to 251 in 2013-14) has been associated with cuts to local authority and central welfare spending; food banks are being used most frequently in places with the highest rates of unemployment, coupled with sanctioning of social benefits and cuts in central welfare spending.[62] It is plausible that individuals who cannot afford food are also unable to bear the costs associated with seeking healthcare and maintaining health.

So are hardship and decreased access to healthcare inevitable outcomes of the economic crisis? And if not, what can be done to prevent loss of access?

Ways forward: the case for universalism

The evidence suggests that the association between unemployment and declining health indicators is fragile. Social protection can break this association; a US study found that every US$10 increase of investment in labour market programmes reduces the effect of unemployment on suicides by 0.038%.[63] In the same vein, a study undertaken in 26 EU countries revealed that levels of absolute and relative social inequality in sickness are lower in countries with more comprehensive social policies. Active labour market programmes and generous benefits were clearly associated with lower levels of sickness and sickness inequalities.[64] These macro level findings are supported by individual level data showing that

[61] Dave, D.M. & Kelly, I.R. (2012). How does the business cycle affect eating habits? *Social Science and Medicine*, 74(2), pp.254–262.
[62] Loopstra, R. et al. (2015). Austerity, sanctions, and the rise of food banks in the UK. *Bmj*, 350(apr08 9), pp.h1775–h1775. Available at: http://www.bmj.com/cgi/doi/10.1136/bmj.h1775
[63] Stuckler, D. et al. (2009). The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. *Lancet*, 374(9686), pp.315–23. Available at: http://www.ncbi.nlm.nih.gov/pubmed/19589588
[64] Van der Wel, K. a., Dahl, E. & Thielen, K. (2011). Social inequalities in "sickness": European welfare states and non-employment among the chronically ill. *Social Science and Medicine*, 73(11), pp.1608–1617. Available at: http://dx.doi.org/10.1016/j.socscimed.2011.09.012

active labour market programs in Finland had protective effects on the mental health toll of unemployment.[65]

These findings are of great importance in finding solutions for the large-scale loss of access. Europe appears to be progressively moving from what once was a universal system with wide coverage to systems where sections of the population are excluded from the scope of publicly available services.

The vast majority of studies, however, find that universal, comprehensive welfare regimes deliver better health indicators at the population level. The points below provide the empirical evidence of improved access to healthcare and health outcomes for children, women, the elderly and oral health in welfare regimes with an egalitarian, comprehensive and universally minded approach.

- Countries with universal social policies, for instance the Northern European countries have much lower poverty rates than countries that opt for residual and targeted social policies, such as for instance the UK. Moreover the Nordic countries in particular have low poverty rates among vulnerable groups like children, single parents and elderly people[66]
- Family policies providing for comprehensive, earnings-related parental leave benefits, universal child benefits and childcare support are associated with lower infant mortality: an increase by one percentage point of "dual earner support" lowers infant mortality by 0.04 deaths per 1000 births. Targeted family policies do not show such an association[67]
- Similarly, a study of the impact of welfare characteristics on infant mortality rate, under five mortality rates and low birth weight found that the strongest predictor of these three population health indicators was the percentage of the population benefitting from public medical coverage. Factors associated with the generosity of the welfare state also explained inter-country variability in the first two indicators[68]

[65] Vuori, J. et al. (2002). The Työhön Job Search Program in Finland: Benefits for the unemployed with risk of depression or discouragement. *Journal of Occupational Health Psychology*, 7(1), pp.5–19. Available at: http://doi.apa.org/getdoi.cfm?doi=10.1037/1076-8998.7.1.5

[66] Ferrarini, T. (2006). *Families, statesand labour markets. Institutions causes and consequences of familiy policy in post war welfare states.*, Cheltenham: Elgar, Edward.

[67] Lundberg, O. et al. (2008). The role of welfare state principles and generosity in social policy programmes for public health: an international comparative study. *Lancet*, 372(9650), pp.1633–40. Available at: http://www.ncbi.nlm.nih.gov/pubmed/18994660

[68] Chung, H. & Muntaner, C.C. (2006). Political and welfare state determinants of infant and child health indicators: an analysis of wealthy countries. *Social Science & Medicine*, 63(3), pp.829–842. Available at: http://www.ncbi.nlm.nih.gov/pubmed/16574291

- Generosity in retirement pensions has been associated with a decrease in old age excess mortality[69]
- A cross-national analysis across different European welfare regimes found that countries with more redistributive and universal welfare policies had better population oral health in several indicators of oral health quality[70]

Conclusions and policy recommendations

Based on the findings of this report, EPHA proposes the following recommendations to policymakers working at national and European level in order to realise the goal of universal access to healthcare:

- EPHA calls on governments to reverse the trend favouring means tested health and social benefits and redirect their effort to the universality of their health systems
- EPHA also advocate for health systems that are free at the point of delivery, and for putting an end to co-payments
- There is a need to coordinate health policy decisions with broader social policy, including unemployment benefits, old age pensions and child benefits
- EPHA calls on the academic community to document the comparative advantages of universal healthcare systems versus means-tested models, namely the cost effectiveness of one versus the other.
- The European Commission should ensure proper assessments of the health and health system impacts of non-health policies, especially economic and fiscal
- The European Semester process should focus more on prevention and health-relevant taxes in order to generate revenue for public health measures in support of achieving universal access to healthcare
- The European Structural and Investment Fund should devote more resources towards improving living conditions of society's most vulnerable across Europe – demonstrating concrete improvements should be mandatory for Member States as part of the reporting process

[69] Lundberg et al. (2008)
[70] Guarnizo-Herreno, C., Tsakos, G. & Watt, R. (2013). Oral health and welfare state regimes: a cross national analyisis of European countries. *European Journal of Oral Sciences*, 121, pp.169–175.

- The European Commission should support the implementation of EU-wide health system performance assessments (HSPA), which should take into account qualitative indicators including access to healthcare and health equity
- Health Technology Assessment should be used consistently in order to support evidence-based policy decisions on health and to facilitate access
- New innovation models should be introduced in order to de-link research & development costs from the price of medicines
- The EU's joint procurement mechanism should be expanded and act as a solidarity tool that should also include medicines other than pandemic vaccines and medical countermeasures for infectious diseases to ensure equal access to quality medicines for economically weaker Member States
- An EU solidarity fund for basic primary care should be set up in order to alleviate the access obstacles faced by destitute and vulnerable EU citizens and provide for migrants without legal rights to access healthcare, which could also function in a cross-border healthcare context[71]
- EU Institutions and WHO should collaborate to increase awareness of, and implement, the Sustainable Development Goals' health targets

[71] See also the EPHA report on the implementation of the Cross-border Healthcare Directive, http://www.epha.org/a/6439