EXPERT PANEL ON EFFECTIVE WAYS OF INVESTING IN HEALTH

(EXPH)

Access to health services in the European Union

The EXPH approved this opinion for public consultation by written procedure
on 25 September 2015

About the Expert Panel on effective ways of investing in Health (EXPH)

Sound and timely scientific advice is an essential requirement for the Commission to pursue modern, responsive and sustainable health systems. To this end, the Commission has set up a multidisciplinary and independent Expert Panel which provides advice on effective ways of investing in health (Commission Decision 2012/C 198/06).

The core element of the Expert Panel's mission is to provide the Commission with sound and independent advice in the form of opinions in response to questions (mandates) submitted by the Commission on matters related to health care modernisation, responsiveness, and sustainability. The advice does not bind the Commission.

The areas of competence of the Expert Panel include, and are not limited to, primary care, hospital care, pharmaceuticals, research and development, prevention and promotion, links with the social protection sector, cross-border issues, system financing, information systems and patient registers, health inequalities, etc.

Expert Panel members

Pedro Barros, Margaret Barry, Helmut Brand, Werner Brouwer, Jan De Maeseneer (Chair), Bengt Jönsson (Vice-Chair), Fernando Lamata, Lasse Lehtonen, Dorjan Marušič, Martin McKee, Walter Ricciardi, Sarah Thomson

Contact

European Commission
DG Health & Food Safety
Directorate D: Health Products and Systems
Unit D3 – eHealth and Health Technology Assessment
Office: B232 B-1049 Brussels

SANTE-EXPERT-PANEL@ec.europa.eu

ACKNOWLEDGMENTS

Members of the Working Group are acknowledged for their valuable contribution to this opinion.

The members of the Working Group are:

Expert Panel members
Professor Pedro Barros
Professor Margaret Barry
Professor Werner Brouwer
Professor Jan De Maeseneer (Chair)
Dr Fernando Lamata
Professor Lasse Lehtonen
Professor Martin McKee
Dr Sarah Thomson (Rapporteur)

External experts
Dr Michele Cecchini
Professor Sara Willems

The declarations of the Working Group members are available at:
http://ec.europa.eu/health/expert_panel/experts/working_groups/index_en.htm

The Working Group would like to thank Pooja Yerramili and Jens Detollenaere for their help in preparing some of the figures.

ABSTRACT

Access is a critical component of universal health coverage. The 28 Member States of the European Union (EU) have a clear mandate to ensure equitable access to health services for everyone living in their countries. This does not mean making everything available to everyone at all times. Rather, it means addressing unmet need for health care by ensuring that the resources required to deliver relevant, appropriate and cost-effective health services are as closely matched to need as possible.

Between 2005 and 2009, EU Member States made huge progress in improving access to health care. The number of people reporting unmet need fell steadily from 24 million in 2005 to 15 million in 2009. Since 2009, however, this positive trend has been reversed – a visible sign of the damage caused by the financial and economic crisis. By 2013, the number of people reporting unmet need for health care had risen to 18 million (3.6% of the population).

Access is multi-dimensional. Barriers to access can be found at the level of individuals, health service providers and the health system. Access is also affected by public policy beyond the health system – especially fiscal policy, but also social protection, education, transport and regional development policy. Survey data suggest that financial barriers are the largest single driver of unmet need in the European Union.

This report aims to highlight key access problems and policy responses in EU health systems. It is structured around eight policy areas: financial resources linked to health need; services affordable for everyone; relevant, appropriate and cost-effective services; well-equipped facilities within easy reach; staff with the right skills in the right place; quality medicines and medical devices available at fair prices; everyone can use services when they need them; services acceptable to everyone. The report includes a focus on three groups of people who are systematically underserved in the European Union: Roma, undocumented migrants and people with mental health problems. A final section of the report discusses the roles and responsibilities of the European Union and its Member States in ensuring equitable access to health services. In particular, it emphasises the need for a new generation of data collection for effective, accessible, resilient and accountable health systems.

The report calls for *better monitoring* to identify the magnitude of access problems in a timely manner, to measure changes over time and across groups of people and to enhance international comparability. The ability to disaggregate data at sub-national level and by sub-groups in the population is essential. The report also calls for *more policy analysis* to enable a deeper understanding of the causes of access problems and to identify cost-effective policy responses, underpinned by *research targeting hard to reach groups of people*. Policy responses should reflect the multi-dimensional nature of access problems, the importance of intersectoral action and the specifics of national and regional context.

Keywords: EXPH, Expert Panel on effective ways of investing in Health, scientific opinion, access to health services

Opinion to be cited as: Expert Panel on effective ways of investing in Health (EXPH), Preliminary Report on Access to Health Services in the European Union, 25 September 2015

ISSN 2315-1404 ISBN 978-92-79-48150-5
doi:10.2875/777023 EW-BA-15-003-EN-N

http://ec.europa.eu/health/expert_panel/index_en.htm

NOTE TO THE READER

Each chapter in this report begins with a summary of the chapter's main points.

[This page intentionally left blank]

TABLE OF CONTENTS

TERMS OF REFERENCE

The Expert Panel on Effective ways of Investing in Health (EXPH) is requested to give its views on options for action to improve equity of access to health services in the EU. In particular, the Expert Panel is requested to provide its assessment on the following points:

1. Overall impact of poor access

How do limitations and variations in access to health care affect EU health systems and the broader economy?

2. Measuring and monitoring

Which groups of people are most likely to suffer from limited access to health care? Can the Expert Panel provide a taxonomy of these groups, highlighting the main mechanisms of exclusion? What can policy makers, professional and patients' associations, and other stakeholders do to identify in a timely way problems in access to health care, including those affecting the most vulnerable population groups, and to reduce inequities in access to health services? Which monitoring tools are already in place and which tools could be developed?

3. Acceptable variations

How can the limits of acceptable variation in health care access within and across Member States be defined?

4. Policy measures

How can the main barriers to access be overcome? Which tools can be used to tackle unmet need for health care and unwarranted variation? What role can the financing of the system, legislative tools or best-practice sharing play? With regard to this point, the opinion of the Expert Panel should focus on general policies and actions which can be taken at health system and health service level. Additionally, the Expert Panel is requested to reflect on how the added-value of EU action on access to health care may be maximised.

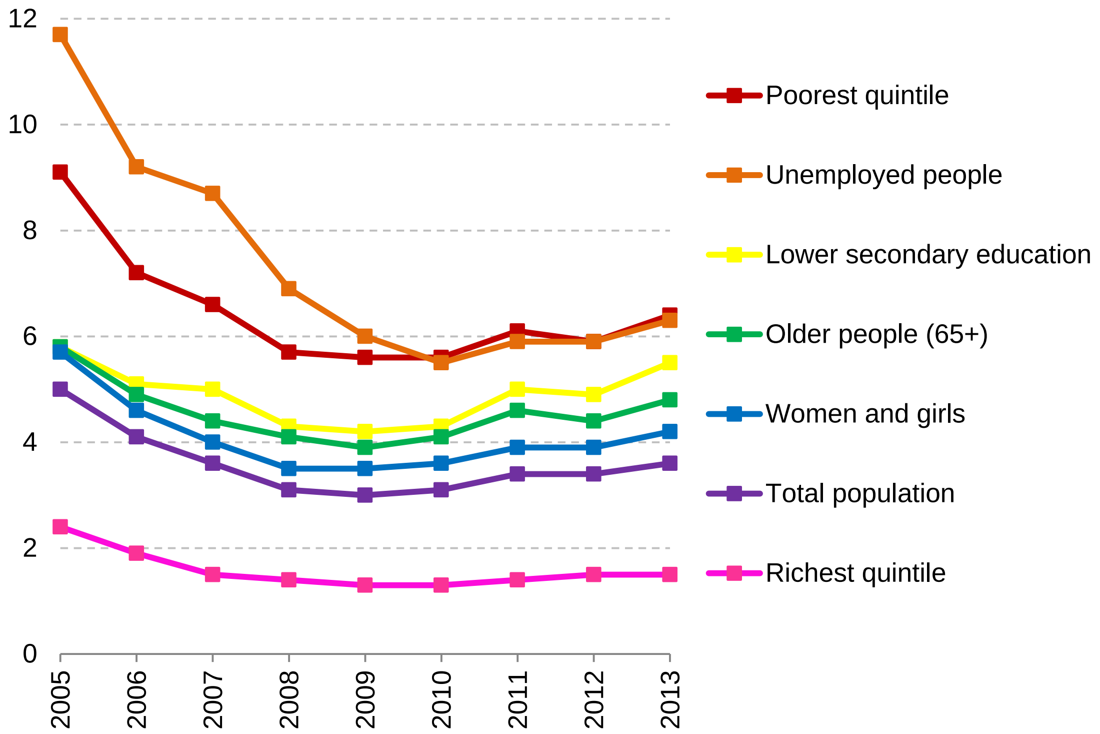
An introduction to access to health services in the European Union

Chapter summary

Access is a critical component of universal health coverage. The 28 Member States of the European Union (EU) have a clear mandate to ensure equitable access to health services for everyone living in their countries. This does not mean making everything available to everyone at all times. Rather, it means addressing unmet need for health care by ensuring that the resources required to deliver relevant, appropriate and cost-effective health services are as closely matched to need as possible.

Survey data indicate that in 2013 around 18 million people living in the European Union experienced unmet need for health care (3.6% of the population). Between 2005 and 2009, Member States made huge progress in improving access to health care: the number of people experiencing unmet need fell from 24 million in 2005 (5%) to 15 million in 2009 (3%). This positive trend has been reversed since 2009 – a very visible sign of the damage caused by the financial and economic crisis.

Share (%) of the population reporting unmet need for health care due to cost, travel distance and waiting time, EU27, 2005-2013



Source: Authors based on EU-SILC (2015)

Note: Lower secondary education refers to people who did not complete their secondary education.

Access is a multi-dimensional issue. Barriers to access can be found at the level of individuals, health service providers and the health system. Access is also affected by public policy beyond the health system – especially fiscal policy, but also social protection, education, transport and regional development policy.

Survey data suggest that financial barriers to access are the largest single driver of unmet need in the European Union. The figure above shows how unmet need disproportionately affects people of lower socio-economic status, older people and women and girls, although the precise composition of the worst-affected groups varies across countries. The Annex provides details of unmet need by country and over time for all 28 Member States.

If policy makers responsible for the health system are to avoid or overcome barriers to access and to promote equity in service use, they need to take action in many areas, as highlighted in the figure below. Policy responses should reflect the multi-dimensional nature of access problems, the importance of intersectoral action and the specifics of national and regional context.

The following chapters discuss these eight policy areas in turn, using a common template. A further chapter focuses on issues and policy responses in relation to three groups of people who are systematically underserved in the European Union: Roma, undocumented migrants and people with mental health problems. A final chapter discusses the roles and responsibilities of the European Union and its Member States in ensuring equitable access to health services; focuses on the need for a new generation of data collection for effective, accessible, resilient and accountable health systems; summarises policy responses identified in previous chapters; and comments on the challenges and opportunities these actions entail.

Factors affecting equitable access to health services

Source: Authors

What is access?

In 2006, the Council of Health Ministers in the European Union (EU) agreed common values and principles for EU health systems: universality, access to good quality care, equity and solidarity (OJEU 2006: 2). The Council defined these terms as follows:

> Universality means that no one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay.

Article 35 of the Charter of Fundamental Rights, which has been legally binding on the European Union since 2009 (European Union 2010), states that:

> Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities'.

These documents commit EU Member States to promote access to health services by:

- reducing the gap between a person's need for health care and their use of health services; that is, addressing unmet need

- ensuring people do not experience financial hardship when using health services; having to pay for health care at a given point in time may mean people do not have money to pay for other essentials or on health care in the future

- ensuring health services are provided in a way that is responsive to people's needs and expectations; a poor user experience at a given point in time may prevent people from using services in the future

- ensuring health services are effective enough to improve health, because access is instrumental to health improvement, and cost-effective, because resources for health care are limited

- ensuring equity in all of the above

Personal preferences may result in legitimate differences in demand and, ultimately, use for a given level of need. For this reason, health systems generally aim to promote equity of access to health services, as opposed to equity in the use of health services.

Promoting equitable access to health care does not mean making everything available to everyone at all times. Rather, it means addressing unmet need for health care by ensuring that the resources required to deliver relevant, appropriate and cost-effective health services – financial and human resources, facilities and interventions – are as closely matched to need as possible. Access is a critical component of universal health coverage (WHO 2010).

This report focuses on formal care, but the availability of informal care is an important issue that deserves further policy attention (see Annex 1).

Why does access matter?

Access to health services should be a matter of concern for the European Union as a whole, and for each of the Member States, for four main reasons. First, extensive evidence shows how access to effective health care by those in need improves health, prolongs life and prevents suffering. Health is therefore a major determinant of welfare. We know, for example, that there have been substantial reductions in deaths from causes amenable to health care in all Member States in recent decades, although there are considerable differences in what each Member State has achieved (Nolte and McKee 2011).

Second, there is also evidence that better health drives economic growth, greater labour force participation and higher productivity (Figueras and McKee 2011). This is recognised in the European Union's inclusion of the theme 'health is wealth' in its public health strategy, as well as the endorsement by all Member States in 2008 of the World Health Organization's Tallinn Charter (WHO 2008).

Third, persistent inequalities in health within the European Union (Mackenbach et al 2008) conflict with the right to health enshrined in the Charter and with the EU Treaty objective of ensuring 'the development of human resources with a view to lasting high employment and the combating of exclusion' (European Union 2008).

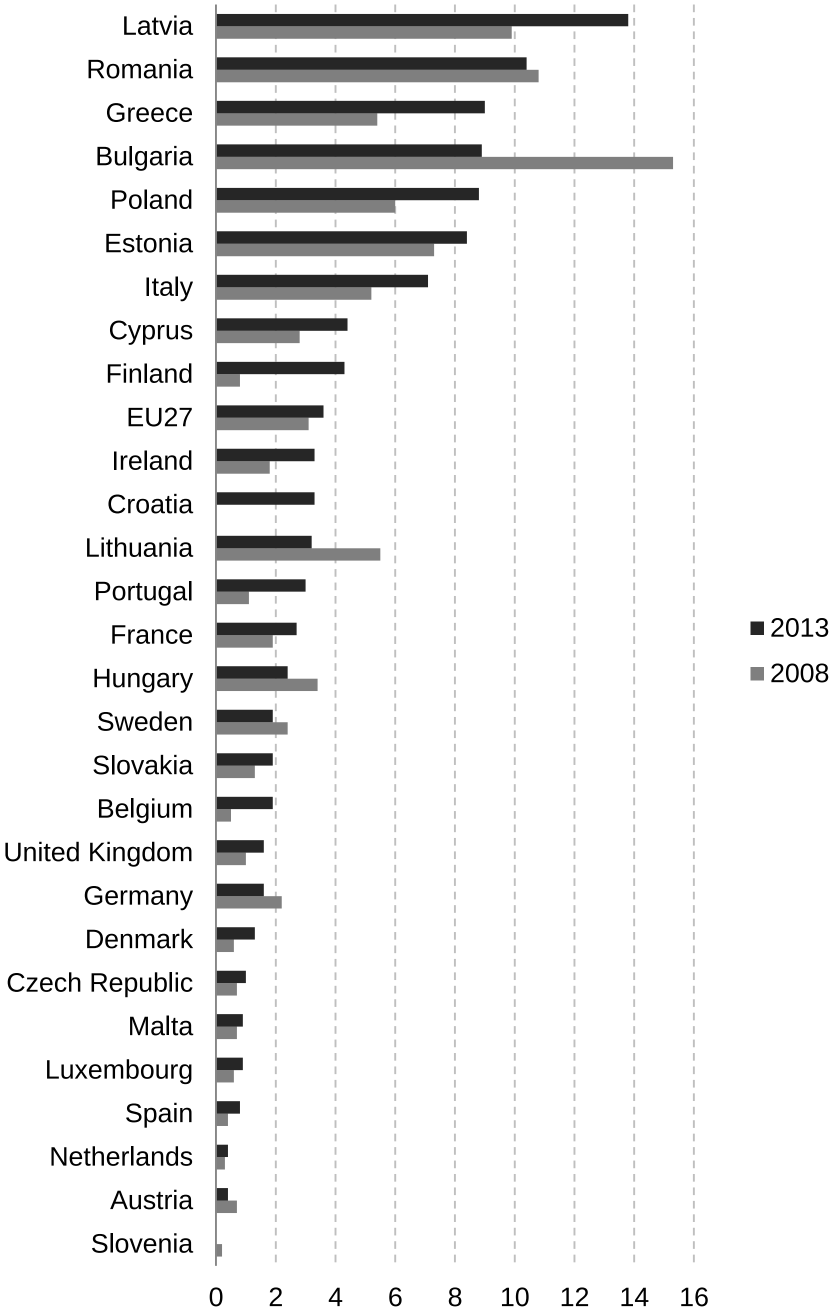
Fourth, survey data routinely collected by the European Union provide evidence of significant variation in unmet need for health care – a major indicator of lack of access – across and within EU Member States. Inadequate access to needed health services affects millions of people across the European Union. These numbers have grown substantially since 2009.

Evidence of variation in unmet need for health care

Health need has been defined as the ability to benefit from health care. This implies that there is information on the presence of a health problem and the existence of a corresponding treatment. It also implies that there is a defined threshold above which treatment is appropriate. In practice, this type of information is not readily available outside surveys undertaken for research purposes, such as those that have looked at the need for hip replacement (Wilcock 1979) or treatment for prostatic enlargement (Hunter et al 1995). Given the challenges of undertaking such studies on a large scale, social surveys typically use a question that seeks to elicit self-reported unmet need, asking respondents whether they were unable to obtain health care when they believed it to be medically necessary. The main source of such data within the European Union is the European Union Survey on Income and Living Conditions (EU-SILC), undertaken annually in all EU Member States since 2005 (see Arora et al 2015 for an overview of this data source).

Figure I.1 shows how the level of self-reported unmet need for health care varies across EU Member States. Most of these data are consistent with other evidence on health system performance, but some are less easily explicable, such as the very low figure for Slovenia. This suggests a need for caution when comparing across countries and additional research to understand how the survey question is understood by different people. The data do, however, present a useful picture of changes over time. Data for each country can be found in Annex 2.

Figure I.1 Share (%) of people reporting unmet need for health care due to cost, travel distance and waiting time, EU28, 2008 and 2013

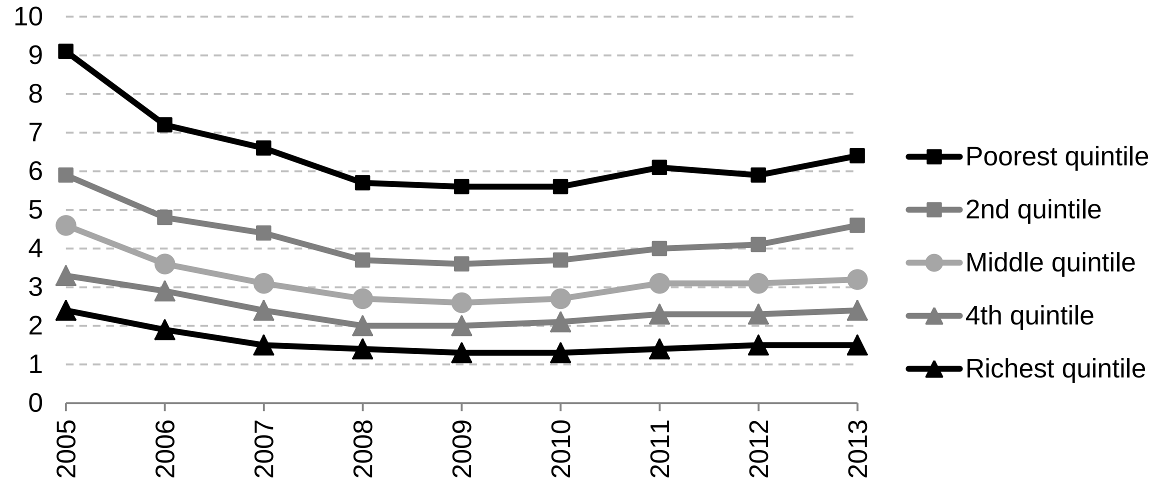


Source: Authors based on EU-SILC (2015)

Note: In Slovenia, in 2013, 0.1% of the population experienced unmet need for 'other reasons'.

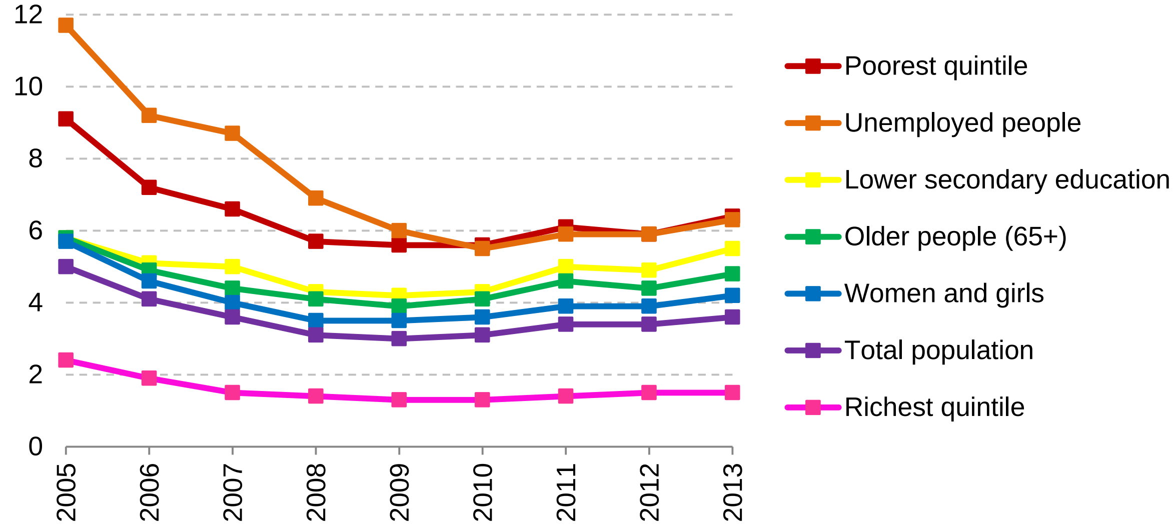
Figures 1.2, 1.3 and 1.4 show how unmet differs among different groups of people. Poorer people experience much higher levels of unmet need than richer people. The gap between the richest and poorest quintiles had narrowed before the crisis, mainly due to a reduction in unmet need among the poorest quintile (3.5 percentage points between 2005 and 2010), but began to grow again in 2011 (Figure I.2). In comparison to the population as a whole, unmet need is also higher among unemployed people, older people, girls and women and people who did not complete their secondary education (Figure I.3).

Figure I.2 Share (%) of people reporting unmet need for health care due to cost, travel distance and waiting time by income group, EU27, 2005-2013



Source: Authors based on EU-SILC (2015)

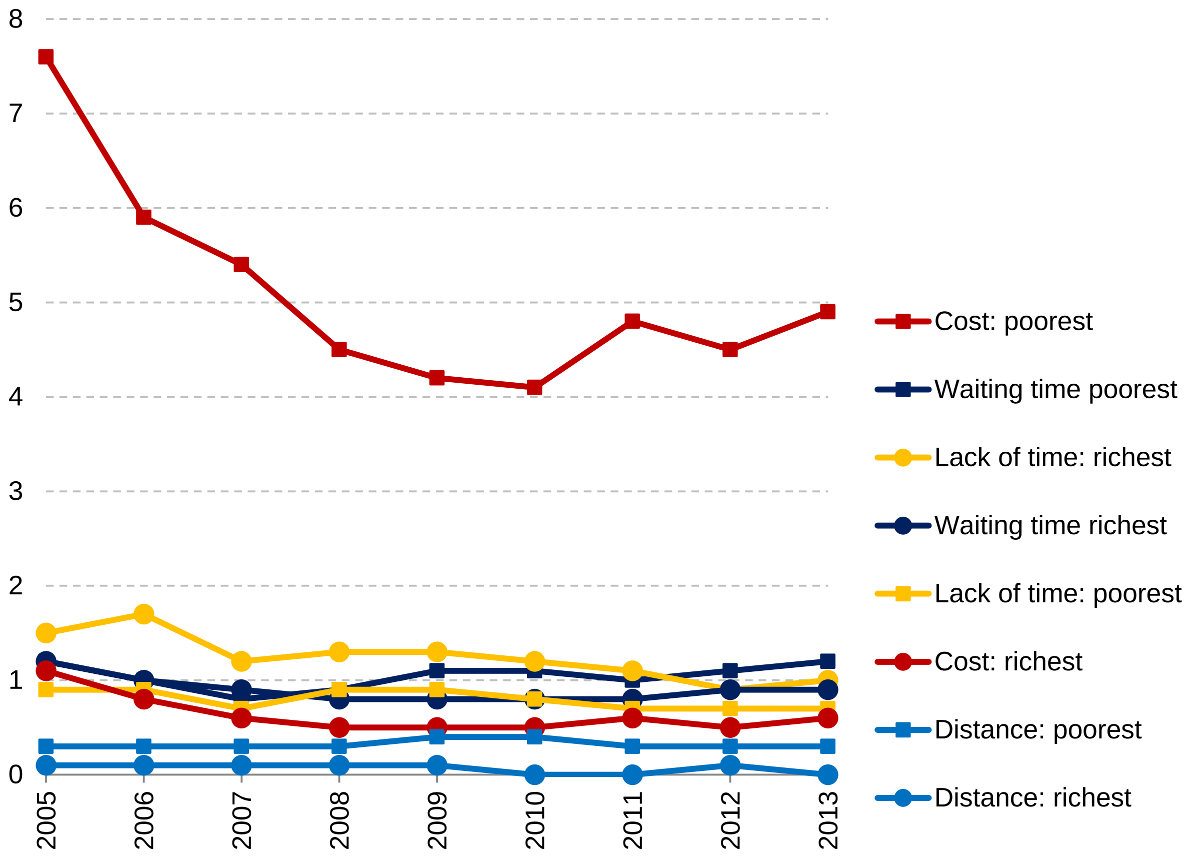
Figure I.3 Share (%) of people reporting unmet need for health care due to cost, travel distance and waiting time by income, age, gender, education and employment status, EU27, 2005-2013



Source: Authors based on EU-SILC (2015)
Note: Lower secondary education refers to people who did not complete their secondary education.

Figure I.4 shows how cost is by far the most important determinant of unmet need among poorer people. It is also the aspect of unmet need that has risen most sharply in recent years.

Figure I.4 Share (%) of people reporting unmet need for health care due to cost, travel distance, waiting time and lack of time, poorest and richest quintiles, EU27, 2005-2013



Source: Authors based on EU-SILC (2015)

The crisis has reversed a downward trend in unmet need

All of these figures indicate changes in unmet need over time. Between 2005 and 2009, unmet need fell by two percentage points across the European Union as a whole, from 5.0% to 3.0%. From 2009, unmet need began to grow again, reaching 3.6% in 2013. This notable change in trend coincided with the onset of the financial and economic crisis and the introduction of austerity measures in many countries, often including a reduction in public spending on health and other forms of social protection

A recent study of the implications of rising unmet need looked at two counterfactual scenarios (Reeves et al 2015). The first was conservative, assuming that, in the absence of austerity measures, levels of unmet need would have plateaued after 2010, resulting in an additional 1.5 million people facing unmet need in 2013 in comparison to 2008. The second scenario assumed that unmet need would have continued to decline at the earlier rate, in which case the equivalent figure facing additional unmet need would be 7.3 million people. In both scenarios, the increase in unmet need was approximately six times larger among people in the poorest quintile compared to the richest quintile.

Several studies have documented health policy responses to the crisis in Europe and the impact of the crisis on health and health systems (see, for example, Stuckler and Basu 2013, Eurofound 2014, Lamata and Oñorbe 2014, Thomson et al 2014, Maresso et al 2015, Thomson et al 2015). Although there are still unanswered questions about the mechanisms leading to rising unmet need, these may include health system factors such as changes to entitlement to publicly financed health services, higher user charges, the de-listing of some publicly financed benefits, large and sustained cuts in public spending on health, the closure of facilities and reduced opening hours. For example, public spending on health per person was lower in 2013 than it had been in 2008 in eight EU Member States (Croatia, Greece, Ireland, Italy, Latvia, Portugal, Spain and Slovenia); five countries reported reducing entitlement to publicly financed health services for relatively vulnerable groups of people in response to the crisis (Cyprus, the Czech Republic, Ireland, Spain and Slovenia); and twelve countries reported increasing user charges in response to the crisis (Thomson et al 2015).

Non-health systems factors are also highly likely to have played a part, especially rising unemployment and reduced incomes. Table I.1 shows how the share of the population at risk of poverty or social exclusion has increased steadily in the last few years in every EU country except Poland.

Table I.1 The share (%) of the population at risk of poverty or social exclusion, EU28, 2005-2014

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Germany	18.4	20.2	20.6	20.1	20.0	19.7	19.9	19.6	20.3	
Slovenia	18.5	17.1	17.1	18.5	17.1	18.3	19.3	19.6	20.4	
Malta	20.5	19.5	19.7	20.1	20.3	21.2	22.1	23.1	24.0	
Sweden	14.4	16.3	13.9	14.9	15.9	15.0	16.1	15.6	16.4	
Austria	17.4	17.8	16.7	20.6	19.1	18.9	19.2	18.5	18.8	19.2
Ireland	25.0	23.3	23.1	23.7	25.7	27.3	29.4	30.0	29.5	
Spain	24.3	24.0	23.3	24.5	24.7	26.1	26.7	27.2	27.3	29.2
Netherlands	16.7	16.0	15.7	14.9	15.1	15.1	15.7	15.0	15.9	
Luxembourg	17.3	16.5	15.9	15.5	17.8	17.1	16.8	18.4	19.0	
Denmark	17.2	16.7	16.8	16.3	17.6	18.3	18.9	19.0	18.9	
Cyprus	25.3	25.4	25.2	23.3	23.5	24.6	24.6	27.1	27.8	
Hungary	32.1	31.4	29.4	28.2	29.6	29.9	31.0	32.4	33.5	31.1
Lithuania	41.0	35.9	28.7	28.3	29.6	34.0	33.1	32.5	30.8	
Latvia	46.3	42.2	35.1	34.2	37.9	38.2	40.1	36.2	35.1	32.7
Bulgaria		61.3	60.7	44.8	46.2	49.2	49.1	49.3	48.0	
Czech Republic	19.6	18.0	15.8	15.3	14.0	14.4	15.3	15.4	14.6	
Slovakia	32.0	26.7	21.3	20.6	19.6	20.6	20.6	20.5	19.8	
Belgium	22.6	21.5	21.6	20.8	20.2	20.8	21.0	21.6	20.8	
United Kingdom	24.8	23.7	22.6	23.2	22.0	23.2	22.7	24.1	24.8	
EU27 average	25.7	25.3	24.4	23.8	23.3	23.6	24.2	24.7	24.5	
Greece	29.4	29.3	28.3	28.1	27.6	27.7	31.0	34.6	35.7	36.0
Estonia	25.9	22.0	22.0	21.8	23.4	21.7	23.1	23.4	23.5	
Italy	25.0	25.9	26.0	25.3	24.7	24.5	28.2	29.9	28.4	28.1
Portugal	26.1	25.0	25.0	26.0	24.9	25.3	24.4	25.3	27.5	
Romania			45.9	44.2	43.1	41.4	40.3	41.7	40.4	
Finland	17.2	17.1	17.4	17.4	16.9	16.9	17.9	17.2	16.0	17.3
France	18.9	18.8	19.0	18.5	18.5	19.2	19.3	19.1	18.1	
Poland	45.3	39.5	34.4	30.5	27.8	27.8	27.2	26.7	25.8	
Croatia						31.1	32.6	32.6	29.9	

Source: Authors based on Eurostat (2015)

Note: Green shading indicates the lowest share since 2005; red shading indicates an increase in the share. Countries are ranked from 2005 to 2013 by the year in which the share has been lowest since 2005.

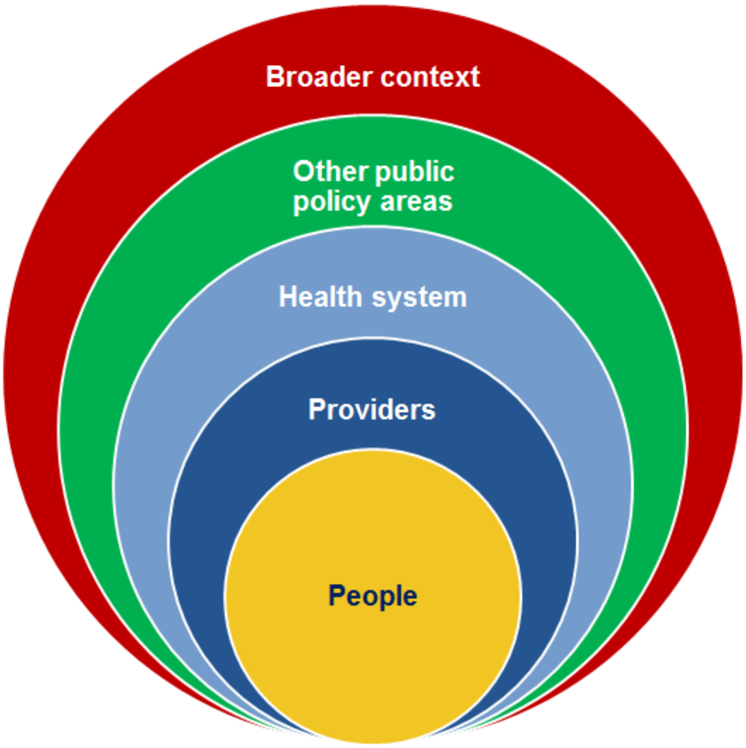
What causes unmet need?

In 1971 Tudor Hart formulated the Inverse Care Law, which states that 'the availability of good medical care tends to vary inversely with the need for it in the population served' (Tudor Hart 1971). In other words, those with the greatest need for care often have the least access to it. This outcome has been attributed to the behaviour of providers – for example, Illich noted that 'doctors tend to gather where the climate is healthy and where patients can pay for their services' (Illich 1974). It can also be linked to the goals and content of public policy: 'to the extent that health care becomes a commodity it becomes distributed just like champagne ... Rich people gets lots of it, poor people don't get any of it' (Tudor Hart 1971).

Defining need: A prerequisite for health care use is that a person perceives a need for health care (felt need) and formulates a demand for help from the health system (expressed need) (Bradshaw 1972). Use can be triggered by individuals, by health professionals (through referral) and by the health system (through the implementation of screening programmes, for example). Need defined by experts is referred to as normative need. Standards for need may vary across experts (see chapter 3).

Barriers to using health services: Access is a multi-dimensional issue. Barriers that prevent individuals from using necessary health services may be found at different levels: individual people (potential users), health service providers, the health system and – more broadly – public policy in areas beyond the health system, as depicted in Figure I.5.

Figure I.5 The determinants of health service use



Source: Authors, based on Dahlgren and Whitehead (1991)

There are likely to be important interactions across these levels and over time. For example, a person’s experience of using health services at one point in time can influence health care-seeking behaviour later on. In some instances, barriers may be systematically experienced by an entire group of people, such as people from ethnic minorities, undocumented migrants or people with disabilities. In other instances, barriers will only be experienced by some people – perhaps those with lower incomes or limited mobility.

Systematic reviews of barriers to effective care for hypertension have identified barriers related to capability (communication skills or ability to recognise risk factors) and intention (health beliefs and fatalism) at the level of health professionals and patients, as well as health system barriers related to the cost and availability of staff, equipment, referral networks and guidelines for treatment.

Barriers at the level of individual people: As noted above, whether or not people feel and express need for health care can be influenced by a wide range of personal characteristics, including beliefs about health, levels of health literacy, coping and communication skills, other psychosocial factors and access to different resources. As a result of differences in personal characteristics, two people with the same ‘objective’ need may express need and use health services in different ways.

Health beliefs **–** people’s views about the nature of their health problems, about their ability to take care of problems themselves and the forms of help they regard as appropriate – differ widely across and within social groups (O’Malley and Forrest 2002). Although the decision to use health services is an individual choice, this choice is framed by social context (Bussing et al 2003). For example, in the Roma culture the concept of *marime* (meaning polluted, defiled or unclean) is central to their understanding of disease and death and explains why Roma may consider hospitals as potentially dangerous places in which they are unable to adhere to purity rules (Honer 2004). Similarly, higher socioeconomic groups often consider health to be a value in itself, something to be sought and achieved, whereas lower socioeconomic groups might view health from a utilitarian perspective – particularly as a means of being able to work (Chamberlain and O’Neill 1998).

Health literacy refers to people’s knowledge, motivation and competence to access, understand, appraise and apply health information in order to make judgments and take decisions about health care, disease prevention and health promotion to maintain or improve quality of life throughout their lives (UNESCO 2010; Sorensen 2012). Low health literacy is linked to reduced safety of care due to medication errors and poor adherence to medication and treatment, less use of preventive care, more hospitalisation, worse health outcomes and greater risk of death (Omachi et al 2013; IOM 2013; Parker and Ratzan 2010).

In addition to coping and communication skills (requesting information, giving information and opinions and negotiating the system), need and use may be influenced by other psychosocial factors such as self-determination, the time perspective adopted (long-term focused on future gains versus short-term focused on immediate survival), strength of belief in one’s own ability to complete tasks and reach goals (self-efficacy) (Bandura 1977), and preferences among competing priorities such as health, food and shelter. Finally, health care use requires recourse to financial resources and other resources such as_a supportive social network of family, friends and informal carers. The relevance of these different factors is illustrated in the case of screening for breast cancer (Box I.1).

Box I.1 Low participation of women from lower socioeconomic groups in the national breast cancer screening program in Flanders (Belgium)

In 2013, 76% of Flemish women in the target group for breast cancer screening reported having had a mammogram in the last two years, ranging from 56% among the least-educated women and 76% among the most-educated women (Drieskens 2015). Physicians indicate that participation rates remain low even after the importance of this screening programme has been explained to the least-educated women. Qualitative research reveals a wide range of barriers to use among this group, beyond knowledge or lack of information: fear of the outcome of the examination, struggles in other areas of life requiring all the women’s time and energy and the lack of a supporting network. Outreach interventions tackling the true causes of non-participation were the only ones able to increase the participation rate (Willems 2005).

Provider-level barriers: Provider-level barriers relate to the size, composition and socioeconomic and demographic characteristics of the health workforce, as well as the knowledge, skills, preferences, perceptions attitudes and prejudices of both patients and providers (Goddard and Smith 2001). Good provider-patient communication is associated with better access to care, a higher level of patient satisfaction, better compliance and better care outcomes (Verlinde et al 2012; Bensing 1991; Jensen et al 2010). Sub-optimal doctor-patient relations may lead to a negative experience for the patient, which can in turn become a potential barrier to access in the future (Bensing 1991). The concept of cultural competence encompasses interpersonal and organisational interventions and strategies that enable health systems, agencies and health professionals to understand the needs of diverse patient groups and facilitate the provision of culturally and linguistically appropriate health services (Fortier and Bishop 2003).

Health system-level barriers: To avoid or overcome barriers to using health services and to promote equitable access to health services, policy makers responsible for the health system need to take action in many areas. Figure I.6 highlights common areas requiring policy attention. It provides a form of ‘checklist’ to remind policy makers of the multiple factors that need to be considered when thinking about access to health services. The specific actions needed to address access problems will, of course, vary from one health system to another. These eight policy areas are used to structure the report’s discussion of access to (formal) health services in the European Union.

Figure I.6 Factors affecting equitable access to health services

Source: Authors

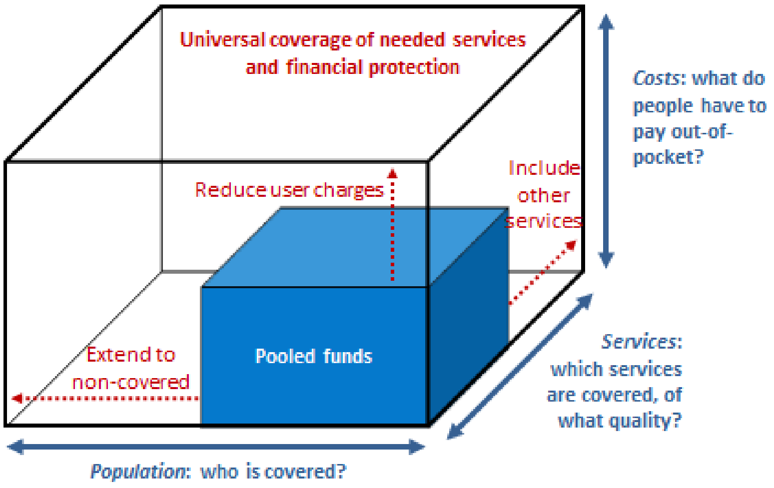
The role of public policy beyond the health system: Non-health areas of public policy such as fiscal policy, social protection, education, transport and regional development (among others) can have an important effect on access to health services. Sometimes the relationship between access to health care and other areas of public policy is direct – for example, where changes in labour market, pension or other non-health benefits affect entitlement to publicly financed health services, or where changes in transport policy affect people’s ability to travel to health facilities. Often, however, the relationship may be more indirect, with changes in public policy affecting socioeconomic status leading to knock-on effects on health status and ability to use health services.

Interaction between users, providers, the health system and other areas of public policy: Access barriers are rarely attributable simply to the user, the provider or the health system alone but rather to the lack of alignment between these different levels. Health literacy, for example, is the result of a mismatch between a person’s ability to understand health information and the provider or health system response (Parker and Ratzan 2010). Tackling the negative effects of inadequate health literacy therefore requires a double approach: helping patients to make well-informed decisions and at the same time reducing the complexity of the health system (Parker and Ratzan 2010, IOM 2013).

Addressing financial barriers to access is another example of the need for awareness of interactions across levels and a multidimensional and intersectoral approach. Financial barriers may be related to an individual’s income, provider attitudes, health system policy regarding the three dimensions of coverage depicted in Figure I.7 (population entitlement, the benefits package and user charges) and broader public policy. Changes at each level can create or exacerbate financial barriers to access at the level of individual people. For example, in countries where fiscal policy promotes greater rich-poor redistribution and pensioners enjoy a standard of living similar to the rest of the population, user charges may not create financial barriers to access or result in income-related inequalities in use.

An important implication is that policy responses to access to health care should reflect the multidimensional nature of access problems, the need for intersectoral action and the specifics of national or local context.

Figure I.7 The three dimensions of health coverage



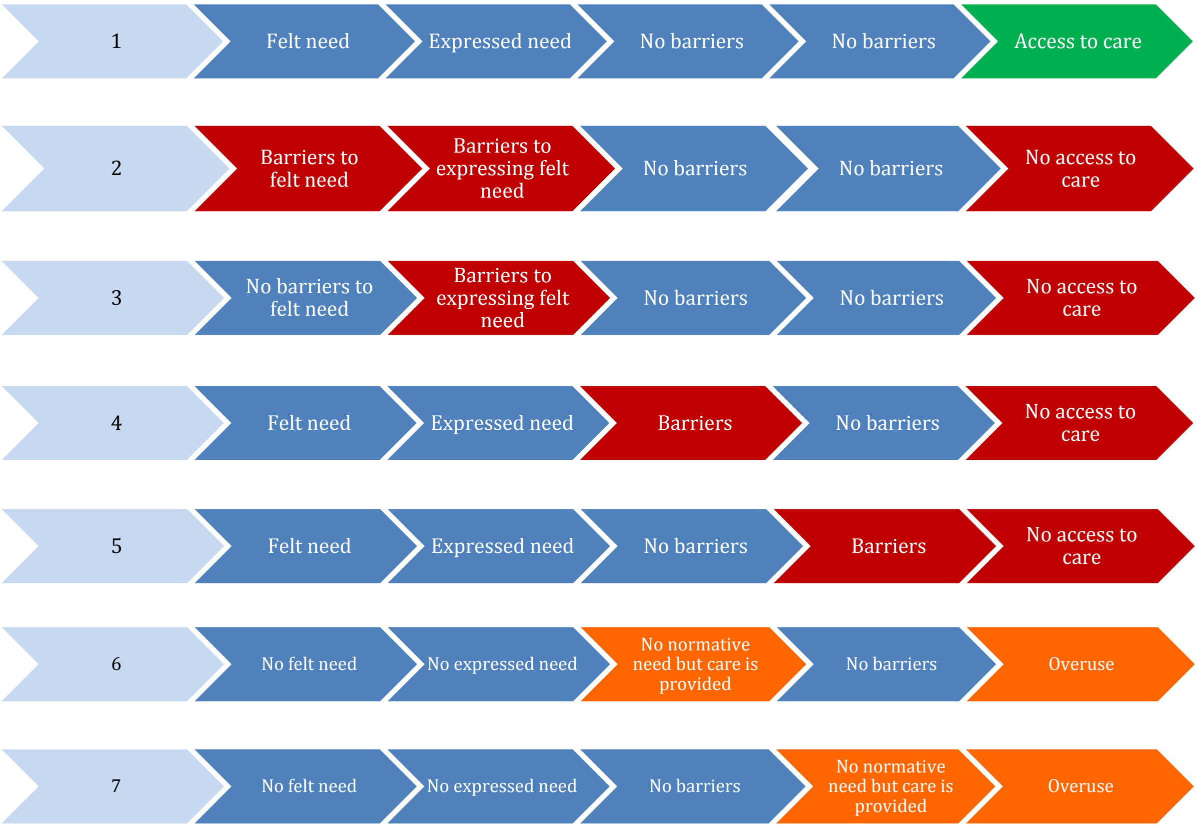
Source: Adapted from WHO (2010)

Note: In almost every country in the world, the vast majority of pooled funds are public – that is, they are generated through compulsory forms of pre-payment (the government budget or contributions earmarked for health). Quality of care and timely access to care are included under 'services'. Where services provided through pooled funds are not provided in a timely way or are of poor quality, some people may pay out-of-pocket for alternatives.

Figure I.8 shows where access barriers can occur and how different scenarios may lead to non-use, use and overuse. In the first scenario, people do not face any barriers to access. In the second, they do not perceive their condition to be a problem, perhaps due to health norms in their social context or low health literacy. In the third, people feel a need for health care but are unable to express it due to low health literacy or fear and anxiety. In the fourth, people express need but experience barriers when interacting with the provider or due to the way in which the health facility is organised (for example, limited opening hours). In the fifth, people express need but experience barriers in the organisation of the health system (for example, the system requires registration prior to consultation). In the sixth, people do not feel a need for health care, and experts would agree, but are encouraged by something they saw on television or read on the Internet to seek non-evidence-based treatment, resulting in overuse. In the seventh scenario, people do not feel a need for health care, and experts would agree, but the organisation of the health system induces care (for example, a patient undergoes duplicate diagnostic tests due to the absence of any (electronic) medical record of treatment), resulting in overuse.

Figure I.8 Barriers to access and the use, non-use or overuse of health services

Scenario Individual level Provider Health
system Outcome
level level



Source: Authors

European efforts to monitor access

Since the mid-1980s countries and international organisations have invested in tools to monitor population health status and its determinants. The scope of these tools has expanded over time to include dimensions relating to access to health services and quality of care. In 1998, the European Union established a pan-European health monitoring system (Box I.2) and a programme to define and collect a core set of indicators to generate evidence for the implementation of its Health Strategy. The development of these indicators built on the earlier experience of the OECD and the WHO Regional Office for Europe in international data collection and reporting.

The production of EU-wide statistics is regulated under a multi-year programme and achieved through close collaboration between Eurostat (the EU Statistical Authority), national statistical authorities designated by the Member States, the OECD and WHO. The results of this joint effort constitute the backbone of an online database (Eurostat), which provides data on a relatively comprehensive set of indicators. A significant number of the European Core Health Indicators are based on data collected by Eurostat (see Box I.2). Only a few relate to health services, most of which describe inputs, such as the number of health professionals or hospital beds. Data on unmet need are reported using figures from EU-SILC. They also include data on the numbers of certain procedures undertaken, although in most cases the most recent figures are from 2010 or earlier. Moreover, given the many challenges involved in collecting data from all providers, public and private, there must be many questions about the validity of the information. Technical and strategic direction is determined through consultation with the Expert Group on Health Information (delegates from Member States), which works with the Commission (mainly DG Santé).

Box I.2 The European Core Health Indicators

The European Core Health Indicators (ECHI) are a list of 88 health indicators classified in five areas:

- demography and socio-economic situation
- health status
- determinants of health
- health services
- health promotion

The indicators are selected based on policy relevance and potential policy impact at EU and Member State level and on the magnitude of the public health problems considered. They are usually drawn from existing databases such as Eurostat, the WHO health for all database and OECD health data.

The following indicators are relevant to monitoring access to health services:

- expenditure on health
- insurance coverage
- hospital beds; practising physicians; practising nurses; MRI units and CT scans
- timing of first antenatal visit among pregnant women; patient mobility; waiting times for elective surgeries; equity in unmet need for health care (13 sub-indicators by gender, age, income, educational attainment and labour market status)
- vaccination coverage in children; influenza vaccination rate among older people; breast cancer screening; cervical cancer screening; colon cancer screening; cancer survival rates; 30-day in-hospital case-fatality for acute myocardial infarction and ischaemic stroke; surgical wound infections; cancer treatment quality; diabetes control

Source: http://ec.europa.eu/health/indicators/echi/list/index_en.htm

Table I.2 Sources of data collected at EU level

Data routinely provided by national statistical authorities
OECD/Eurostat/WHO-Europe joint questionnaire on non-monetary health care statistics (data on human and technical resources for health) and joint questionnaire on health accounts (data on health expenditure by function)
Data routinely obtained through nationally representative surveys
EU Survey on Income and Living Conditions (EU-SILC) European Health Interview Survey (EHIS)
Non-routine EU-supported sources of data
PHAMEU: designed to establish an information and knowledge system on the state and development of primary care in Europe, including access to primary care QUALICOPC: designed to investigate primary care costs, quality and access in 31 countries

Source: Authors

About this report

This report builds on previous studies of access to health care in high-income countries (see, for example, Gulliford and Morgan 2003 and Healy and McKee 2004). It aims to highlight key issues in promoting access to health care in EU health systems and includes a focus on access issues among underserved groups of people.

The report is structured around the eight policy areas identified in Figure I.6. The next eight chapters discuss each of these policy areas in turn, using a common template. Each chapter begins with an overview of common access problems then reviews the range of tools used to monitor effects on access; comments on data availability at EU level; presents evidence of variation in access across and within countries; notes whether specific groups of people are systematically disadvantaged; and highlights key policy actions to promote equitable access. Where possible, we include examples of good practice from EU Member States. This set of eight chapters is meant to be succinct and illustrative rather than exhaustive.

A further chapter focuses on issues and policy responses in relation to three groups of people who are systematically underserved in the European Union: Roma, undocumented migrants and people with mental health problems.

A final chapter discusses the roles and responsibilities of the European Union and its Member States in ensuring equitable access to health services; focuses on the need for a new generation of data collection for effective, accessible, resilient and accountable health systems; summarises policy responses identified in previous chapters; and comments on the challenges and opportunities these actions entail.

Annex 1 briefly discusses the issue of informal care.

Annex 2 presents data on unmet need across time and across different groups of people by country for all 28 EU Member States.

Annex 3 lists access-related indicators that are routinely collected by Eurostat, the OECD or the WHO Regional Office for Europe.

Every chapter in the report begins with a one-page summary of the chapter’s main points.

1. Financial resources are linked to health need

Chapter summary

Health needs vary across and within countries. Financial resources for the health system should reflect a country's health needs at national and sub-national levels. Failing to match financial resources to need will result in unequal access to health care and is likely to lead to inequalities in the use of health services. It is also inefficient: if some people in need of health care are not able to use services while others are using too much relative to their need, the ensuing mismatch wastes resources. Across and within EU Member States, financial resources for health care vary in ways that are unrelated to health needs.

The mismatch between need for health care and ability to pay means that collective, public spending, incorporating a degree of redistribution, is essential to ensure equitable access to health. In 2013, public spending on health varied from a low of 3.4% of GDP in Cyprus to a high of 10.3% of GDP in the Netherlands, with a median of 6.1%. The health share of the government budget (total public spending) ranged from 7.5% in Cyprus to 20.7% in the Netherlands, with a median of 13.5%.

To ensure an adequate level of spending on health:

- All countries should link the availability of public funding for health to population health needs. This is especially important during economic downturns, when funds may decline but needs are likely to increase.

- Countries with low levels of public spending on health should allocate a higher share of the government budget to the health sector.

- Countries should ensure that public funding is used effectively, rather than simply driving up the prices of technology or highly specialised staff.

Evidence from several countries suggests that the relationship between regional health needs and levels of public spending on health is imperfect, even in countries that have developed needs-based resource allocation formulas.

To ensure the distribution of spending meets regional health needs:

- Countries should introduce and improve sub-national resource allocation formulas, building on the long experience of developing formulas in countries such as England and Sweden. Provider payment should not be based primarily on inputs and should for population health needs and provider performance.

- The European Union can facilitate this by routinely collecting data on sub-national health care expenditure patterns; identifying regions and groups in particular need of additional public spending on health; ensuring unmet need is accounted for in country-specific recommendations made as part of the European Semester; and helping countries develop secure systems of record linkage, including unique patient identifiers.

1.1. Ensuring an adequate level of spending on health

There is little evidence to suggest that governments of EU Member States explicitly link the availability of public funding for health to population needs and the contents of the publicly financed benefits package. Although all EU Member States carry out long-term forecasts of current and future health care spending, very few report using forecasts to define an overall budget for the health system (OECD budget survey 2014). Linking public funding to health need is especially important when the economy is shrinking (see Box 1.1).

Inadequate public funding for the health system creates and exacerbates barriers to access. Private spending through voluntary health insurance (VHI) and out-of-pocket payments is sometimes seen as a way to make up for public shortfalls. However, private spending on health is far from a perfect substitute for public spending. Out-of-pocket payments place an undue burden on poorer households and undermine financial protection, potentially leading to access problems (see chapter 2). Both OOPs and VHI can undermine equity of access by skewing the distribution of health spending in favour of richer people, sometimes at the expense of poorer, sicker and older people (see Box 1.2). They are usually more expensive to collect than funding raised from taxation and social insurance. The extent to which this is a concern for public policy will vary across countries.

Box 1.1 Economic downturns call for more – not less – public social spending

The financial and economic crisis has drawn attention to the need for countercyclical (as opposed to pro-cyclical) public social spending, including public spending on health. Linking the availability of public funding for health to population health needs is especially important during economic downturns. First, at such times, health needs can increase, reflecting the health consequences of job loss and cuts to the social sector. Second, health expenditure can, to some extent, act as an automatic stabiliser, increasing demand in the economy, especially where the money is used to increase employment among low-paid workers. Third, health expenditure has a positive impact on economic growth, with a fiscal multiplier effect of three or more (Reeves et al 2013).

Cyclicality in public spending on health can occur regardless of the nature of public funding for the health system – whether the health system is funded through direct transfers from the government budget or via earmarked contributions is not important in this respect.

A survey of policy responses to the economic crisis in Europe shows how, during the crisis, some EU countries benefited from automatic stabilisers such as health insurance reserves and formulas for government budget transfers to the health insurance system, while others struggled because means-tested entitlement was not automatically linked to additional public funding (Thomson et al 2015).[1] Although the largest annual reductions in public spending on health occurred as a result of government decisions (for example, in Greece, Ireland, Latvia and Portugal), as opposed to due to reductions in employment-based revenue, this largely reflected the magnitude of the economic shock, including external intervention through EU-IMF economic adjustment programmes. It also reflected the absence of automatic stabilisers: Greece had no reserves or countercyclical formulas to compensate the health insurance system for falling revenue from payroll taxes, and Ireland had no countercyclical formula to cover a huge increase in the share of the population entitled to means-tested benefits (Thomson et al 2015).

Overall, just over half of all EU Member States demonstrated pro-cyclical patterns of public spending on health between 2008 and 2013, bucking a global trend in which pro-cyclical social spending has historically been the preserve of low-income countries and countries with weak institutions (Velenyi and Smitz 2014).

---

[1] Some automatic stabilisers have the added advantage of helping to moderate growth in public spending on health when the economy is expanding.

Box 1.2 Private spending often undermines equitable access to health care

Richer households usually spend much higher absolute amounts out-of-pocket than poorer households and are much more likely than poorer households to be covered by VHI (OECD 2004, Thomson and Mossialos 2009, Sagan and Thomson 2015). Consistent evidence shows how user charges disproportionately negatively affect access, adherence to medication, cost-effective patterns of use and health outcomes among poorer people (Swartz 2010), even where the poor benefit from reduced user charges or exemptions. VHI not only disproportionately benefits richer people but can sometimes make people who rely on publicly financed services worse off – for example, where doctors have incentives to prioritise treatment of privately financed patients, leading to longer waiting times for publicly financed patients (OECD 2004, Thomson and Mossialos 2009). Tax subsidies for VHI, which also often disproportionately benefit richer people, are not usually a cost-effective use of public revenue.

Tools for monitoring and evidence of variation

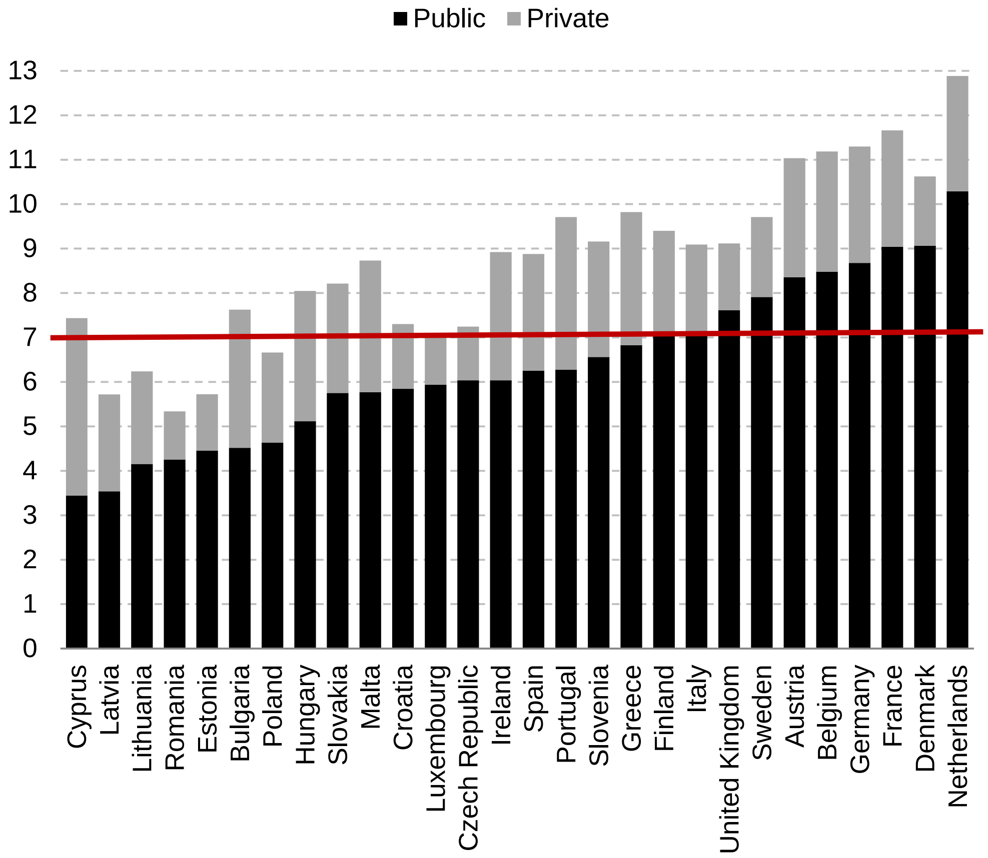
Data on national levels of public (and private) spending on health are routinely available from Eurostat, but with a 15-month delay – for example, internationally comparable data for 2013 became available in April 2015.

There is no international standard for the ‘right’ level of public spending on health, nor any single measure that indicates whether or not public spending levels are adequate to meet population health needs. Such an assessment calls, instead, for a combination of political and technical judgements based on a range of factors and making trade-offs where appropriate between competing goals. Factors to be considered include: historic levels of spending on health (for example, whether there is a backlog of requirements for capital spending); indicators of health system performance, because how available resources are spent is important, not just the absolute amount; the socioeconomic and health context; the fiscal context, including levels of tax fraud; the value of public spending in different sectors; and political values and societal preferences. International comparisons are further complicated by differences in national income, which influences the fiscal space within which decisions are made, political decisions on raising tax revenues, differences in the cost of inputs and differences in price.

Having said that, a low level of public spending on health is likely to lead to access problems. International analysis shows how out-of-pocket payments fall as a share of total spending on health as public spending rises (see Figure 2.1 in chapter 2). There is also some correlation between public spending on health and the levels of unmet need shown in Figure I.1, although there are notable outliers such as France, which has relatively high levels of unmet need and a very high level of public spending on health.

Figure 1.1 shows the extent of variation in public and private spending on health as a share of GDP in EU Member States. Public spending on health ranges from a low of 3.4% of GDP in Cyprus to a high of 10.3% in the Netherlands, with a median of 6.1%. Differences in levels of total spending on health across EU Member States are strongly associated with levels of public spending on health ($R^2 = 0.86$) – in other words, countries that spend a higher share of GDP on health publicly are also likely to spend more on health overall.

Figure 1.1 Spending on health as a share (%) of GDP, EU28, 2013

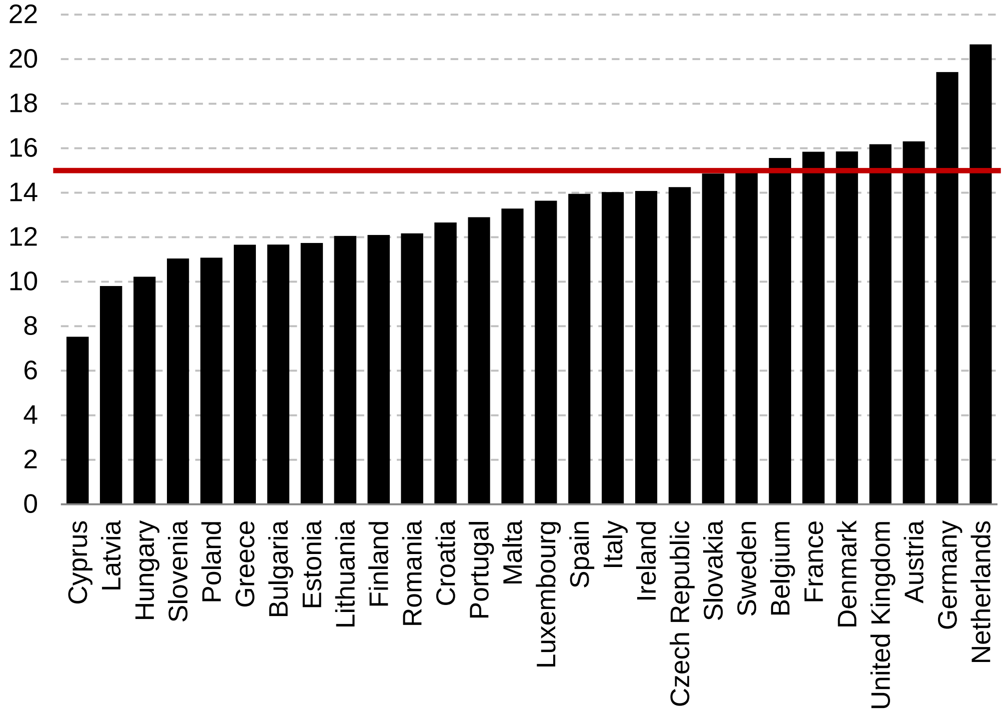


Source: WHO (2015)

Note: Countries ranked from low to high by public spending on health as a share of GDP.

Public spending on health as a share of GDP is a function of the size of government (tax revenue as a share of GDP) and the 'priority' given to the health sector in decisions about how to allocate the government budget. Some EU countries allocate around 20% of the government budget to the health sector (Germany and the Netherlands), while others do not even allocate 10% (Cyprus and Latvia) (Figure 1.2).

Figure 1.2 Public spending on health as a share (%) of total government spending, EU28, 2013



Source: WHO (2015)

Policy responses

To ensure an adequate level of spending on health:

- All countries should link the availability of public funding for health to population health needs. This is especially important during economic downturns.

- Countries can also establish mechanisms in which health financing acts as an automatic stabiliser to address fluctuation in need (changes in population size, age structure and health need) and revenue (changes in unemployment, wages and tax revenue).

- Countries with low levels of public spending on health should allocate a higher share of the government budget to the health sector.

- It is important for public funding to be used effectively, rather than simply driving up the prices of resources whose supply is constrained, such as technology or highly specialised staff.

1.2. Ensuring the distribution of spending meets regional health needs

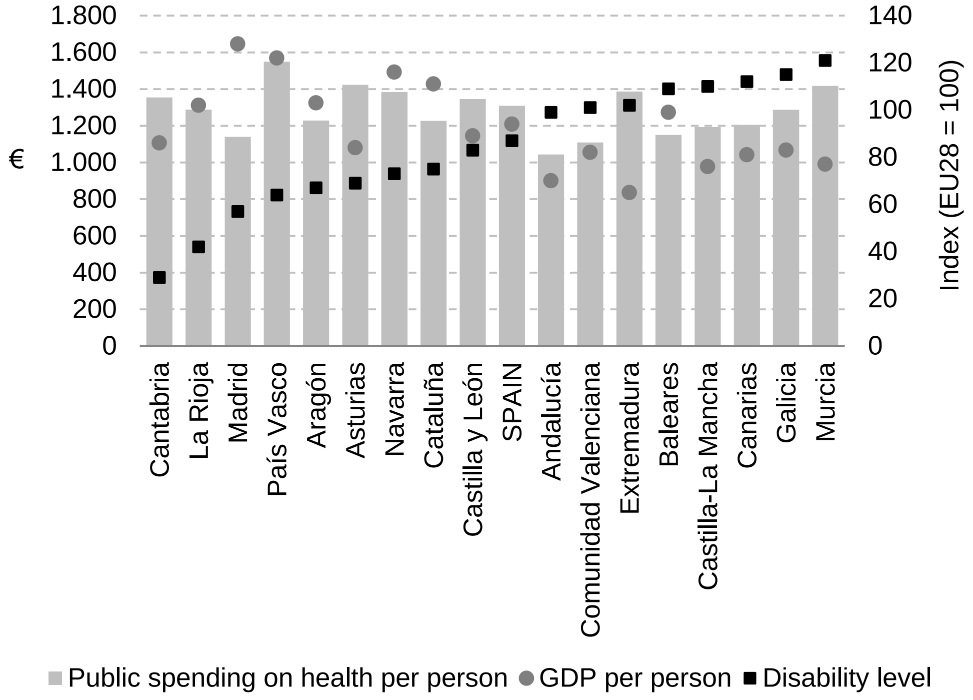
To ensure equity of access, countries need to match the allocation of health system resources to variation in health need across regions. Regions with higher health need (lower health status and higher unmet need) should benefit from higher levels of per capita public spending on health. This may be more difficult to achieve where public revenue collection is decentralised, contribution rates vary across the country and there are no mechanisms for the (re)allocation of public funds across the country. It can also be difficult where (re)allocation mechanisms are weak – for example, they are based on inputs such as the number of beds, they do not adjust for health risk or they only include crude health risk adjusters (age and sex). The methods used to pay health care providers or to set priorities for health system sub-sectors and health care interventions often play an important in linking resources to need.

Tools for monitoring and evidence of variation

To understand the distribution of health spending within a country, it is useful to compare levels of per capita spending on health by region and to note differences between richer and poorer regions and differences in health status. Regional expenditure data are not routinely available at EU level. Qualitative analysis of resource allocation processes from national to sub-national level is therefore important in identifying potential access problems, although it is not sufficient for monitoring.

National data indicate a degree of regional variation that is not linked to need. For example, data from Spain show there is little relationship between a region’s level of wealth, level of disability and level of public spending on health (Figure 1.3). While Spain has a formula for allocating resources for public services in a way that is intended to reflect regional needs (Table 1.1), its health spending patterns suggest the formula does not adequately reflect regional health needs.

Figure 1.3 GDP, disability and public spending on health across regions in Spain, 2013



Source: Ministry of Health of Spain (2015), Eurostat (2015)

Note: Regions ranked from low to high by size of GDP per person and extent of disability

Table 1.1 Variables used to allocate resources for public services (health, education and social services) to regions in Spain, 2015

Variable	Weighting
Protected population in seven age groups	38.0%
Population size	30.0%
Population aged between 0 and 16	20.5%
Population aged over 65	8.5%
Geographical size of region	1.8%
Distribution of the population across the region	0.6%
Insularity of the region (for example, being an island)	0.6%
Total	100.0%

Source: Ministry of Economy of Spain http://www.minhap.gob.es/en-GB/Areas%20Tematicas/Financiacion%20Autonomica/Paginas/Regimen%20comun.aspx

Policy responses

Many EU Member States have already moved away from historical resource allocation based on health system inputs (beds, health workers) and other line items. To strengthen resource allocation mechanisms, countries should aim to link national and sub-national health budgets to objective measures of population health need and its determinants, including geographical deprivation. This requires going beyond the use of demographic factors (population size, age structure and sex). Some countries are also trying to move away from simply reimbursing health care provider costs (retrospective payment) towards the use of prospective payment, including payment linked to objective measures of performance.

Needs-based resource allocation presents different challenges in different contexts. In a handful of EU countries (for example, Cyprus), it requires reform of public financial management rules, so that resources do not need to be linked to inputs. In health systems with competing purchasers (the Czech Republic, Germany, the Netherlands and Slovakia), it requires access to highly sophisticated, unified databases. Very few countries currently have the capacity to engage in record linkage within the health sector or across different social sectors. For example, many do not yet use unique patient identifiers. Needs-based resource allocation to regions is easier to achieve, from an information perspective, although implementation may be challenging for political reasons, as the UK experience shows (see Box 1.3, Figure 1.4 and Figure 1.5).

The European Union can facilitate this by routinely collecting data on sub-national health care expenditure patterns; identifying regions in particular need of additional public spending on health; ensuring unmet need is accounted for in country-specific recommendations made as part of the European Semester; and helping countries develop secure systems of record linkage, including unique patient identifiers.

Box 1.3 Resource allocation for health in England: the politics of redistribution

England first developed a regional resource allocation formula in the 1970s, in response to concerns about unequal access to health care identified by Julian Tudor Hart and others. The formula is still in use today. It is based on clear principles that are the result of compromise between what is technically sound and what is politically feasible:

- a target allocation for each region
- allocations reflecting population size and health need – 'weighted capitation'
- the formula is defined by independent technical experts
- the speed at which target allocations should be reached – the 'pace of change' – is determined based on political judgement
- the formula aims to promote equal access to health care for people at equal risk of ill health
- it also aims to reduce avoidable inequalities in health – areas with higher unmet need should receive more funds (a principle introduced by a Labour government in the 1990s)

The formula adjusts for a wide range of factors to reflect not only health needs but also unavoidable regional differences in the costs of providing health services, such as wage levels and cross-boundary patient flows. Over time, the formula has been extended to apply to GP and prescribing services as well as hospitals. The complexity of the formula is shown in Figure 1.4.

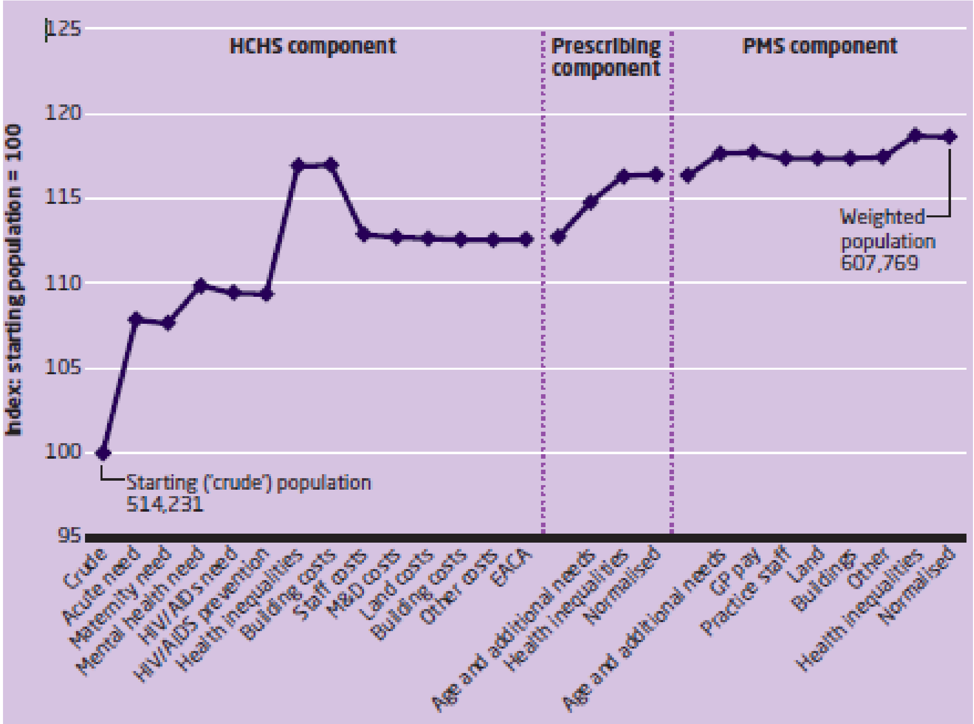
From the outset, the formula revealed a large difference between what regions were getting and what they should have been getting. This raised a technical challenge: how quickly could regions adjust to potentially large changes in funding (increases and reductions)? It also raised a political one: the creation of regional 'winners' and 'losers'. The solution was to allow target allocations to be met over a period of time, at a pace to be determined by politicians. What this has meant in practice is, first, that the formula has always been applied in a way that does not take funds away from regions and, second, that the amount of money available for reallocation is quite small. As a result, under-funded areas have never actually caught up. What is more, the rate of catch-up is slower when the NHS budget is stable or falling, leading to pro-cyclical allocations that systematically disadvantage more deprived regions. Figure 1.5 shows the difference between target and actual allocations in 2011/2012.

The formula was changed by the Conservative-Liberal Democrat coalition government of 2010-2015, which reduced the weight given to health inequalities from 15% to 10%. While this makes a significant difference in target allocations, it has not yet had much impact in practice given the overall squeeze on NHS funding in recent years. As NHS funding begins to rise, however, the change in formula will shift resources away from more deprived areas to more affluent areas.

The English experience clearly demonstrates how a technically robust formula determined by independent experts can be watered down in implementation to reflect political priorities.

Source: Buck and Dixon (2013)

Figure 1.4 The weighted capitation formula used to allocate health care resources in England and its effect in one region, 2009-2011



Source: Buck and Dixon (2013)
Note: HCHS = hospital services; PMS = GP services

Figure 1.5 Target vs actual allocations by region in England, 2011-2012

Source: Buck and Dixon (2013)
Note: SHA = strategic health authority

2. Services are affordable for everyone

Chapter summary

People should not be prevented from using necessary health services because the costs associated with use are too high. Financial barriers to access can be caused by a wide range of factors at individual, provider and health system levels, including factors beyond the health system – for example, the adequacy of pensions and unemployment benefits or the cost of transport. Affordability issues most commonly arise where public spending is low as a share of total spending on health and where there are gaps in the breadth, scope and depth of publicly financed coverage. As a result of these gaps people have to buy voluntary health insurance or pay out-of-pocket or – if they cannot afford these options – rely on health services provided by NGOs.

Lack of affordability is the single most important factor behind self-reported unmet need in EU countries. In 2013, 12 million people experienced unmet need due to cost (2.4% of the EU population), which was a particular problem among older inactive people, unemployed people, retired people, the poorest 40% of the population, people aged over 75, people with lower educational status and women and girls. EU-level data mask important differences across countries. While older people have very good access to health care in many countries, they experience much higher levels of unmet need due to cost than the general population in Poland, Bulgaria, Italy, Greece, Latvia and Romania.

To ensure affordable access (see Box 2.4 also) countries should:

- Ensure most spending on health comes from collective public rather than private sources.
- Ensure out-of-pocket payments are as low as possible. The incidence of catastrophic and impoverishing spending on health rises as the out-of-pocket share of total spending on health rises.
- Identify and close gaps in publicly financed coverage of cost-effective services.
- Broaden the basis for entitlement to encompass everyone living in a country, regardless of legal status.
- Eschew discriminatory approaches such as entitlement linked to employment status and payment of contributions or situations in which people with different diagnoses are entitled to different benefits (‘inequity by disease’).
- Reduce or eliminate user charges so that they do not create financial barriers to cost-effective services or undermine financial protection.
- Ensure efficiency in spending public resources, paying attention to the scope of the benefits package, prioritising cost-effective health services, including elements of performance in provider payment and developing appropriate pricing strategies.
- Eliminate informal payments using a mix of policy instruments.
- Outside the health sector, fiscal social protection policies are critical to addressing poverty and income inequality.

The European Union can adapt EU-SILC, its main source of comparable data, to include proxy measures of financial hardship; require countries to carry out household budget surveys more regularly; and ensure these surveys use a robust, standardised, extended health module to enable better estimation of financial hardship.

2.1. The rationale for public spending on health

Need for health care varies widely across the population and both need and health care are characterised by uncertainty – people cannot always tell if or when they will become ill, how severe their illness may be or how much their treatment will cost. Because of this uncertainty, out-of-pocket payments, savings and voluntary health insurance are relatively inefficient forms of health care financing.

Over the course of the 20th century, compulsory health insurance – pre-payment with risk pooling, publicly financed through the government budget or via earmarked contributions (often payroll taxes) – developed and spread to cover most people in EU countries. During this time the ability of the health system to prevent, detect and treat acute conditions and chronic disease also grew exponentially, placing treatment in hospitals and through new and expensive medicines beyond the financial reach of many people and reinforcing the need for redistributive financing mechanisms on efficiency and equity grounds (see Box 3.1).

Box 3.1 The principles underpinning affordable access to health care

Promoting affordable access to health care for the whole population is regarded as a predominantly social responsibility in the European Union. The common values for EU health systems agreed by the Council of Health Ministers in 2006 imply that revenue for the health system should be raised in line with three closely related principles (OJEU 2006: 2):

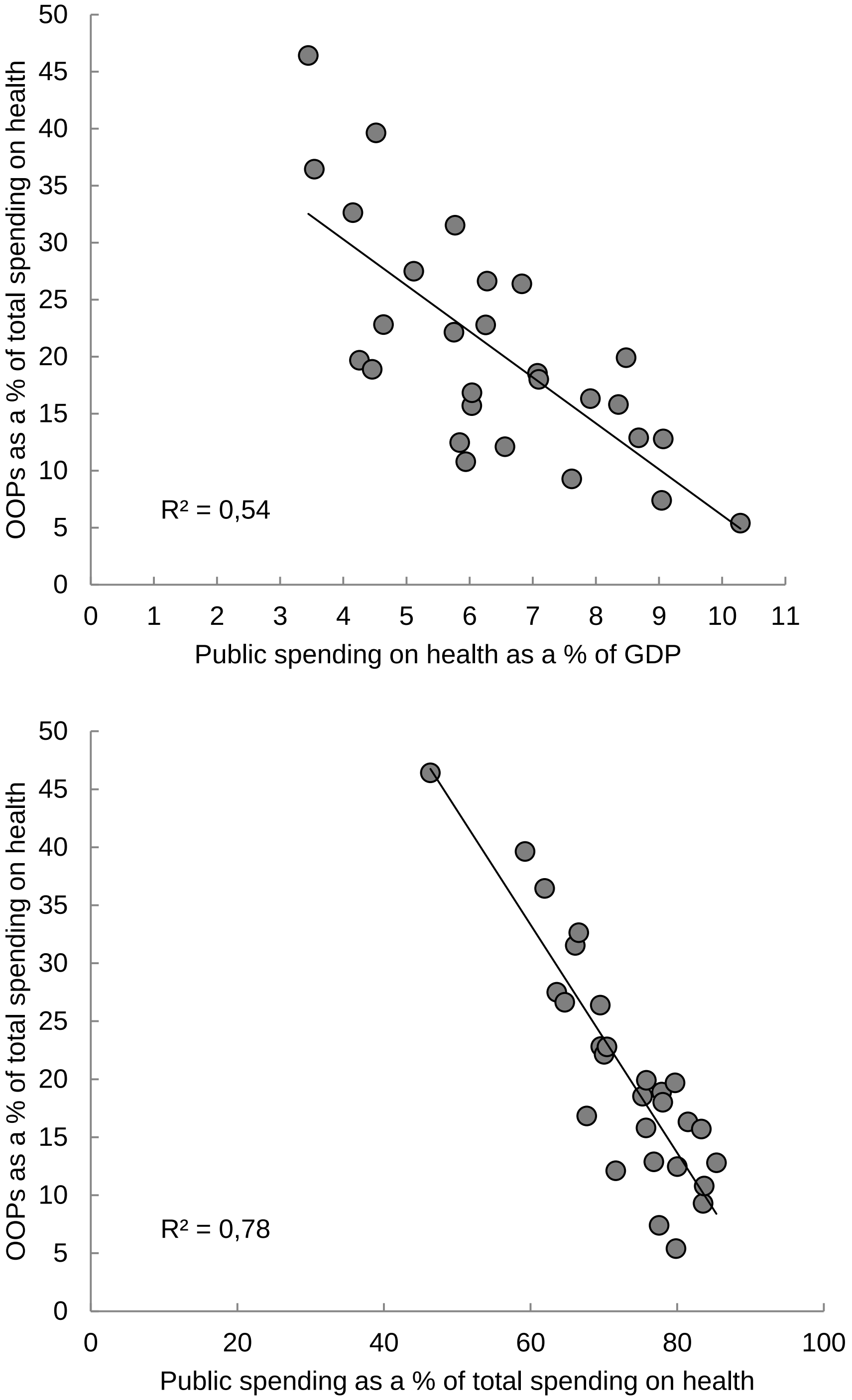
- access to health care based on need rather than ability to pay
- solidarity in the form of redistribution from healthy to sick, richer to poorer, active to non-active, younger to older
- equity in financing, meaning that payment for health care should be proportionate to income (all people pay the same share of income) or progressive (richer people pay a higher share of income than poorer people) and should not be regressive (poorer people pay a higher share of income than richer people)

The degree to which these principles are upheld varies across countries, but the principles themselves are broadly accepted and often explicitly stated in national health documents. Nevertheless, they are not inviolable. In future they may come under challenge as progressive 19th and 20th century movements to establish human rights, rights for workers and social cohesion in the wake of the industrial revolution and two world wars fade from public consciousness. The institutions of the new global economy also increasingly enable the richest people to avoid and evade taxes, placing ever greater responsibility for financing public benefits such as pensions, education and health care on the middle classes.

Affordability issues most commonly arise where there are gaps in publicly financed health coverage – for example, where people lack entitlement to publicly financed health coverage, the benefits package excludes needed services or user charges are imposed (see below). Gaps in publicly financed health coverage mean people have to purchase voluntary health insurance (VHI) or pay out-of-pocket. If they cannot afford either of these options, they will have to rely on health services provided by charitable (non-governmental) organisations (NGOs).

Promoting affordable access to health care requires keeping out-of-pocket payments as low as possible. Figure 2.1 shows the extent of the relationship between levels of public spending on health and levels of out-of-pocket payments in the European Union. To reduce out-of-pocket payments, countries will need to ensure first, that a large majority of total funding for the health system comes from public sources and second, that the level of public funding is adequate (see chapter 1). How public revenues for health are spent is also important.

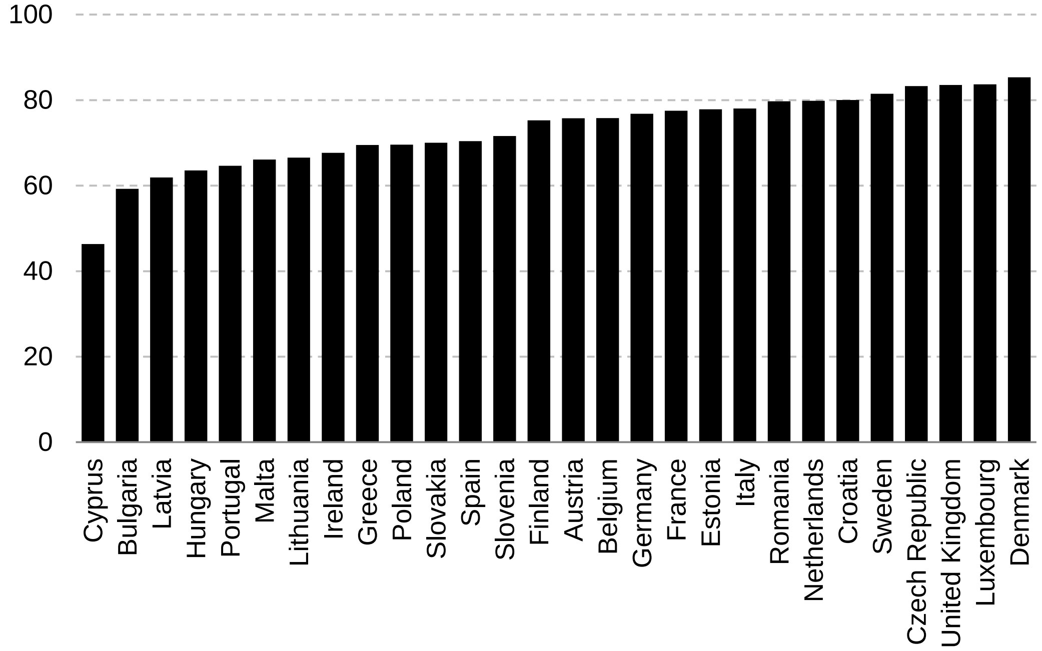
Figure 2.1 Relationship between out-of-pocket payments and public spending on health, EU28, 2013



Source: Authors based on WHO (2015)
Note: OOPs = out-of-pocket payments

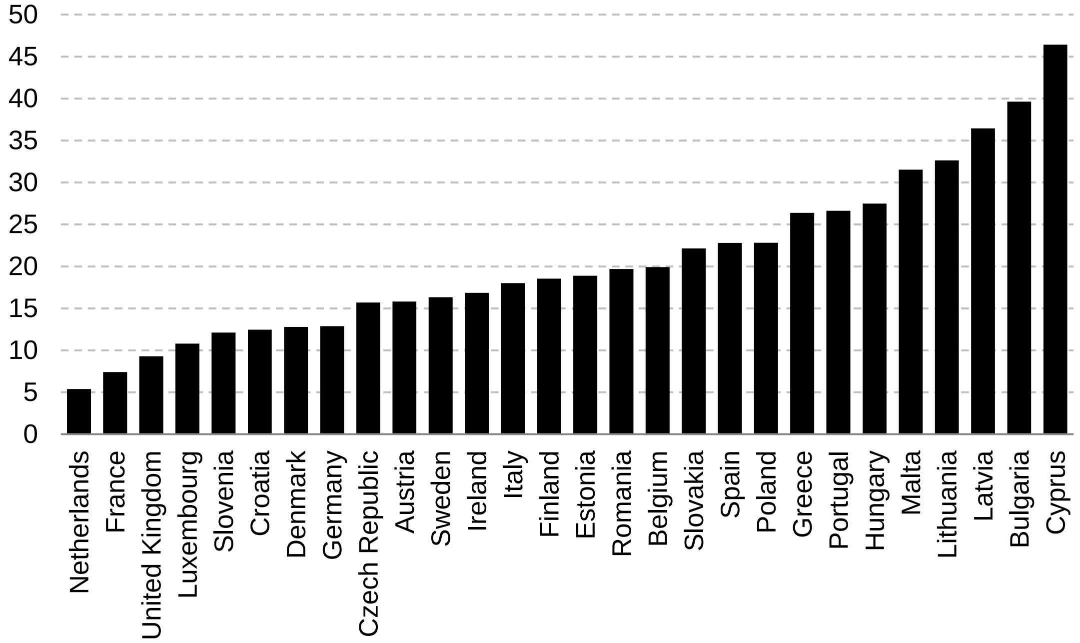
Levels of public spending on health vary substantially across EU Member States, both as a share of GDP (see Figure 1.1) and as a share of total spending on health (Figure 2.2). The out-of-pocket share of total spending on health also varies, ranging from under 10% in France, the Netherlands and the United Kingdom to over 35% in Latvia, Bulgaria and Cyprus (Figure 2.3).

Figure 2.2 Public as a share (%) of total spending on health, EU28, 2013



Source: WHO (2015)

Figure 2.3 OOPs as a share (%) of total spending on health, EU28, 2013



Source: WHO (2015)

2.2. Gaps in publicly financed health coverage

Policies on health coverage play a key role in ensuring affordable access to health care. Health coverage has three dimensions (see Figure I.7). Gaps in the breadth, scope or depth of publicly financed health coverage are a major source of affordability problems. These gaps mean people have to buy voluntary health insurance (VHI) or pay out-of-pocket or – if they cannot afford these options – rely on health services provided by charitable (non-governmental) organisations (NGOs).

Population entitlement: In the last twenty years the share of the population entitled to publicly financed health services has grown where coverage was not already universal. Entitlement is now increasingly based on residence rather than more restrictive categories such as citizenship or employment status (see Box 2.2). However, entitlement for migrant workers from countries outside the EU and undocumented migrants is often extremely limited (see Table 2.1).

Box 2.2 The basis for entitlement to publicly financed health care

Linking entitlement to employment status or payment of contributions generally makes health care less widely accessible and affordable, since those who lose their entitlement tend to be poorer people. For example, some EU Member States (among them Estonia and Greece) remove entitlement from people who are long-term unemployed, even though these people may have paid contributions for most of their working lives.

In recent years, some countries have considered linking entitlement to payment of contributions (Latvia, for example) as a way of encouraging employers and employees in the informal sector to pay taxes. However, making tax compliance the responsibility of the health sector has not been shown to be an effective strategy for formalising the economy and creates barriers to access.

Requiring people to show evidence of a permanent address or renew a health card on a regular basis can create administrative barriers to entitlement and is likely systematically to prevent certain groups from accessing publicly financed health services – for example, homeless people.

Table 2.1 Access to health services for undocumented migrants, EU28, 2014

Level of entitlement	Countries
Access to emergency care only	Austria, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Germany, Greece, Finland, Hungary, Ireland, Lithuania, Luxembourg, Latvia, Malta, Poland, Romania, Slovakia, Slovenia
Explicit entitlement for specific services or groups only	Belgium, Italy, Spain, Sweden, the United Kingdom
Full access	France, the Netherlands, Portugal

Source: Cuadra and Cattacin (2011) with author updates

The benefits package: Although most EU countries cover a relatively wide range of services, there is evidence of cross-national variation in the content of the benefits package, especially with regard to medicines for chronic conditions and new and expensive medicines. There is also significant variation in expectations and norms around the way in which covered services are delivered – for example, around the use of referral and evidence-based clinical pathways and guidelines.

User charges**:** All EU Member States have some formal user charges for health services. User charges are most widespread for outpatient prescription drugs, but are also often applied to other health services. The depth of publicly financed coverage varies widely across countries. Countries generally apply user charges for three reasons: to limit access to health care in the hope that this will contain public spending on health, to direct people towards more cost-effective services or patterns of use and to raise revenue for the health system. There is little evidence to suggest user charges are an effective instrument for achieving any of these aims. In fact, the need to protect access to cost-effective services, interventions that aim to prevent disease and services used by poorer people and people with chronic conditions is increasingly recognised. However, although there have been improvements in some EU countries, the design of user charges continues to lack any evidence base and is sub-optimal in many countries.

Informal payments**:** Informal payments are frequent in health systems in some Member States, especially some of those in central Europe that joined the EU after 2004. They have been characterised as a form of informal exit ("inxit") from the health system, occurring when supply is limited and the classic mechanisms of exit, such as moving into the private sector, or voice, such as applying political pressure for reform of the system, are unavailable or dysfunctional (Gaál and McKee 2004).

Informal payments have many adverse consequences. First, they are regressive in nature, taking a higher proportion of the income of the poor. Second, because they are typically used for access to interventions, they may encourage oversupply and waste. Third, they create an alternative line of accountability of physicians to those who can pay rather than to those charged with managing the overall system. As a result, they form a powerful barrier to health system reform (Gaál et al 2006).

Because of their covert and pervasive nature, informal payments have proven difficult to overcome. Given what is known of their role, the most promising avenue to addressing them is a comprehensive approach involving adequate funding and the strengthening of health system governance (Kutzin et al 2010).

2.3. The role of VHI in addressing gaps in publicly financed coverage

VHI provides financial protection where it plays a substitutive role (a person's only source of coverage) and a complementary role (covering excluded services or user charges). It provides faster access to health services where it plays a supplementary role. However, with some important exceptions, VHI does not do well in addressing gaps in coverage in EU countries or indeed globally (see Box 2.3). In most countries around the world its share of private spending on health is minimal (see below) and the relationship between VHI and out-of-pocket payments as a share of total spending on health is extremely weak.

Box 2.3 VHI does not do well in addressing gaps in health coverage

In 2013, VHI accounted for over a third of all private spending on health in only 6 EU Member States – Croatia (38%), the Netherlands (38%), Germany (40%), Ireland (41%), Slovenia (48%) and France (59%) – and accounted for under 10% of private spending in 14 EU Member States (see Figure 2.5). Its share is especially low in countries with higher levels of out-of-pocket payments. Thus, while there is evidence of significant gaps in coverage in several EU countries, VHI does not systematically address these gaps. Gaps in publicly financed coverage (or perceptions about the quality of publicly financed coverage) are a necessary but not sufficient prerequisite for VHI market development.

International analysis suggests that if VHI is to address gaps in coverage it must (Sagan and Thomson 2015 in press):

- be easily accessible and affordable, including to older people and people in poor health
- cover a very high share of the population (over 80% in Slovenia, the Netherlands and France, over 50% in Croatia and close to 50% in Ireland)
- or play a significant substitutive role in countries where public spending dominates

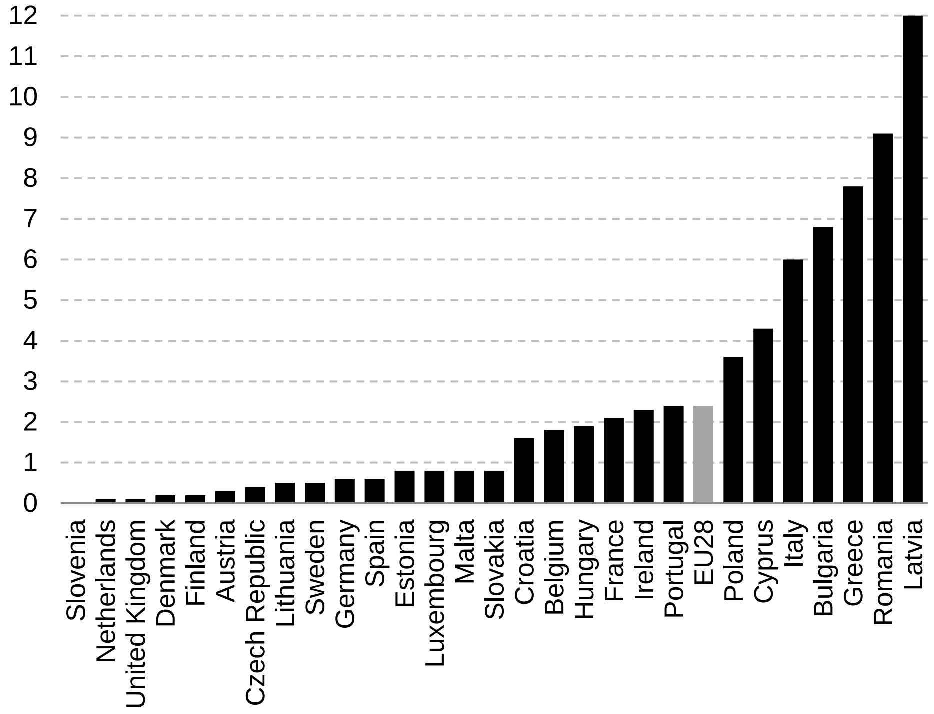
Although VHI can and does play a role in enhancing the affordability of health care, the EU experience suggests that the conditions under which this is most likely to happen are not easy to replicate. They also involve a number of risks for policy, including excluding richer people from publicly financed coverage (as in Germany) and introducing very high user charges in the form of co-insurance across the board (as in France and Slovenia).

Promoting VHI through tax subsidies – in the hope that this will relieve pressure on the health budget – has not been shown to be a cost-effective or equitable way of enhancing access. As we noted in chapter 2, due to sometimes complex interactions between publicly and privately financed and delivered care – and poor policy design – the promotion of VHI can skew the distribution of public and private health care resources away from need.

Tools for monitoring and evidence of variation

The most common way of monitoring affordability issues it to look at data on unmet need due to cost (see Figure 2.4). These data are routinely available in the European Union. They show how unmet need due to cost was experienced by around 12 million people across the European Union in 2013 (2.4% of the EU population). It is also relatively high as a share of the total population in some EU countries.

Figure 2.4 Share (%) of the population reporting unmet need for health care due to cost, EU28, 2013

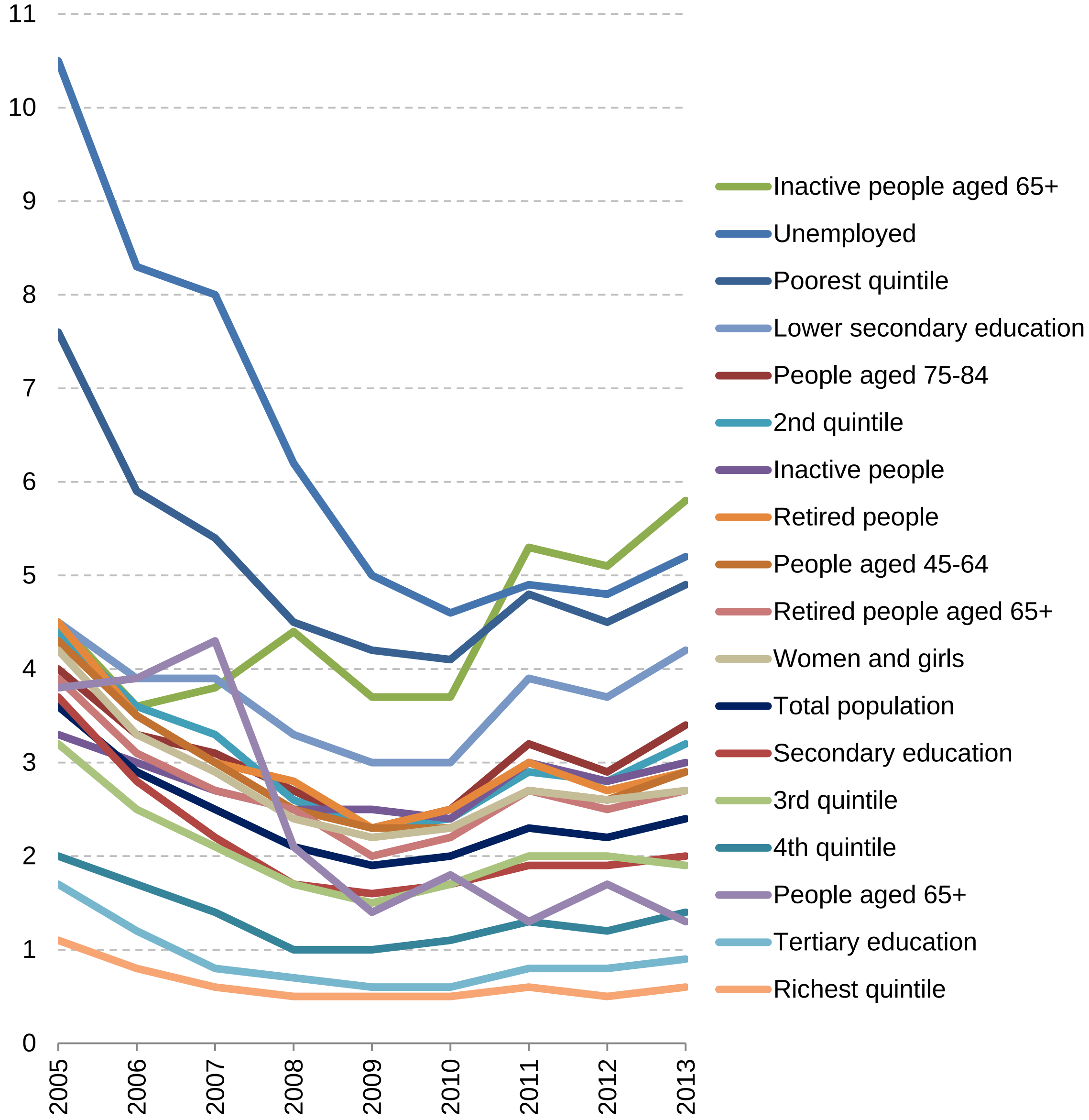


Source: Authors based on EU-SILC (2015)

At EU level, unmet need due to cost is a particular problem among older inactive people, unemployed people, retired people, the poorest 40% of the population, people aged over 75, people with lower educational status and women and girls (see Figure 2.5). In comparison, people aged 65 and over experience quite low levels of unmet need due to cost. EU-level data mask important differences across countries, however. Figure 2.6 shows how older people have very good access to health care in many countries – and do not, in fact, report any unmet need due to cost in the Netherlands, the United Kingdom and Slovenia – but experience much higher levels of unmet need due to cost than the general population in Poland, Bulgaria, Italy, Greece, Latvia and Romania.

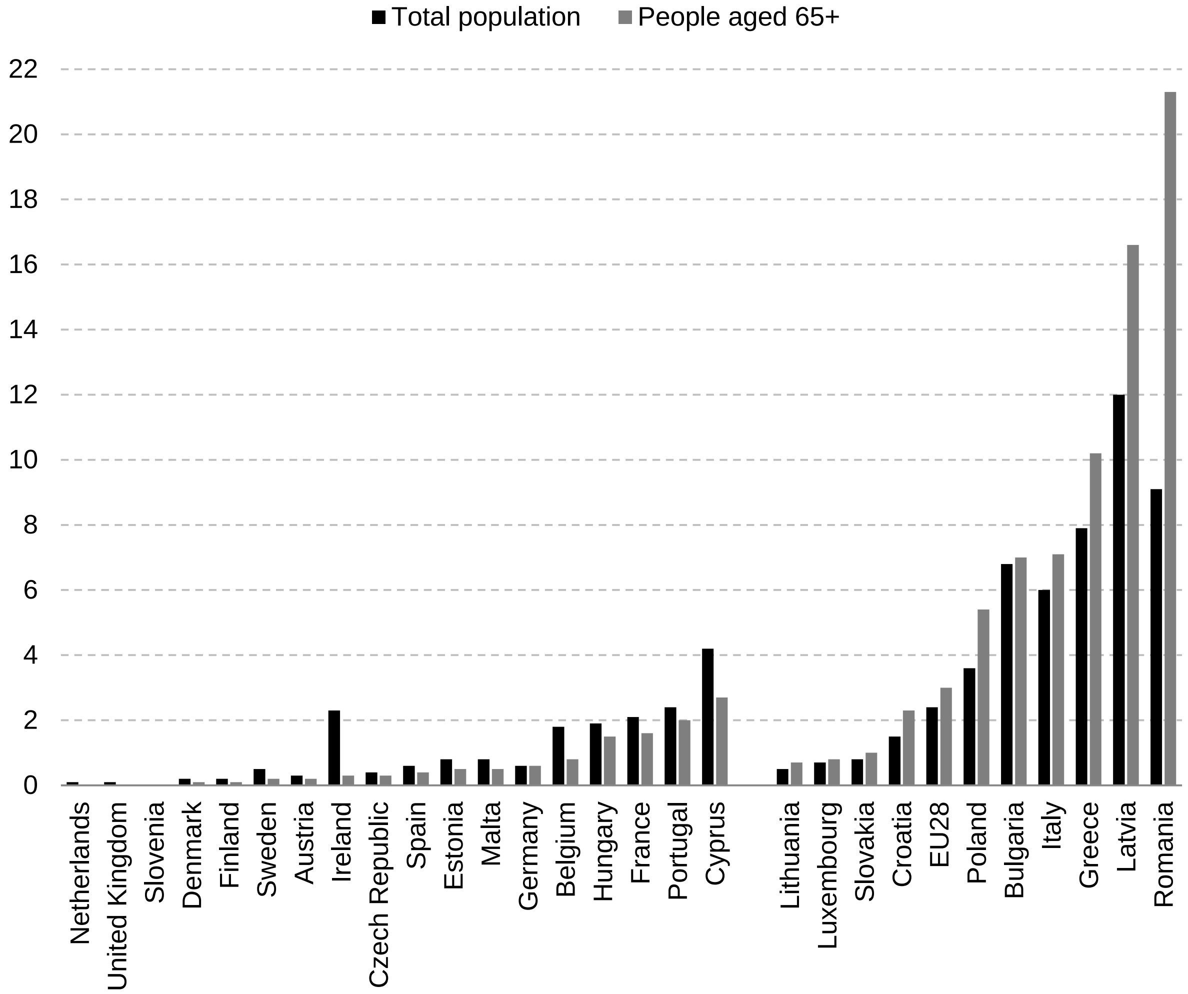
Although the unmet need data currently collected through EU-SILC are of limited value for comparative purposes, as we noted in the introduction, and lack explanatory power, they are useful for identifying trends over time within a country. For example, Figure 2.7 shows how unmet need due to cost has increased quite substantially for the poorest quintile in 12 countries since 2008.

Figure 2.5 Share (%) of the population reporting unmet need for health care due to cost by gender, age, education, income and labour market status, EU27, 2015-2013



Source: Authors based on EU-SILC (2015)

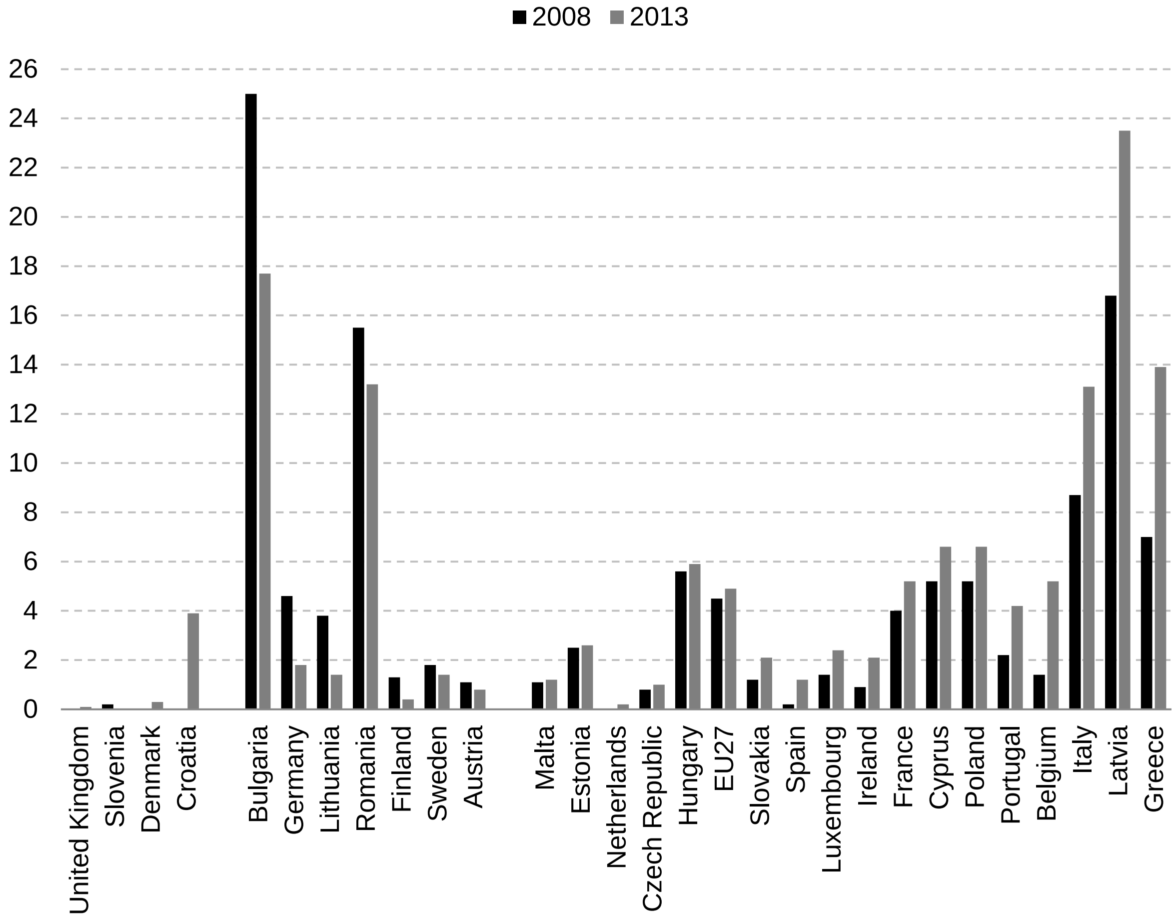
Figure 2.6 Share (%) of the population reporting unmet need for health care due to cost, total population vs older people, EU28, 2013



Source: Authors based on EU-SILC (2015)

Note: Countries in two groups – older people experience lower (left) or higher (right) levels of unmet need than the general population – ranked by difference in percentage points between older people and the total population.

Figure 2.7 Change in the share (%) of the poorest quintile perceiving an unmet need for a medical examination due to cost, 2008-2013



Source: Authors based on EU-SILC (2015)

Note: Countries are shown in three groups: on the left, countries with only one year of data; in the middle, countries in which unmet need has fallen since 2008; on the right, countries in which unmet need has increased since 2008. Countries ranked from high to low by the extent to which unmet has improved for the poorest quintile since 2008.

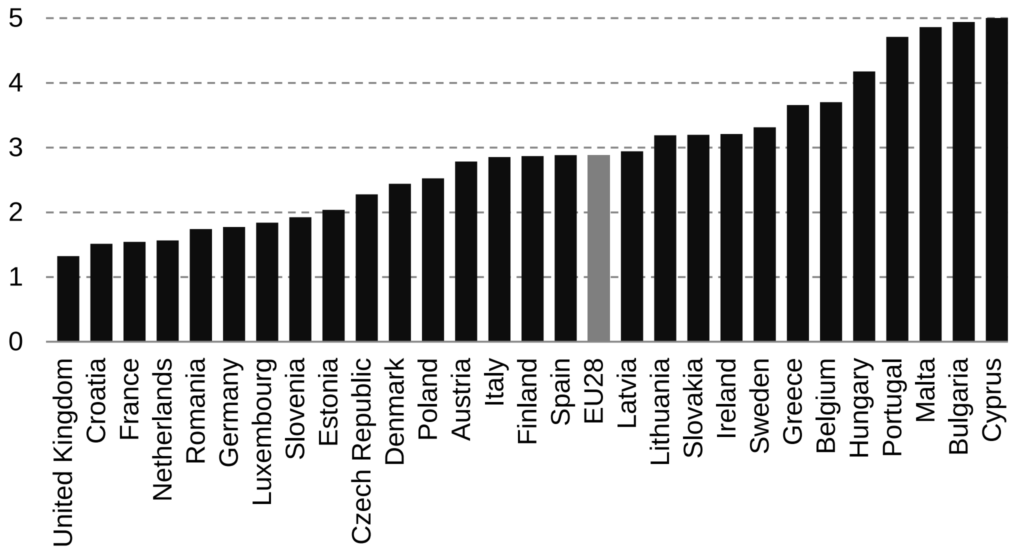
Estimates of financial hardship among people who use health services are important, because having to pay for health care at a given point in time may reduce affordability in the future. Financial hardship is usually measured by calculating how much a household spends on health care out-of-pocket and then assessing this against measures of poverty and capacity to pay. This type of analysis provides valuable information on the incidence and distribution of financial hardship caused by out-of-pocket payments by income level and other household characteristics. It also provides useful information on the drivers of financial hardship – that is, what

While this calculation is straightforward, the household survey data required are not routinely available. EU Member States are only required to conduct household budget surveys every five years (although some do this on an annual basis) and the number of questions relating to health spending is usually very low in this type of survey and the recall period is often very short, which means financial hardship due to health spending is likely to be systematically underestimated. The WHO

Regional Office for Europe is currently conducting a regional study on financial protection. Results for 15-20 countries will be available in 2016 and 2017.

The Eurostat database can be used to calculate the share of total household consumption spent on out-of-pocket payments for health, as shown in Figure 2.8. However, these data are only available at five-year intervals and, more importantly, they do not permit any disaggregation by income or type of household. As a result, they can provide a rough picture of differences across countries and over time but do not really capture the incidence, distribution or drivers of financial hardship.

Figure 2.8 OOPs as a share (%) of total household consumption, EU28, 2012



Source: OECD health data (2014)

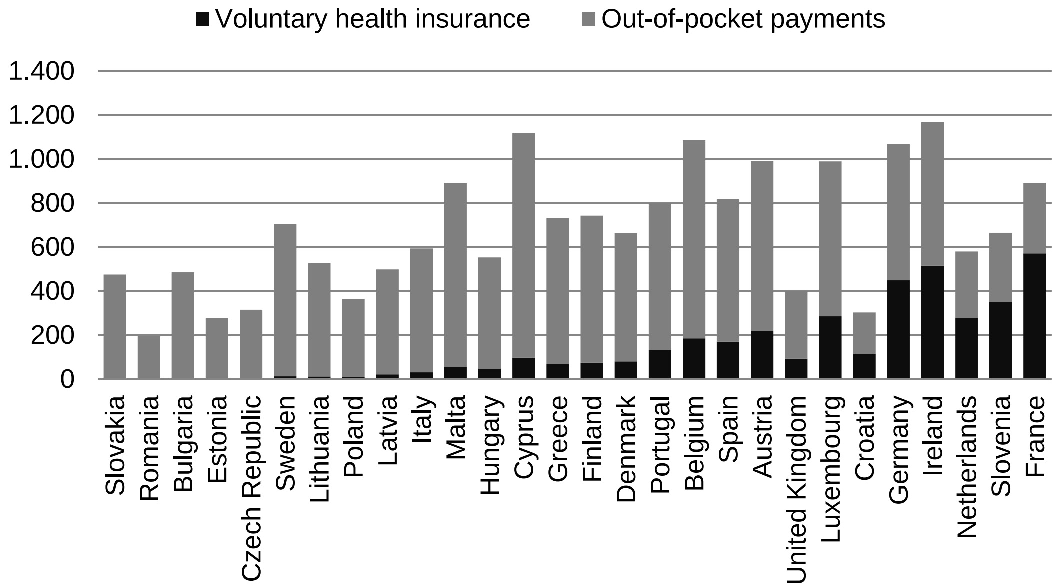
The simplest proxy indicator for affordability and financial protection is the out-of-pocket share of total spending on health (Figure 2.3). International analysis shows the incidence of catastrophic and impoverishing out-of-pocket payments rises sharply when out-of-pocket payments exceed 15% of total spending on health (Xu et al 2010). OOPs vary enormously as a share of total spending on health across EU countries, with two-thirds of countries having shares of over 15% and almost one third having shares of over 25% (see Figure 1.4).

Similarly, the VHI share of private spending on health can shed light on how well VHI addresses gaps in publicly financed coverage. Figure 2.9 shows how VHI does not do well in addressing gaps in publicly financed coverage in all but a handful of countries. In many countries its share of private spending is minimal, particularly in countries where the private share of total spending on health is high (see Figure 2.2).

Data on patterns of service use are useful if they can be disaggregated by coverage status (publicly covered, VHI coverage, uninsured), income quintile and other individual characteristics. Unfortunately, such data are not available at EU level.

Qualitative assessment of health coverage is important in understanding where affordability is likely to be an issue. Looking at which groups are excluded from entitlement, whether certain essential services are available only to those who are eligible for specific schemes and the design of user charges policy is a useful starting point for analysis.

Figure 2.9 Per capita spending on health through VHI and OOPs (PPP), EU28, 2013



Source: WHO (2015)

Note: Countries ranked from low to high by VHI as a share (%) of private spending on health

Resonance for specific people

Affordability is most likely to be problematic for poorer people and people in poor health, especially people with chronic conditions, who use health services and medicines on a regular and ongoing basis. In 2013, one in four people in the European Union (24.5%) – about 122 million people in total – was at risk of poverty or social exclusion. This number has risen since substantially since 2009, following a period of decline (see Table I.1). Women, young adults, unemployed people and less-educated people face the highest risks.

Policy responses

Within the health sector, ensuring affordable access to health care requires the following actions (see also Box 2.4):

- Ensure most spending on health comes from collective public rather than private sources.
- Ensure out-of-pocket payments are as low as possible. The incidence of catastrophic and impoverishing spending on health rises as the out-of-pocket share of total spending on health rises.
- Identify and close gaps in publicly financed coverage of cost-effective services.
- Broaden the basis for entitlement to encompass everyone living in a country, regardless of legal status.
- Eschew discriminatory approaches such as entitlement linked to employment status or payment of contribution or situations in which people with different diagnoses are entitled to different benefits (‘inequity by disease’).
- Reduce or eliminate user charges so that they do not create financial barriers to cost-effective services or undermine financial protection.
- Ensure efficiency in spending public resources, paying attention to the scope of the benefits package, prioritising cost-effective health services, including elements of performance in provider payment and developing appropriate pricing strategies.
- Eliminate informal payments using a mix of policy instruments.

Outside the health sector, fiscal social protection policies are critical to addressing poverty and income inequality.

To support Member States, the European Union can adapt EU-SILC, its main source of comparable data, to include proxy measures of financial hardship; require countries to carry out household budget surveys more regularly; and ensure these surveys use a robust, standardised, extended health module to enable better estimation of financial hardship.

Box 2.4 Coverage policies for equitable access to health services

The basis for entitlement is living in a country rather than employment status, payment of contributions or income.

Everyone living in a country is in the same (risk) pool. This may be a virtual pool , achieved through risk-adjusted transfers to or among purchasing agencies.

Everyone living in a country is entitled to the same publicly financed benefits.

There are no incentives for providers to treat people differently.

The publicly financed benefits package covers the full spectrum of health services, from prevention to treatment, rehabilitation and palliative care.

The publicly financed benefits package includes evidence-based clinical pathways, including referral.

Before applying user charges, consideration should be given to the potential costs involved: the costs of increasing the complexity of entitlements; the costs of administering user charges and exemptions from user charges; the costs of creating barriers to cost-effective services and patterns of use; and the costs of any care foregone or delayed as a result of user charges.

If user charges are applied, they should be carefully designed to avoid creating barriers to cost-effective services and patterns of use and to avoid creating uncertainty about how much people have to pay for health care. Poorer people and people who regularly use health services (including medicines) require special protection. Some examples of good practice include:

- exempting poorer people, economically inactive people, people with chronic conditions, minors, pregnant women and new mothers from user charges

- exempting preventive services from user charges

- the use of (low) co-payments (a fixed rate per prescription or service) rather than co-insurance (a share of the medicine or service price), so that people know exactly how much they will have to pay for a prescription or physician visit or stay in hospital

- setting a ceiling or cap on user charges so that people know they will not have to pay more than a certain share of their income every year; Germany uses this policy and the share of annual income is set at 2% or 1% for people with chronic conditions

Entitlements should be defined as simply and transparently as possible to avoid confusing users and health workers.

[This page intentionally left blank]

3. Services are relevant, appropriate and cost-effective

Chapter summary

Promoting access does not mean making everything available to everyone at all times. In the context of limited resources, it is important to ensure that spending on health is as cost-effective as possible. While the publicly financed benefits package needs to be broad, covering the full spectrum of services from health promotion, disease prevention and early detection to disease management, treatment, rehabilitation and palliative care, it should also be relevant to the health needs of the population and defined and delivered in a way that is consistent with need and evidence, including evidence of cost-effectiveness. Otherwise, the right services may not be provided to the right people at the right time at least cost, with negative implications for quality, efficiency, equity and financial protection.

Evidence of the provision of non-cost-effective health services, of avoidable hospitalisations and of unwarranted variations in clinical practice is growing in EU Member States. International research on unwarranted clinical variations indicates that geography is the main determinant of health care use and spending at the population level, not need, and that higher-spending regions fail to achieve better outcomes. European analysis reveals significant room for improving efficiency by lowering the provision of non-cost-effective health services. Data on avoidable hospitalisations for ambulatory care-sensitive conditions such as asthma and diabetes also show substantial variation within and across countries. Both types of data highlight a social gradient, indicating that people living in more deprived areas may be subject to more unnecessary and potentially harmful overuse than others.

To address these issues, countries should adopt a comprehensive strategy mainly targeting health workers, but also patients and the public:

- Ensure the publicly financed benefits package covers the full spectrum of services, is correlated with population health needs and does not result in inequity by disease.
- Take steps to avoid over-medicalisation.
- Put in place systematic priority-setting processes to enable HTA-informed, cost-effective coverage decisions for both new *and* existing technologies.
- Develop clinical pathways, guidelines and systems of referral, adapt single-condition guidelines to meet the needs of people with multiple morbidities and monitor adherence to guidelines.
- Train and support health workers to deliver services in line with evidence.
- Ensure all patients have access to adequate and accessible information about treatment options and outcomes.
- Establish information systems to identify (and publicly report on) practice variations and patient outcomes and to support effective decision making by health professionals and patients. This should include decision aids for patients to help them assess the potential benefits and risks of different treatment options.

People should have access to a full spectrum of publicly financed health services: health promotion, disease prevention, early detection, disease management, treatment, rehabilitation and palliative care. However, as we noted in the introduction, promoting equitable access does *not* mean making everything available to everyone at all times. Rather, it aims to ensure three things:

- The services available broadly correspond to the health needs of the population, including people with rare diseases. This notion of 'relevance' (Maxwell 1992) refers to an optimal overall pattern and balance of services given the needs and desires of a specific population.

- Services are delivered in way that is consistent with the needs of a particular individual and with evidence. This is often referred to as appropriate care (see the EXPH opinion on quality and patient safety).[2]

- Services are defined and delivered in relation to cost-effectiveness, meaning that benefits should outweigh costs and, where alternatives are available, the most cost-effective option is chosen.

Meeting these aims is an important dimension of access because public resources are limited and it is therefore wasteful – and unethical – from a societal perspective, to promote access to services that are ineffective or more costly than alternatives offering the same degree of benefit. The provision of non-cost-effective services is not only inefficient. It can also undermine quality of care and may diminish financial protection and equity if it causes people to use unnecessary services or draws resources away from cost-effective services.

Evidence of the provision of non-cost-effective health services, of avoidable hospitalisations and of unwarranted variations in clinical practice is growing in EU Member States. International research on unwarranted clinical variations indicates that geography is the main determinant of health care use and spending (at the population level), not need, and that higher-spending regions fail to achieve better outcomes.

Data on avoidable hospitalisations for ambulatory care sensitive conditions such as asthma and diabetes also show substantial variation within and across countries. In 2012, the rate of hospital admission for uncontrolled diabetes ranged from under 25 to over 150 per 100,000 people (Figure 3.1).

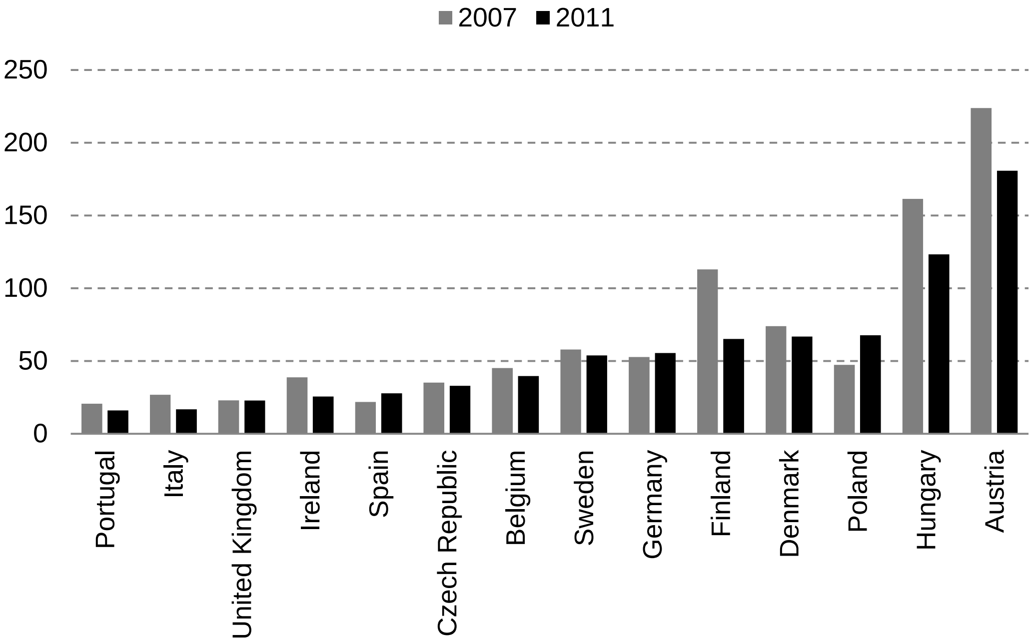
Both types of data highlight a social gradient, indicating that people living in more deprived areas may be more subject to unnecessary and potentially harmful over use than others.

There is significant evidence of variation across countries in the use of – for example – antibiotic drugs and in the effectiveness of basic but vital preventive programmes such as immunisation. In 2013, the share of children immunised against diphtheria, tetanus and pertussis ranged from 83% to 99% (Figure 3.2).

---

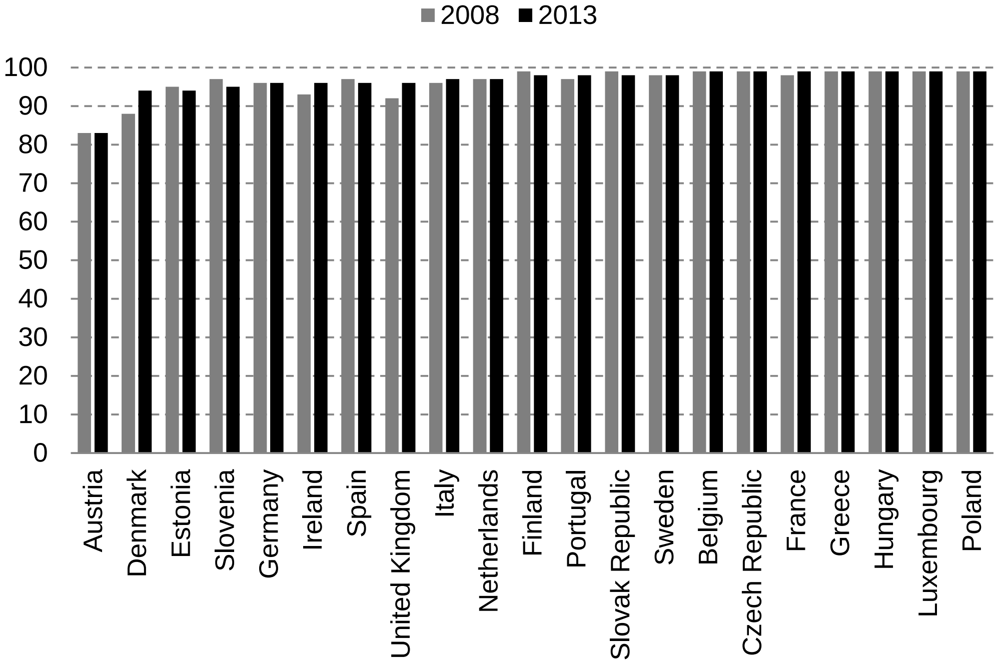
[2] http://ec.europa.eu/health/expert_panel/index_en.htm

Figure 3.1 Hospital admissions for uncontrolled diabetes (age-sex standardised rates per 100,000 people), EU28, 2007 and 2012 or latest available year



Source: OECD health data (2015)
Note: Countries ranked from low to high in latest available year; no data available for most EU countries; data are for people aged 15 and over; data for Austria and Italy are for 2009 for the earlier year; data for the UK and Germany for the later year are 2009 and 2010 respectively.

Figure 3.2 Share (%) of children immunised against DTP, EU28, 2008 and 2013



Source: OECD health data (2015)
Note: Countries ranked from low to high in 2013. DPT = diphtheria, tetanus, pertussis.

In theory, ensuring services are relevant, appropriate and cost-effective can be achieved by using systematic and evidence-based approaches such as health needs assessment to define overall service availability at national and local levels and health technology assessment (HTA) to inform coverage decisions (the content of the publicly financed benefits package) and clinical practice. Health needs assessment is a systematic method of identifying the unmet health and health care needs of a population, so that resources can be effectively targeted. It may involve working with other agencies, local people and service users (Stevens and Gillam 1998). HTA identifies safe, effective, patient-focused and cost-effective interventions (Velasco Garrido et al 2008). In reality, evidence-based approaches frequently fall short of expectations for a variety of reasons.

Limited uptake of HTA to inform coverage decisions: Some EU health systems use HTA evidence to inform coverage decisions although it tends to be the exception rather than the norm – limits to coverage more often focus on whole areas of service and usually those not provided by physicians such as dental care and physiotherapy. Countries are increasingly trying to use cost-effectiveness as a decision criterion (Sorenson et al 2008). However, HTA presents technical, financial and political challenges, which may explain why it is not as widely used as it might be, especially for disinvestment, and why it is mainly applied to new technologies.

HTA focuses on new technologies rather than on disinvestment: To date, only a handful of EU countries systematically uses HTA for disinvestment (de-listing of existing benefits) (Ettelt et al 2007).

Evidence is ill-equipped to meet changing health and policy needs: Since the early 1990s, evidence-based medicine has played an increasingly prominent role in health service delivery, resulting in the development of a vast set of guidelines to inform clinical practice. However, most guidelines focus on a single disease or condition and draw on evidence from trials in which people with multiple morbidities were excluded. As a result, they are frequently unsuited to – even inappropriate in – a context in which many people have more than one illness or condition – 'multi-morbidity' (De Maeseneer et al 2003). There is also the view that clinical evidence should be complemented by contextual and policy evidence, taking into account the history, expectations and goals of specific patients and the cost-effective use of resources.

Evidence-based practice guidelines are lacking or ignored: Evidence of large variations in delivering care to similar patients has stimulated efforts to optimise and, where appropriate, standardise treatment of specific conditions or groups of patients over the course of care using practice guidelines, protocols or care pathways. These tools have been shown to improve the quality of care provided by physicians and allied health professionals (Grimshaw et al 2004a, Grimshaw et al 2004b, Thomas et al 2000). A small body of evidence suggests guidelines can also enhance efficiency and reduce costs, although care needs to be paid to implementation (Bahtsevani et al 2004, Legido-Quigley et al 2013).

In general, it is difficult to assess to what extent available guidelines are implemented, adhered to and influence outcomes. A recent survey mapping the use of practice guidelines in 29 (mainly EU) countries identified relatively few as being 'leaders' in the field (Belgium, England, France, Germany, the Netherlands) or having well-established programmes (Finland, Norway, Sweden), but noted recent albeit sometimes fragmented developments in a few other countries (the Czech Republic, Greece, Hungary, Ireland, Luxembourg, Malta, Spain) (Legido-Quigley et al 2013). This suggests considerable scope for action in EU and non-EU countries.

Lack of processes to ensure access is based on severity of need: Ensuring equitable access means treatment should be prioritised according to the severity of a person's condition or need for health care. This requires the use of effective referral systems and triage. Most health problems are self-limiting and appropriate use of basic diagnostic tools – starting with low-cost strategies such as history-taking and clinical examination, then moving onto simple technologies (lab tests or imaging) – can therefore address over 90% of all new health problems. For this reason it is most cost-effective for most people to enter the health system at the primary care level and then, when needed, to be referred to secondary care.

Referral systems aim to improve quality and efficiency in health service delivery by ensuring that people receive appropriate and well-coordinated care. Through referral, patients are guided to the professionals and facilities most suited to treating them. Referral systems can contribute to efficiency by minimising inappropriate care and duplication and by upholding the principle of subsidiarity – that is, that tasks should be carried out at higher levels if they cannot be performed effectively at lower levels (and vice-versa). In the absence of a referral system, hospitals and secondary care doctors would see too many self-limiting cases, eroding their ability to deal with complex cases, while family physicians would not see enough children (for example), eroding their ability to provide effective out-of-hours care to children; and sometimes a second opinion is called for to confirm or reject an initial diagnosis. As a result, effective referral systems benefit patients and health professionals.[3]

Over medicalisation: Some domains of daily life are increasingly subjected to medical definition and jurisdiction, often as a result of 'disease mongering', a process in which interested parties create public awareness of and demand for specific treatments through direct to consumer advertising, use of the news media and other strategies (Moynihan and Cassels 2005). Disease mongering has been defined as 'the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments . . . [it leads to] aspects of ordinary life, such as menopause, being medicalised; mild problems portrayed as serious illnesses, as has occurred in the drug-company-sponsored promotion of irritable bowel syndrome, and risk factors, such as high cholesterol and osteoporosis, being framed as diseases' (Moynihan and Henry 2006). Disease mongering is problematic because it can turn healthy people into patients, it wastes limited resources and it may harm health.

Inequity by disease: This can occur when people with the same need but with a different diagnosis receive different levels of care. A good example includes the increasing tendency to prioritise the treatment of cancer. The UK government set up a Cancer Drugs Fund in 2010 to ring-fence funding for cancer drugs and enable the use of drugs normally deemed non-cost-effective. Similarly, in Belgium, patients with hemiplegia caused by a brain tumour are much better off than patients with the same condition caused by stroke because the government's cancer plan offers cancer patients access to all kinds of additional support (very often free of charge) that is not available to stroke patients. It will be important to monitor this phenomenon in the future (De Maeseneer et al 2012).

Politics: The examples highlighted in the last paragraphs reflect the role of interests, politics and the media in determining which patients obtain access to which services. Systematic, evidence-based approaches attempt to overcome the

---

[3] For more information see the EXPH opinion on primary care, which includes a section on referral. http://ec.europa.eu/health/expert_panel/opinions/docs/004_definitionprimarycare_en.pdf

pitfalls of arbitrary or interest-driven decision-making, but other factors inevitably intervene, often in response to the limits imposed by those same approaches. This does not undermine the case for such approaches. It emphasises the importance of ensuring that efforts to allocate resources based on explicit criteria or to influence clinical practice pay careful attention to the views of the public, patients and health professionals in a transparent way.

Tools for monitoring and evidence of variation

There is now a growing body of evidence on variations in clinical practice within and across countries, indicating potentially substantial amounts of waste and harm due to misuse, overuse and underuse of a wide range of health services. Four EU countries have established atlases of clinical practice variations (Spain, the United Kingdom, Germany and the Netherlands), there are national studies in other countries (Peiró and Maynard 2015) and the OECD has recently analysed variations in nine EU Member States (OECD 2014). Analysis from the five countries involved in the EU-funded European Collaboration for Health Optimization (ECHO)[4] reveals significant scope for improving efficiency by lowering the provision of non-cost-effective health services.

Resonance for specific people

The absence of relevant, appropriate and cost-effective care will ultimately affect all those in need of health services, but has particular resonance for the rising share of patients with multiple morbidities.

Policy responses

Public reporting via atlases are a first step towards promoting change. Less is known about how to address the problem of unwarranted variations, which has proved to be intractable over a long period of time. However, countries should adopt a comprehensive strategy that mainly targets health workers, but also patients and the public:

- Ensure the publicly financed benefits package covers the full spectrum of services, is correlated with population health needs and does not result in inequity by disease.
- Take steps to avoid over-medicalisation.
- Put in place systematic priority-setting processes to enable HTA-informed, cost-effective coverage decisions for both new *and* existing technologies.
- Develop clinical pathways, guidelines and systems of referral, adapt single-condition guidelines to meet the needs of people with multiple morbidities and monitor adherence to guidelines.
- Train and support health workers to deliver services in line with evidence.
- Ensure all patients have access to adequate and accessible information about treatment options and outcomes.
- Establish information systems to identify (and publicly report on) practice variations and patient outcomes and to support effective decision making by

---

[4] http://echo-health.eu/?doing_wp_cron=1443262769.6446959972381591796875

health professionals and patients. This should include decision aids for patients to help them assess the potential benefits and risks of different treatment options.

[This page intentionally left blank]

4. Well-equipped facilities are within easy reach

Chapter summary

Proximity to health facilities is determined by a number of interrelated factors, including the topography of the land, the density of the population and the quality of the transport infrastructure. The situation may be compounded by the maldistribution of facilities due to a failure of planning or official neglect, as is the case with Roma people in some countries in central Europe.

Geographical barriers present inevitable trade-offs. The provision of modern health services requires facilities with 24-hour cover of a range of specialties. An equitable distribution of services is not simply a matter of funding. It also requires a substantial number of staff with qualifications that cannot easily be substituted, as well as a sufficient workload to justify employment and ensure staff retain their skills.

Although in many places the problems are obvious – for example, small islands, mountainous terrain or remote areas – those involved have typically developed their own solutions, influenced by the resources available and what is provided in the facilities that serve them. Few of these approaches have been evaluated systematically and evidence of the health impact of differences in access to facilities in Europe is limited.

Potential solutions lie in two broad areas:

- To engage in area-level planning with the aim of creating networks of dispersed facilities feeding into a central one, based on agreed clinical pathways.

- To develop mechanisms to facilitate the transport of patients to health facilities or health professionals to patients.

Both sets of policy responses require administrative structures that can take a population-wide perspective and have the managerial tools required for capacity planning. In the absence of geographical responsibility for health, instruments such as certificates of need for particular forms of advanced medical technology can be used.

Ensuring policy responses are effective is challenging and there is a need to accept trade-offs. Where barriers are social rather than geographical – for example, those that lead to a relative lack of facilities in areas populated by poorer people or ethnic minorities – there is a need to document the extent of inequalities and to take action within the context of health planning systems.

The European Union can support Member States by continuing work to develop reference networks.

Facilities and equipment should be distributed so that they are in easy reach of everyone. However, this is a goal that is much easier to state than to achieve in practice. In many parts of Europe there are significant barriers to achieving equitable geographic access to appropriate facilities. These can be related to supply factors, with a number of considerations serving to increase pressure to centralise services in large facilities providing a high volume of care – notably, the challenge of providing 24-hour cover safely in certain specialties and evidence of a relationship between volume and outcome in some areas of care. For example, paediatric cardiac surgery is now organised on a national basis in England following revelations of sub-standard care in one facility and clear evidence of a volume-outcome relationship, while in Germany there are continuing concerns about the large number of low-volume and solo practitioners.

Other factors are related to demand. This is the case in isolated rural areas with a very low population density, such as northern Sweden and Finland. To a lesser extent, similar problems can arise around large cities, many of which have hospitals occupying the same land as they did several centuries previously, even though the distribution and composition of the population around the hospital may have changed beyond recognition. Particular challenges arise in places that are isolated by the presence of natural barriers. The most obvious examples are islands and mountainous areas.

Even where these geographical problems do not exist, facilities providing appropriate care may not be effectively distributed. The nature of health care has changed dramatically in the past century. The modern hospital was created around three major technological developments: operating theatres, laboratories and x-ray machines. The advent of minimally invasive surgery, interventional radiology, handheld or desktop analysers and ultrasound have challenged the traditional model. In addition, the growth of multi-morbidity and chronic disease means that many patients will be managed not as a series of isolated episodes requiring hospitalisation but as a continuum that spans primary, secondary, tertiary and social care.

These developments call for systems that can put in place co-ordinated or integrated models of service delivery that allow patients and carers to move seamlessly between different settings. The ability of health systems to respond effectively varies greatly, with many facing considerable organisational and financial barriers to change.

Tools for monitoring and evidence of variation

Traditionally, indicators of health system capacity, and particularly those that relate to facilities, have been based on counting structures such as hospitals or hospital beds. However, these measures are largely meaningless. Definitions vary enormously, both among countries and over time, as when the Belgian authorities reclassified many small facilities that had been described as hospitals, recognising that in effect they were nursing homes.

More appropriate measures would look at the experience of people seeking care. There may be questions on unmet need for health care in individual surveys conducted within countries or comparing a few countries, as well as surveys of unmet need for specific conditions. The only comparable source of such data across Europe is EU-SILC (Arora et al 2015), which includes a question on unmet need for medical and dental examinations due to travelling distance. However, interpreting these data is challenging given the complex nature of the interaction between people and the health system. Thus, it may be relatively easy to make first contact with the health system then face significant barriers in progressing further.

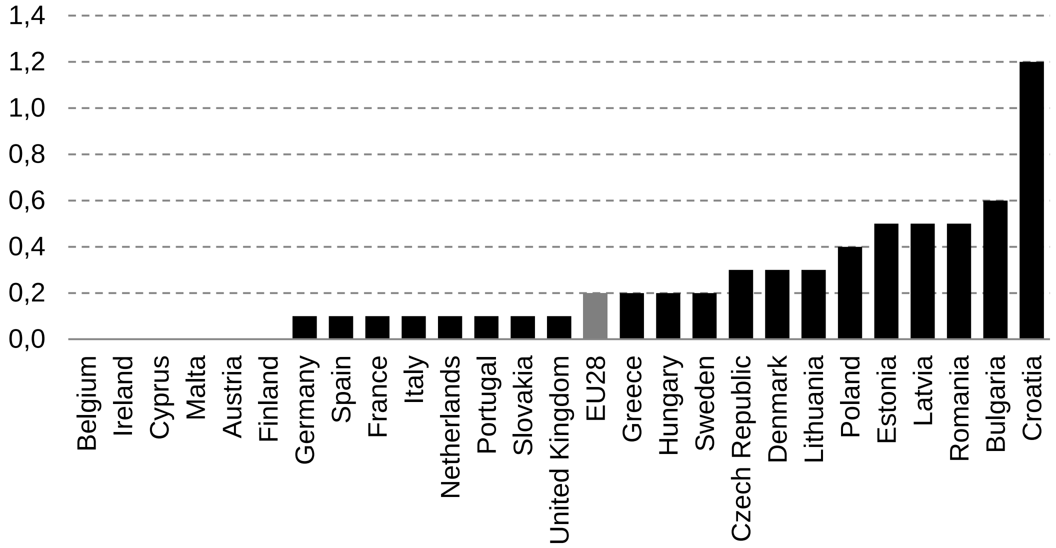
Measurement is also complicated in countries that have adopted targets and have imposed either incentives to meet targets or penalties for failing to do so. The experience of England illustrates the pitfalls. During the 2000s, the imposition of targets led to numerous imaginative gaming strategies, allowing providers to meet the targets without necessarily conferring any benefit on patients (Wismar et al 2008).

A further problem is that aggregate figures may obscure important differences. Thus, the population overall may be able to obtain access to care at nearby facilities but there may be barriers facing particular groups within the population (see below).

For all of these reasons, it is unlikely that any single indicator can be used to assess unmet need related to the distribution of health facilities. Instead, it is likely to require specific studies to understand the barriers facing different groups of people as they seek to obtain care at different levels of the health system and at different points in their trajectory through it.

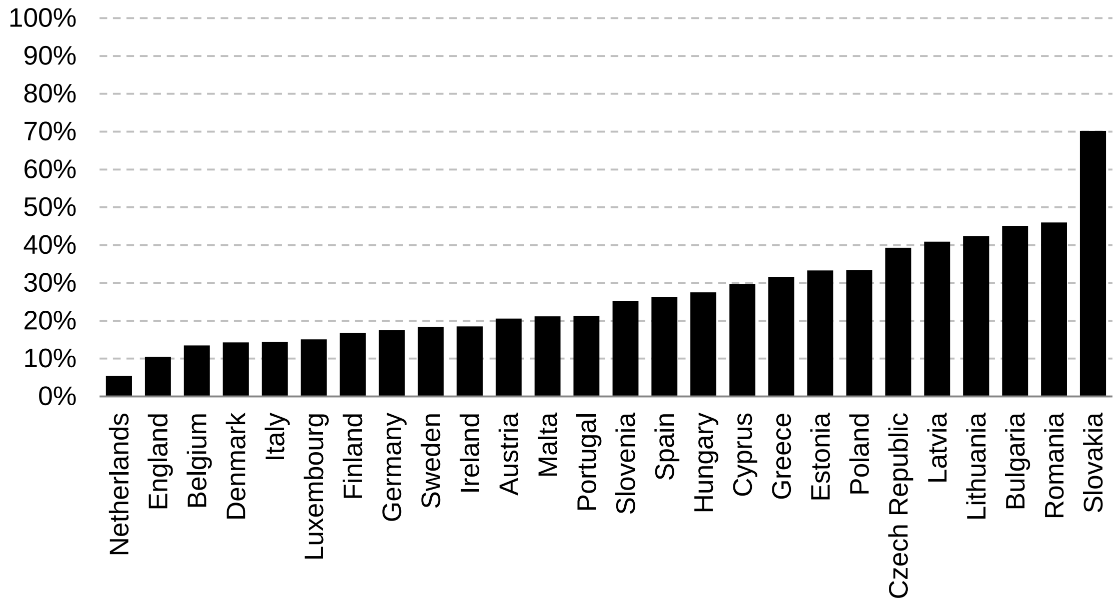
EU-SILC data suggest that levels of unmet need attributable to travel distance are low in most Member States, at under 1% in all except Croatia (Figure 4.1). In about half of EU Member States reported rates were 1 in 1000 or less. However, as noted above, this indicator has many limitations and it is possible that the sampling strategy tends to exclude those in most need. Survey data from the EU-funded QUALICOPC study (Figure 4.2) confirm that problems with distance to facilities is mainly experienced among people living in the Member States that joined the European Union in 2004.

Figure 4.1 Share (%) of the population reporting unmet need for a medical examination because it was too far to travel, EU28, 2013



Source: Authors based on EU-SILC (2015)

Figure 4.2 Share (%) of people that have to travel for more than 20 minutes to reach their nearest primary care facility, EU27, 2013



Source: QUALICOPC (2015)

Note: No data are available for Croatia and France.

Resonance for specific people

In some cases it is straightforward to identify those groups who will be particularly disadvantaged by the distribution of health facilities. However, there will also be many problems that are not so obvious. The former include the delivery of health care in sparsely populated rural areas, especially where there are geographical barriers like mountains and stretches of water, and in locations experiencing severe deprivation. The less obvious barriers are often to do with social and economic disadvantages facing particular groups of people.

One group that faces particular barriers within the EU are the Roma. In some countries Roma people live in separate settlements or in rundown areas on the outskirts of larger settlements. A number of studies have documented how these places are underserved by health facilities and often have poor transport connections to the facilities that do exist. The situation is compounded by widespread discrimination, so that emergency services are often inaccessible. The title of a seminal report on the experiences of Roma people – *Ambulance Not on the Way* – conveys this issue very clearly (ERRC 2006).

Policy responses

Working from first principles, there are two ways in which access to health facilities might be improved. The first is to design health systems in ways that allow the dispersal of facilities, for example through the creation of integrated networks allowing individuals to have rapid access to immediate or basic routine care and then be referred to more specialised facilities when required. A recent study includes two examples of area-wide approaches to planning, both of which involve creating networks of health facilities offering different levels of care (Northern Ireland and the region of Tuscany in Italy). Both are based on a comprehensive assessment of health needs in the population and the definition of appropriate clinical pathways. Both also involved investment in new facilities, including hospitals and peripheral clinics.

However, such approaches face considerable challenges. First, there may be problems with recruiting and retaining adequately trained staff in peripheral facilities, and in particular providing full-time staffing for emergencies. Second, this will often require a high level of co-ordination between different agencies coupled with measures to overcome fragmentation imposed by organisational and financial barriers to co-operation.

The second approach involves moving patients to a central facility or health professionals to the patient or a dispersed facility. This may call for investment in public transport, recognising that services have declined dramatically in many rural areas in recent years. In some places this may require public funding for helicopter or aircraft services (see Box 4.1). When health professionals move into the community it is inevitable that a lot of time will be taken up with travelling. This has a significant opportunity cost in terms of treating patients.

The advent of high-speed Internet holds out the possibility of innovative models of care delivery, although so far claims about benefits have far outweighed actual evidence of cost-effectiveness. For example, numerous systematic reviews of telemedicine have concluded that evidence of cost-effectiveness is lacking and published papers are subject to considerable publication bias (Nordheim et al 2014, Hasselberg et al 2014, Mistry et al 2014).

Box 4.1 Helicopter emergency medical services in a region of Spain

Ensuring access to emergency services in case of serious illness or accident is not easy in very remote and isolated villages. Castilla-La Mancha is an autonomous community of Spain, between Madrid and Andalusia. Is one of the most sparsely populated European Regions, with an average population density of 26.16 per square kilometres (2,076,000 inhabitants; 79,463 k2). Of its 919 municipalities, only 297 have more than 1,000 inhabitants. 100 municipalities have less than 100 inhabitants. Some of these villages are in mountain areas, at a distance of more than 1 hour and a half to the nearest hospital.

The rural areas are equipped with Health Centres, multidisciplinary primary health teams, and road ambulances equipped for transport of patients or for advance treatment. Districts are equipped with Diagnostic and Treatment Centres or with General Hospitals depending on the covered population. But it is not possible, nor is convenient, creating this kind of services in all the villages.

Since 2002, in order to improve emergency and urgency services in remote areas, the Regional Health Service put in place 4 Helicopters fully equipped as Mobile ICUs for treating severe patients: the "Helicopter Emergency Medical Service" (HEMS) can reach remote areas in 20’, patients can be stabilised and treated while they are transported to the hospital. The emergency team (doctor and nurse), adequately trained, is connected to their colleagues at the Hospital Emergency service, and is able to transmit the relevant information on-line. The HEMS is able to operate 24 hours/ day, 365 days/ year. From 2002 this service has treated people affected by heart attack, strokes, traffic and train accidents, work injuries, etc. There have been built 225 landing sites at the rural areas of Castilla-La Mancha, making it possible to offer safe and quality health services to isolated people living in places with difficult access by road (mainly in the winter).

Effective policy responses are complicated because they will often require major changes to the organisation of health systems, in terms of governance and service delivery. Most will require the creation of some form of administrative structure that can take a population-wide perspective and has the managerial tools needed for capacity planning. The precise approach taken will depend on the nature of the health system. There are major differences in approaches to hospital planning in Europe (Thompson and McKee 2011). For example, where health services are provided by geographically defined bodies, such as county councils in Denmark or Sweden, it is relatively easy – at least in theory – to design service delivery in a way that reflects the health needs of the population and, over time, to realign it in accordance with changing needs (Saltman et al 2006). The situation is more challenging where those responsible for financing and delivering health services do not have a geographical responsibility. There are, however, instruments that can be used, such as certificates of need for particular forms of advanced medical technology.

The European Union can support Member States by continuing work in the area of reference networks.

5. There are enough health workers, with the right skills, in the right place

Chapter summary

Health systems across Europe are facing shortages of health workers for a number of reasons. First, few countries are training adequate numbers of health professionals. Second, health workers are increasingly mobile in a globalised economy and in the context of the single market in Europe; those who feel they are not being adequately rewarded for what they are doing can easily move somewhere else. Third, there may be problems within countries, where it can be difficult to recruit and retain health workers in isolated rural areas with few employment opportunities for partners, limited leisure infrastructure or weak provision of education for children.

The extent to which access to care is hindered by inadequate health workers is difficult to ascertain, even though the problem is widely accepted to be important. Systems of data collection are unable to answer the most important policy questions.

To address these issues countries should:

- Put in place processes to train adequate numbers of health workers. Unfortunately, workforce planning has had a very poor record in most countries.

- Establish working conditions designed to retain staff in underserved countries and areas: not only remuneration commensurate with skills, but also attention to broader working conditions, including access to peer support and continuing professional development.

- Ensure an appropriate mix of skills is in place. This may require investment in additional administrative or care staff to relieve pressure on specialised health professionals (and, in a period of austerity, avoiding short-sighted cuts in staff); the development of new roles, with more advanced skills, such as specialist nurses; and task shifting, with delegation of certain roles to less specialised staff. Skill mix developments often require significant changes to the organisational structure of the health facility, recognising that new responsibilities require different reward systems and can challenge existing professional hierarchies. They must also take account of the widespread existence of financial incentives that serve to maintain the status quo.

The European Union can support Member States through better data collection on health worker roles and functions, remuneration and working conditions; ensuring ethical international recruitment; promoting cooperation on health workforce policies through the Expert Group on European Health Workforce and Joint Action on health workforce planning and forecasting.

Access to effective and appropriate health care requires that there are sufficient numbers of health workers, with the right combination of skills and expertise, in the places that they are needed. Within Europe there are significant problems with regard to all of these issues (Dubois et al 2005).

For decades, many European countries have been failing to train adequate numbers of health workers to meet their own needs. Instead, they have depended on importing health workers from other parts of the world, and in particular from some of the poorest countries where they are most needed (Buchan and Sochalski 2004).

Historically, there have also been long-standing patterns of migration within Europe, such as the movement of doctors and nurses from Ireland to the United Kingdom and from Austria to Germany. These intra-European movements have increased with progressive European Union enlargements (Garcia Perez et al 2007). Initially, this involved movement of health workers from Spain and Portugal to countries such as the United Kingdom but more recently there has been large-scale migration from some of the countries of Central and Eastern Europe to those in Western Europe. This has created major challenges for some of the countries that have lost large numbers of skilled health workers, such as Lithuania (Starkiene et al 2005).

Another problem is the failure to train health workers with the combination of skills that are needed in a rapidly changing health care environment. Ageing populations bring with them higher rates of multi-morbidity (Barnett et al 2012). This calls for more generalist physicians who can support those patients with problems spanning several different body systems, both in primary care and in hospitals. In practice, in many countries there has been a tendency to emphasise the training of specialists, encouraged by payment systems that offer disproportionate rewards to those with specialist skills, in particular where this involves undertaking specialised procedures.

There are also areas where more health workers with certain specialist skills are also required. Many countries struggle to recruit and retain adequate numbers of nurses with specialist skills in areas such as critical care, stoma care, and other forms of cancer care. There are some areas where all countries find it difficult to recruit and retain staff, such as mental health and the care of those with intellectual disabilities (Patel et al 2007). The problem extends beyond shortages of specific types of staff. Many countries have struggled to put in place mechanisms that will support the multi-professional team working required to care for patients with chronic conditions (Nolte and McKee 2008), especially where the payment system encourages individualism and fragmentation.

A third problem relates to the geographical distribution of health workers within countries. Some countries face the challenge of attracting and retaining staff in isolated rural areas and deprived urban areas where there is a high burden of disease, and associated workload, and where the quality of life for health workers and their families maybe poor.

Tools for monitoring and evidence of variation

Although data on health workforce are widely available, their interpretation is often very problematic. Much work has been done to standardised definitions but there are still many blurred boundaries. There are several different sources of data but all have limitations. For example, while most doctors on a medical register will be providing direct patient care, a significant number may be involved in other activities, such as medical management, academic research, or the pharmaceutical industry among others. Others may be retired, taking a break from work for family reasons, or working abroad. Data can also be obtained from employers, but this typically captures only a subset of all possible employers. For example, it may exclude those providing care in private facilities. Such data may also vary as to whether it records the headcount or the whole time equivalent numbers, taking account of growing rates of part-time working. The problem is further complicated by the indistinct and often varying boundary between health and social care in many countries. Thus, a substantial number of nurses may be working in facilities that would be considered to lie within the health sector in one country within the social care sector in another.

Most data collection systems have failed to keep up with changing patterns of health care. They tend to focus on numbers of doctors, dentists, and nurses, even though modern health care requires the input of many other professional groups, such as specialist therapists and laboratory workers.

Routine data are even more problematic at finer levels of disaggregation. Thus, even the definition of medical specialties varies across Europe. Dermato-venerology is a distinct specialty in many countries, while others have separate groups of physicians who specialise either in dermatology or sexually-transmitted diseases. The situation is complicated further because of variation among countries in whether such specialists operate in hospitals or in ambulatory care facilities and who is included in the data gathering system (Box 5.1).

Box 5.1 Definitions of medical specialists included in data from selected Member States

France: Data refer to active physicians in metropolitan France and D.O.M. (overseas departments). Interns and residents are not included.

Germany: Data are on the number of specialists who are actively practising medicine in public and private institutions and provide services directly to patients (head-count data).

The Netherlands: Data are for professionally active and licensed physicians based on BIG register (a register of (para)medical professions) and the SSB database (a micro-integrated database of Statistics Netherlands with data from municipal register, tax register, social security, business register). Data on doctors in training are from the KNMG (Royal Dutch Society for the Advancement of Medicine).

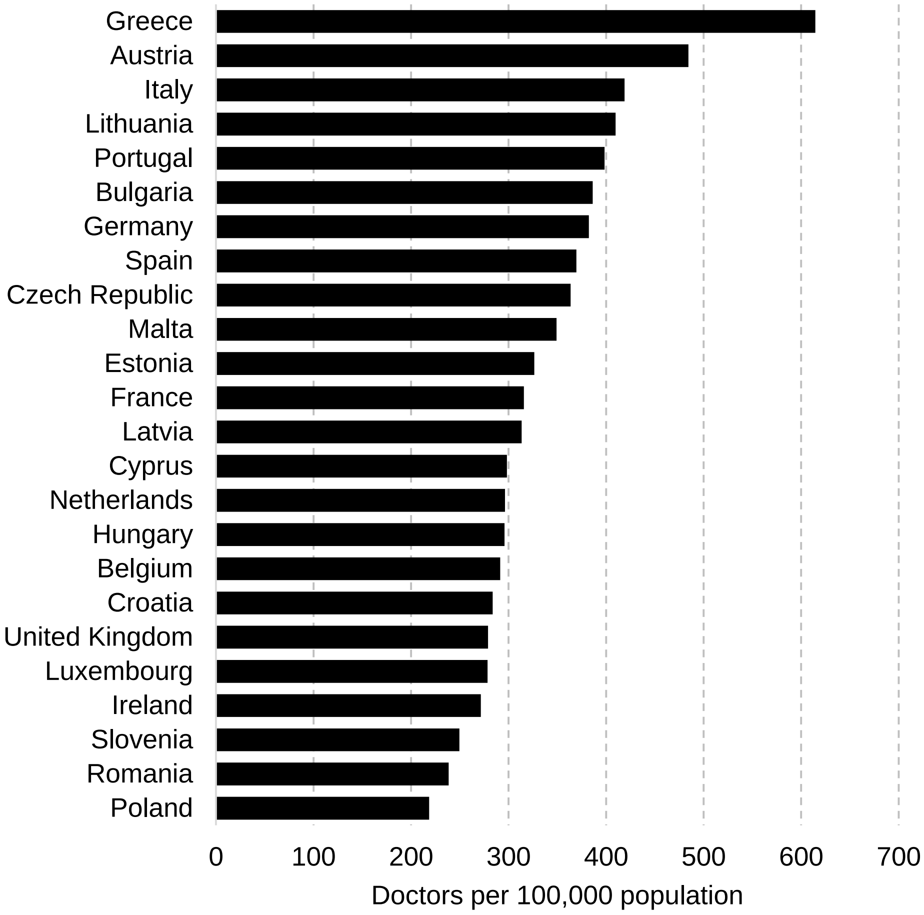
United Kingdom: Data do not include the private sector. In Northern Ireland, data exclude bank staff, research fellows, clinical assistants and hospital/medical practitioners. In Scotland the sum of GPs and specialists is greater than the total number of physicians due to some staff holding more than one post. There is currently no simple way of assigning such staff to one group only. Scottish data also exclude Ophthalmic Medical Practitioners.

Source: WHO

In addition to routinely collected data, there are a number of ad hoc studies and surveys that provide some comparative data. These are often undertaken by European professional bodies to inform their policies and practice and many depend on the availability of committed individuals in each country to collect the data. Although they have the advantage of using standardised definitions and survey methods and, in many cases, providing information on the scope of practice of the professionals concerned, a disadvantage is that they do not cover all countries and are undertaken infrequently and at irregular intervals. An example is the European Primary Care Monitor.

For all these reasons, the limited published data on the health workforce in Europe are extremely difficult to interpret and comparisons must be made with great caution. Recognising this, there is evidence of considerable variation (Figures 5.1 and 5.2), with an almost threefold difference in the density of physicians and an almost fourfold difference in the density of nurses, although some of the figures at the extremes of the range raise questions about the definitions in use. Data collected by the OECD also show that there are very substantial differences in health worker density within countries, where the definitions should be consistent (Figure 5.3).

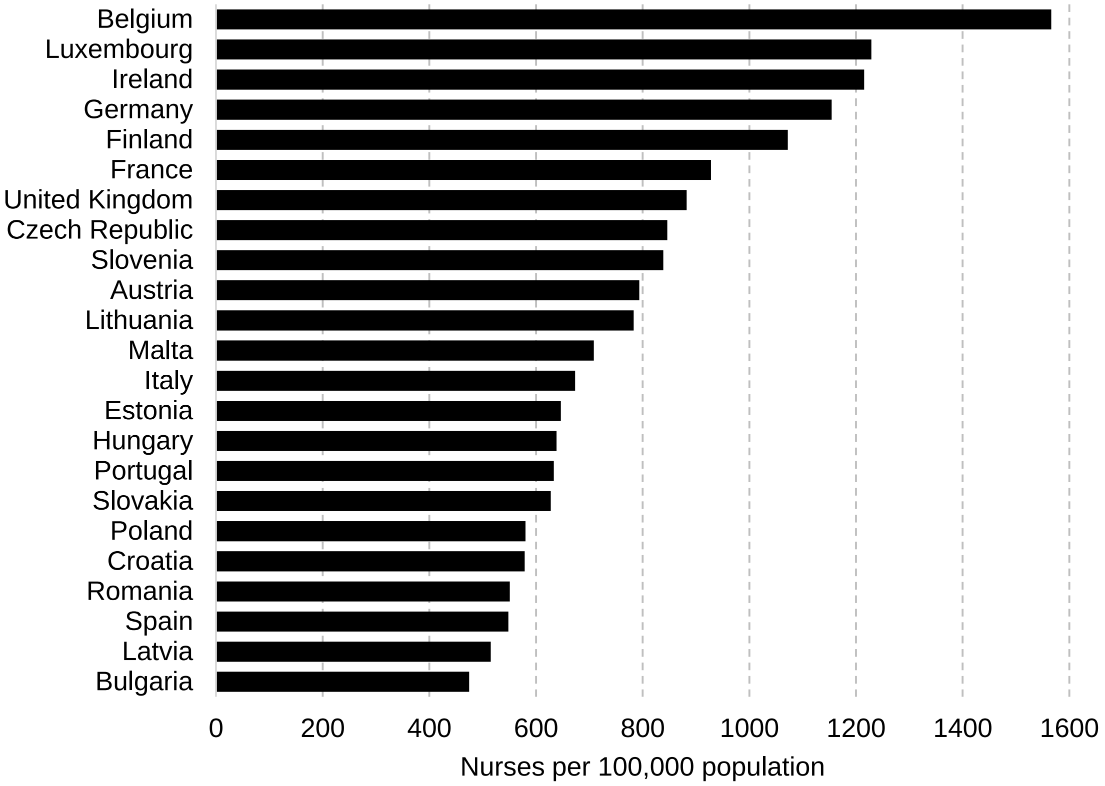
Figure 5.1 Density of physicians, EU28, most recent year



Source: WHO

Note: Data since 2010 unavailable for Denmark, Finland, Slovakia and Sweden

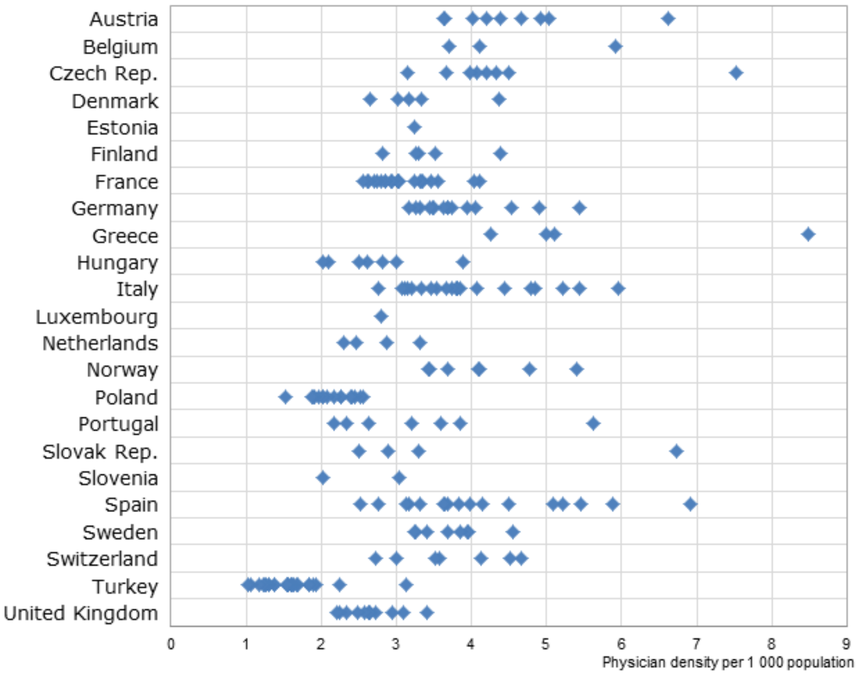
Figure 5.2 Density of nurses, EU28, 2012



Source: WHO

Note: Data since 2010 unavailable for Cyprus, Denmark, Greece, Netherlands, and Sweden

Figure 5.3 Physician density by territorial Level 2 regions, European OECD countries, 2011 (or nearest year)



Source: OECD (2013)

Policy responses

Policy responses to shortages of health workers are simple in theory but difficult to implement in practice. Many health workers have portable skills that are in demand in a wide range of high-income countries. Thus, it is clear that there is a global market for them. Following from this, responses can be considered under the headings of demand and supply.

If the price a country is willing to pay for health workers is substantially lower than elsewhere, this implies it has expressed a low level demand as a government or a society (this is separate from the demand that individuals may express). In such circumstances, the logical response is to raise the price that it will pay, by increasing salaries or by provision of non-monetary incentives, such as improved working conditions. Of course, there may be many obstacles to doing so, including affordability, but also political willingness and concerns about differentials with other workers whose skills can less easily be traded internationally.

The other response is to increase supply, with greater investment in training. However, this is unlikely to be effective unless attention is paid to the demand side, as otherwise the additional health workers will simply move abroad.

Potential responses to maldistribution of health workers within a country, especially shortages in rural areas, were examined in a comprehensive review conducted by the World Health Organization (Dolea et al 2010). It found that the quality of the evidence overall was weak and there were few evaluations using robust designs. Interventions for which there was some evidence of effectiveness included recruitment of students from rural areas, reorienting training to prepare health workers for practice in rural areas, financial incentives and support programmes for isolated practitioners, such as those linking them to peers for mutual support.

There is a growing body of evidence on skill mix, ensuring that patients are cared for by those with the most appropriate skills. The evidence mainly relates to nurses taking on roles traditionally associated with physicians and there are an increasing number of well-designed comparisons, including randomised controlled trials (Martinez-Gonzalez et al 2015). Many studies have methodological limitations and results cannot easily be extrapolated from one setting to another because of differences in nurses' roles and competencies. Nevertheless, findings show that specially trained nurses can provide care for patients with chronic diseases that is at least equivalent to care provided by physicians, in terms of process of care.

Research into which physician is most appropriate to manage patients show that general practitioners working in hospital emergency departments request fewer tests and get better results than junior doctors in training (Dale et al 1996). A recent trial in which severe head injuries were randomised to be managed at the site of injury by paramedics only or with additional input from a physician transported by helicopter produced results that tended to favour the latter (Garner et al 2015). However, skill mix developments often require significant changes to the organisational structure of the health facility, recognising that new responsibilities require different reward systems and can challenge existing professional hierarchies. They must also take account of the widespread existence of financial incentives that serve to maintain the status quo.

The European Union can support Member States through better data collection on health worker functions, remuneration and working conditions; ensuring ethical international recruitment; promoting cooperation on health workforce policies through the Expert Group on European Health Workforce and Joint Action on health workforce planning and forecasting.

6. Quality medicines and medical devices are available at fair prices

Chapter summary

Medicines and medical devices contribute significantly to health and quality of life. They account for around 25% of total spending on health care and employ over a million people across the European Union. The efficient use of these vital resources is critical to guaranteeing equitable access to safe and high quality health services. Yet across and within EU countries, many people find it hard to access necessary medicines, supplies and diagnostic tests. In some countries, high out-of-pocket costs are a significant barrier to access and medicines are frequently the most important driver of financial hardship when using health services. In others, people face long waiting times for diagnostics due to lack or inappropriate use of equipment and staff.

The high price of many medicines is becoming an increasing problem for health systems in EU countries, threatening fiscal sustainability. Ironically, this is a problem the European Union has often debated in the context of international development – an issue for the world’s poorest countries. It is now a challenge for a wide range of its own Member States, as recent experiences with Hepatitis C and cancer drugs have shown. The lack of research and development (R&D) in areas of unmet need, such as antibiotics, is also a major concern. These issues call for an urgent re-think of the way in which investment for R&D for medicines is funded and rewarded. The outcome of the current funding model has been a lack of transparency, excessive profits and a failure to develop new drugs where they are most needed. It is time to consider de-linking pricing from R&D, as well as actions to ensure much greater transparency.

Routinely available data on the use of medicines and medical devices are extremely limited. Interpretation of existing data is hindered by the absence of information on prices. Nevertheless, the extent of variation across countries suggests problems of underuse and overuse of medicines and diagnostic equipment.

To address these problems, countries should:

- Ensure fairer prices by identifying more efficient ways to fund R&D, requiring much greater transparency around costs and prices and developing joint procurement agreements for medicines and medical devices.
- Define national policies on medical devices (in addition to medicines).
- Systematically use HTA, including cost-effectiveness and cost-utility analysis, to inform coverage decisions and disinvestment for medicines *and* medical devices.
- Encourage rational prescribing and use of medicines and medical devices through ‘wise lists’, algorithms, guidelines, capacity planning of big-ticket equipment and specialised medical equipment management units.
- Improve information systems and data collection at regional, national and EU level.

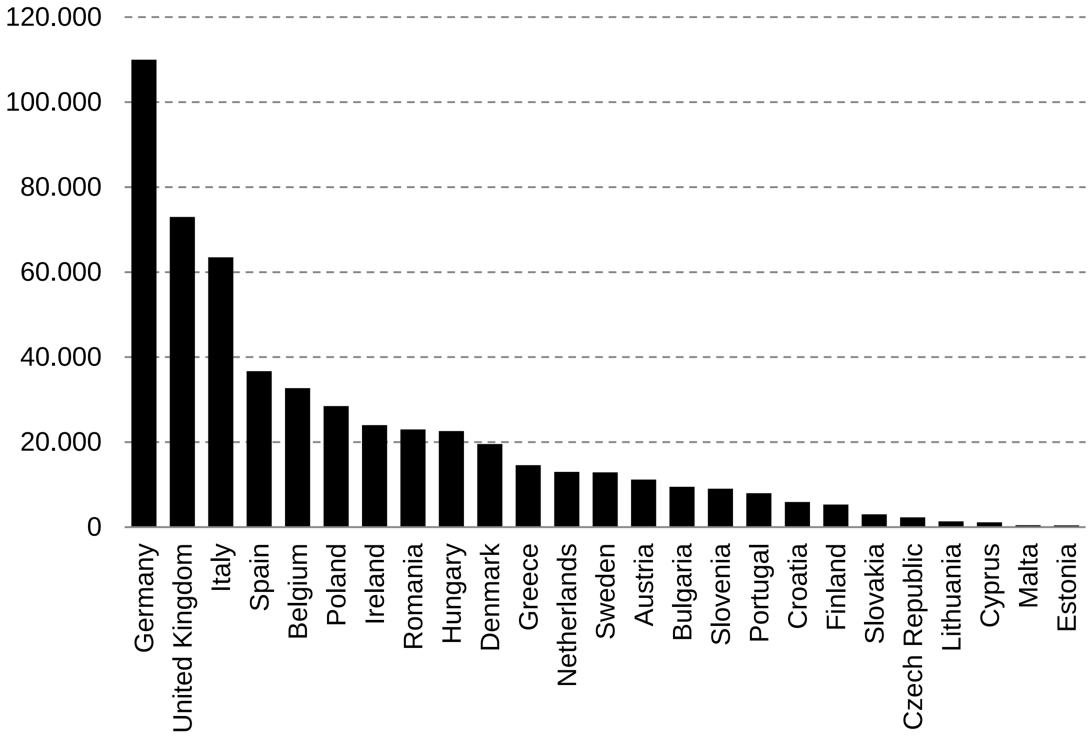
The European Union can support Member States to develop more efficient R&D and pricing systems and better information and assessment strategies and by continuing to foster cooperation in HTA and e-health.

6.1. Medicines

Antibiotics, vaccines, insulin, anti-psychotics and many other medicines have changed the history of diseases and health care in the 20th century. The European Union accounts for around a quarter of all pharmaceutical sales globally, and the pharmaceutical industry employs over half a million people in EU countries, around half of whom are in just three countries, Germany, the United Kingdom and Italy (see Figure 6.1).

People living in EU countries have publicly financed entitlement to a wide range of medicines. And yet there are thousands of people who cannot access the medicines they need and there are many conditions for which effective medicines are lacking. Ensuring access to medicines and addressing issues of underuse and overuse involves tackling interrelated and challenging problems ranging from the way in which research and development (R&D) is funded and rewarded to rational use and disinvestment.

Figure 6.1 Numbers of people employed in the pharmaceutical industry, EU28, 2012 or latest available year



Source: EFPIA (2014)

R&D: The current system of funding R&D through medicine prices encourages pharmaceutical companies to focus on areas likely to be most profitable for them rather than areas in which there is unmet need (see Box 6.1 and Box 6.2) (WHA 2015). The European Union could, however, find more effective ways of funding R&D to meet health needs (Bloemen and Hammerstein 2012). An interesting line of development would be to de-link prices and R&D costs (WHO 2012a; WHO 2012b). In 2010, Council Conclusions on the EU's role in global health asked Member States to explore this option and to ensure that EU investments in health research secure access to the knowledge and tools generated as a global public good and generate socially essential medical products at affordable prices. These ideas were discussed in relation to low- and middle-income countries, but they are equally relevant to EU Member States.

Authorisation: Two key issues warrant attention. First, insufficient controls and unnecessary controls and barriers. Second, the conflicts of interest that arise when regulatory agencies are financed (at least in part) by pharmaceutical companies. For example, 83% of the budget of the European Medicines Agency (EMA) is financed directly by the industry.

Pricing: High prices are becoming an increasingly important barrier to access (WHO 2015). The Council of the European Union has noted with concern "that the prices of many new innovative medicines are very high in relation to the public health expenditure capacities of most Member States, and that this pricing situation could destabilise health systems in Member States already weakened by the financial crisis" (Council 2014). In the US a group of physicians and researchers are supporting a patient-driven initiative and petition to lower the high price of cancer drugs (Tefferi et al 2014).

High prices are usually linked to patent protection and are justified on the grounds of re-couping the costs of R&D. However, information about the real costs of R&D is lacking (EC 2009, Light and Warburton 2011, Light and Kantardjian 2013, DNDi 2014). Some authors have found evidence to suggest "current pricing models are not rational but simply reflect what the market will bear" (Mailankody and Prasal 2015).

Prices can be set based on cost or value. Patent protection was designed to guarantee fair compensation for R&D based on cost (CESCR 2005). When a medicine is protected by patent, prices should be as low as possible, covering costs (production and R&D) and a reasonable profit (return on investment) to promote continued investment. However, pharmaceutical companies have changed the way in which they negotiate prices with national health authorities, moving from a system based on costs to one based on value. Under this new system, prices are based on 'what the market will bear'. At the same time, medicines have become financial products, and companies face tremendous pressure to obtain high profits in the short term.

Pricing needs to achieve a balance between static efficiency (lower prices today) and dynamic efficiency (high prices to maintain incentives for innovation). If, however, companies ask for the highest price the client is willing to pay (pricing per value), then patent protection should be removed, creating the conditions for effective competition through for-profit and non-profit generic companies (OECD 2014).

The Communication from the Commission on effective, accessible and resilient health systems stated that Member States and the Commission should reflect further on how to reconcile the policy objectives of ensuring accessible health care for all EU citizens with the need for cost containment. Consideration should be given to improved cooperation on building mechanisms for increased transparency and better coordination to minimise any unintended effects that current national pricing systems may have in terms of accessibility throughout the EU (European Commission 2014).

Multilateral initiatives have been proposed in order to address this problem, like the one led by France and Italy in relation to Hepatitis C (see Box 5.3), or the agreement signed between the Netherlands, Belgium and Luxembourg to coordinate joint procurement of orphan drugs. At the same time, Council Subgroup

3 of the Working Party on Public Health at Senior Level continues to work on the cost-effective use of medicines.

Another important issue is that price negotiations may require two important features in the negotiation process. First, a maximum price that Member States (on average) are willing to pay for the specific medicine (ideally in relation to its cost plus fair profit). This is a contentious issue in many countries. Second, real bargaining power requires the willingness and ability of negotiators to say 'no' in cases where prices are too high in relation to the benefits produced. Again, this is not in line with current practice or the political and social attitude towards reimbursement decisions in many countries.

During the crisis various Member States approved reduction of prices for different group of medicines. In some cases there have been used reference prices. In other cases there have been achieved agreements with the pharmaceutical industry to limit the total expenditure (or the annual growth). There have been specific confidential negotiations for new expensive medicines (i.e. hepatitis C treatments), with different arrangements. Each country is developing different measures, depending on the context and political balances.

Procurement: Usually there are different procurement mechanisms for hospital medicines and ambulatory medicines. Joint procurement mechanisms have been established in some countries or regions, to obtaining better prices. The EU has created the Joint Procurement Agreement for the purchasing of vaccines. The possibility to use this mechanism for other products should be discussed, acknowledging purchasing power differences between Member States. If joint procurement of medicines results in a single price for medicines throughout Europe, this may result in unaffordability in some Member States even though the average price may be lower than currently the case. Hence, clear ideas about how to deal with such differences between Member States – which may require agreed upon solidarity payments from higher income Member States to lower income Member States need to be installed.

All these mechanisms have to be evaluated periodically in order to redesign the systems, improving efficiency. In particular, the dynamic properties of mechanisms have to be carefully assessed. Extreme competition in price today may create concentrated market structures in the future.

Distribution: Health systems have to guarantee geographical distribution through wholesalers and pharmacies 365 days per year 24 hours per day. There are different ways of organizing distribution. Important efficiencies can be obtained while ensuring safety and quality. Other problems, like drug fakes, non-controlled prescription and dispensation through internet, etc, that can affect access to quality and safety medicines.

Coverage: Member States decide what medicines are included in the package of benefits, and to what extent medicines are funded with public resources. The majority of Member States apply user charges to ambulatory medicines. Cost-effectiveness analysis and HTA are good methods to accept or reject reimbursing of a new medicine, or to disinvest in ineffective ones, according to the therapeutic value of the product. EUnetHTA can play an important role in this field. Determining the social value of a new product is different from defining pricing rules for new products. During the crisis some countries decided to de-list medicines form the package of benefits. It is not clear if the decision has been taken on a cost-effective analysis bases or only to reduce public spending.

Millions of people in EU cannot afford to pay medicines that they need. Medicines that are not publicly financed and reimbursed, or that have too-high user charges are not accessible for patients because of their economic situation. Financial protection should be ensured and not eroded by health systems.

Prescribing: It is possible to improve prescription through adequate continuous training, using helping mechanisms (e-prescription, algorithms, "wise lists"), and prioritising the use of generics and biosimilars. Improving prescription of medicines is not just a question of cost, it is mainly a question of quality and safety, and preventing negative side effects like antimicrobial resistance.

Use of medicines: Patients do not always not take their medicines in the most effective way. It could be that the patients do not understand the dosage. Other patients could forget. Some patients do not believe that the use of generic and biosimilars is effective. Older people can have difficulties if the pharmacist changes the pill that he is used to have. It is important to take time to explain the patient how and why he has to take the medicine and to monitor adherence to treatment. Self-management of complex polypharmacy is a challenge.

Disinvestment: It is necessary to evaluate periodically the list of medicines authorised according to its safety, and efficacy, and to control adverse effects. Successive innovation leads to the presence of products with distinct effectiveness for the same clinical need. The use of electronic health records (databases), and patient registries, could help in this field of management (analysing diagnoses, dosage, outcomes, etc.) and contribute to improved prescription and efficiency.

Box 6.1 Antibiotics

The failure of the current model of drug discovery and development is most obvious with respect to antibiotics. There have been almost no new antibiotics since the 1970s and there are none at all in the current development pipeline. The existing economic model of drug development does not make investment in new antibiotics by profit-maximising corporations worthwhile. This model is based on the production of medicines that will be used by as many people and for as long as possible. Medicines such as those used to treat high blood pressure, a common disorder requiring lifelong treatment, were ideal. In contrast, courses of antibiotics typically last for a few days and should be prescribed as sparingly as possible to avoid the risk of resistance emerging.

Box 6.2 Macular degeneration

In recent years manufacturers have decided that the profit margin on a range of injected generic medicines, such as Phenytoin, do not justify their continued manufacture despite demonstrable clinical need (Fox et al 2014). The development of medicines effective against wet macular degenerative disease, a common cause of blindness, has highlighted a new problem.

Ranibizumab (Lucentis) and Bevacizumab (Avastin) are monoclonal antibody fragments derived from the same parent monoclonal antibody and acting through the same mechanism to prevent blood vessel growth. The intellectual property rights to both are owned by Roche, although Novartis has the rights to market Ranibizumab in Europe. Bevacizumab is only licensed for use in certain cancers and Roche has consistently refused to undertake the necessary clinical trials or to apply for marketing authorisation for its use in eye disease.

Given the resistance by the manufacturer to conduct trials comparing the two drugs, public funders, including the English National Institute for Health Research, have funded them, although it has since been revealed that Novartis and clinicians with close ties to the company lobbied hard to prevent recruitment to the trial (Cohen 2015). The trials have shown that the two drugs are equally effective, but Bevacizumab is 10 to 20 times as expensive as Ranibizumab.

Novartis has subsequently successfully lobbied to change guidance from the UK's medical regulator that would have supported doctors who prescribe medicines where the manufacturer had refused to seek authorisation for a particular indication and the published evidence showed that they are effective (Cohen 2015). As a result, in many parts of the United Kingdom, treatment for this form of preventable blindness is effectively rationed on grounds of cost, despite a much cheaper and equally effective alternative being available. In contrast, the Italian Competition Authority fined the two companies a total of €180 million for maintaining an artificial distinction between the two drugs (Autorità Garante della Concorrenza e del Mercato 2014).

Box 5.3 Hepatitis C

Controversy about impaired access to innovative medicines on grounds of cost has been reignited by the case of Sofosbuvir, a treatment for Hepatitis C that is highly effective in eliminating infection and preventing progress to cirrhosis. In some European countries it is sold for about €25,000 per course (prices have been negotiated under confidentiality clauses). This means that it is, in effect, unaffordable for most of those affected in several European countries. Generic versions of Sofosbuvir can be produced for under $300 per course (Hill et al 2014). Several organisations have argued that the manufacturing process is not innovative, an argument accepted by the Indian Patent Office, which has refused to issue a patent, opening the way for large scale generic manufacture.

In recent years, other new medicines with very high prices have been authorised in Europe, for example, for cancer treatment. The case of Hepatitis C (HCV) is "new" because it affects a large number of people. Current estimates are that between 7.3 and 8.8 million persons are infected with HCV in the European Union (EASL 2014), and the treatment seems to be very effective, safe and without adverse effects.

The case of HCV offers a unique opportunity to discuss the issue of price fixing for new pharmaceutical products, balancing the role of dynamic incentives for R&D investment and extreme value appropriation by companies introducing new products. The pricing of new medicines is a vital issue for the financial sustainability of health systems in the European Union and around the world. It is not a question of discussing the price of a particular product. It is a question of addressing problems created by a pricing process that gives firms strong bargaining power in setting prices with the argument of rewarding innovation.

Tools for monitoring and evidence of variation

Routinely available data are limited to expenditure and consumption only, with substantial variation in both types of indicator across countries. Figure 6.2 shows that pharmaceutical spending per person is more than double in Belgium compared to Denmark. However, data on total or public expenditure on medicines are not particularly useful given differences in consumption (Figure 6.3) and prices across countries. Looking at the out-of-pocket share of spending on pharmaceuticals gives a better idea of access issues across countries. Figure 6.4 shows how the out-of-pocket share varies from under 2% in Luxembourg and the Netherlands to over 15% in Lithuania, Latvia and Hungary.

The lack of policy-relevant data on medicines is surprising and should be addressed as a priority. The types of data that would be useful include expenditure data broken down by region, consumption data for outpatient and hospital settings at national and regional level, survey data on ability to obtain and pay for medicines, comparable information on drug prices across countries, the extent to which health care providers adhere to 'wise lists' at national and regional level and the division of value generated between supply (pharmaceutical companies) and demand (health systems and patients).

Policy responses

Promote dialogue between Member States and stakeholders to reward R&D investment without excessive prices. Prices should cover the costs of R&D and production and allow for a reasonable profit, guaranteeing a fair reward for industry innovation, ensuring access for patients and contributing to the financial sustainability of health systems.

Enforce transparency around the costs of pharmaceutical companies and the price of medicines. The use of mandatory licenses in cases where patents are used to set prices at a level well above production cost (including R&D) should not be excluded.

Link products that have benefited from EU funds such as Horizon 2020 to socially responsible licensing.

Support the use of cost-effectiveness analysis in coverage decisions and disinvestment.

Develop joint procurement agreements for public purchasing of medicines (vaccines, emergency circumstances, others).

Promote the use of 'wise lists', algorithms and guidelines to enhance efficiency in the prescribing of all medicines and especially antibiotics.

Improve information systems and data collection at regional, national and EU level.

The European Union can support Member States in the following ways:

Promote joint action to develop a strategy to ensure equitable access to new medicines and new innovative treatments and fairer prices.

Promote transparency to ensure that patents serve the social purpose for which they were created. This requires detailed knowledge of costs and prices. Without this information there is a risk of patent misuse. Evaluate the possibility of withdrawing patents in cases of misuse.

Consider setting up a European Parliament committee to analyse the prices of new medicines. The committee should be guaranteed transparency around costs and prices.

Review the impact of the Supplementary Protection Certificate in ensuring access to medicines (De Boer 2015).

Link products that have benefited from EU funds such as Horizon 2020 to socially responsible licensing.

Explore models to separate the cost of R&D from prices (Council Conclusions May 10, 2010) and extend these to EU countries (not just low-income countries).

Evaluate and promote the use of joint procurement mechanisms.

Decouple the financing of EU regulatory agencies (the European Medicines Agency, EMA) from the pharmaceutical industry. Currently, 83% of the EMA’s budget comes from the industry via authorisation fees). Introduce stricter control over conflicts of interest.

Figure 6.2

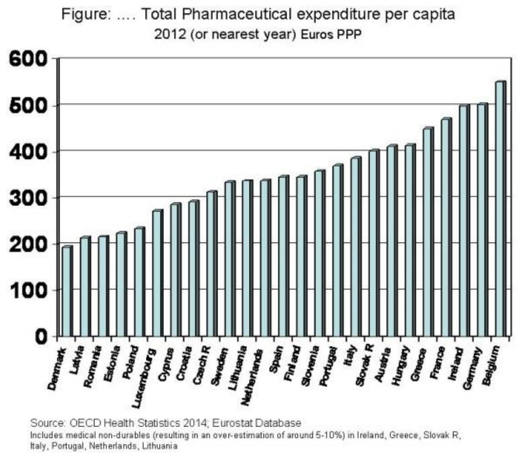
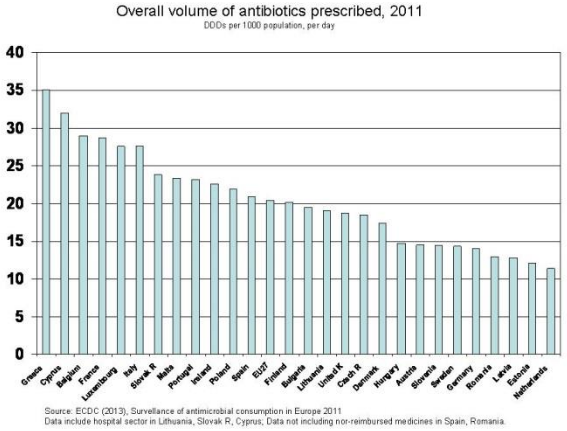


Figure: …. Total Pharmaceutical expenditure per capita
2012 (or nearest year) Euros PPP

Source: OECD Health Statistics 2014; Eurostat Database
Includes medical non-durables (resulting in an over-estimation of around 5-10%) in Ireland, Greece, Slovak R, Italy, Portugal, Netherlands, Lithuania

Source: OECD health data (2015)

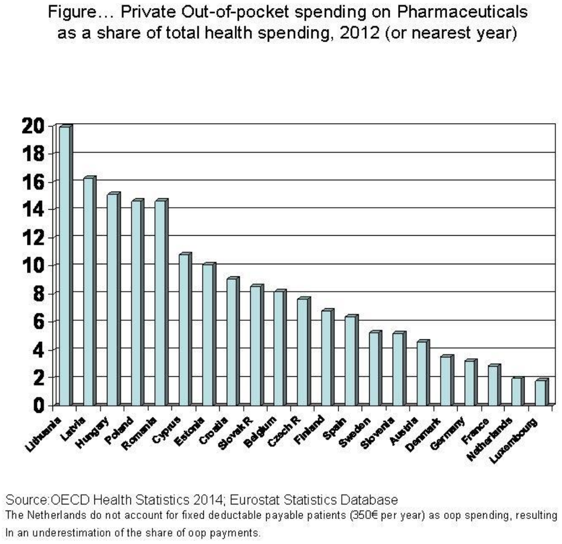
Figure 6.3


Overall volume of antibiotics prescribed, 2011
DDDs per 1000 population, per day

Source: ECDC (2013), Survellance of antimicrobial consumption in Europe 2011
Data include hospital sector in Lithuania, Slovak R, Cyprus; Data not including nor-reimbursed medicines in Spain, Romania.

Source: OECD health data (2015)

Figure 6.4


Figure… Private Out-of-pocket spending on Pharmaceuticals
as a share of total health spending, 2012 (or nearest year)

Source:OECD Health Statistics 2014; Eurostat Statistics Database
The Netherlands do not account for fixed deductable payable patients (350€ per year) as oop spending, resulting
In an underestimation of the share of oop payments.

Source: OECD health data (2015)

6.2. Medical devices

Medical devices include a huge range of products ranging from contact lenses and software to stents, prostheses, ophthalmic lasers, pacemakers, defibrillators, clinical laboratory equipment, surgical equipment, scanning equipment and e-health technologies. These devices can have a substantial impact on health outcomes, quality of life and health care expenditure. In addition, the industry employs over half a million people in Europe and had total sales of €100 billion in 2013. In spite of the crisis, the European market for medical devices grew on average by 4% a year between 2008 and 2013 (MedTech 2014).

The EU regulatory framework for medical devices was reviewed in Directive 2007/47/EC (EU 2007), followed by an exploratory process on the future of medical devices initiated in 2009. The Poly Implant Prothèse breast implant scandal prompted a European Parliament Resolution calling on Member States and the Commission to implement specific actions. In 2012, the Commission adopted a proposal for a Regulation on medical devices and in vitro medical devices (EP 2012, EC 2012). The proposal has been discussed in the European Parliament and in the Council of Ministers and negotiations between them are expected to start soon (Council 2015).

Access issues around medical devices are similar to those around medicines. However, there is even less transparency where medical devices are concerned, and more needs to be known about their certification, distribution and use. In 2010 the World Health Organization established a global atlas of medical devices, which it updated in 2014 (WHO 2014).

Important access issues concern:

Geographical distribution, supply and efficiency in use: There are wide variations in the distribution and use of medical devices within and across countries. Although there are no European guidelines regarding the appropriate rate of use of different devices, the available information suggests there are likely to be significant problems of under-use and over-use. So-called big-ticket equipment needs to be limited in supply to ensure efficiency and quality. If facilities are lacking or equipment is not being operated efficiently, people may have to wait too long, resulting in delayed diagnosis, unnecessary suffering, complications, economic losses and other negative effects.

Maintenance and life-cycle substitution: High technology requires careful instalment and supervision, regular maintenance and attention to replacement as new devices become available.

Reprocessing: The practice of reprocessing and re-using medical devices designed for single use merits attention.

During the crisis some countries cut medical device budgets, affecting the availability of supplies ranging from prostheses to CT scans. However, the crisis also created opportunities for countries to negotiate better prices, organise joint procurement schemes, assess rates of prescribing and use and improve the supply of clinical and epidemiological information.

Tools for monitoring and evidence of variation

There is barely any comparable information on medical devices. The only routinely available data focus on big-ticket technologies, mainly the availability and use of scanning equipment (see Annex 3). There are no data on the prices, cost-effectiveness and use of or waiting times for other medical devices that have an important impact on health outcomes and health care expenditure – notably, pacemakers, prostheses, contact lenses, computer software, etc.

Figure 6.5 indicates the extent of variation across EU Member States in the availability of MRI scanning equipment, with a ten-fold difference in the number of MRI units between Italy and Hungary. There are three- to twelve-fold differences for other scanning equipment (CT, radiation therapy, PET, etc).

Figure 6.6 indicates a huge difference in the number of MRI scans per 1,000 population. A difference of this magnitude is difficult to justify on clinical or epidemiological grounds in countries with similar levels of economic development. It suggests problems of overuse and underuse which are likely to be linked to lack of control over the location of scanning equipment and incentives for overuse created by the procurement, pricing and provider payment mechanisms in place.

Figure 6.5 MRI units per million population, EU28, 2012 or latest available year

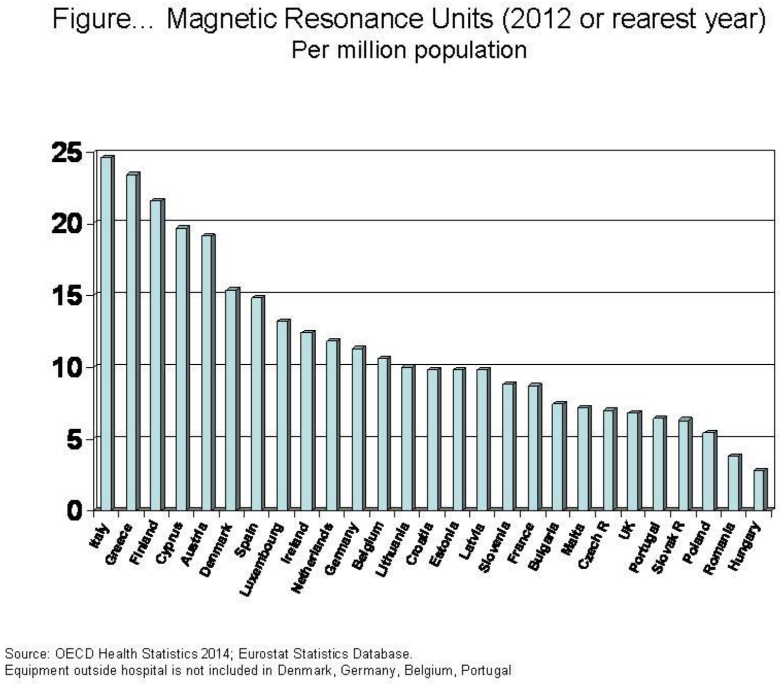
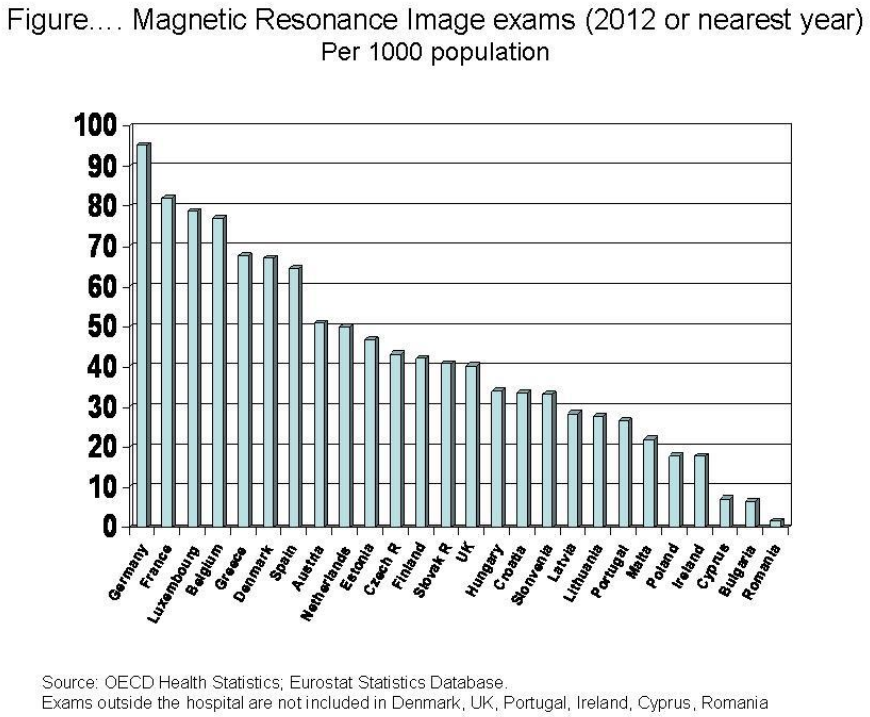


Figure... Magnetic Resonance Units (2012 or rearest year)
Per million population

Source: OECD Health Statistics 2014; Eurostat Statistics Database.
Equipment outside hospital is not included in Denmark, Germany, Belgium, Portugal

Source: OECD health data (2015)

Figure 6.6 MRI units per million population, EU28, 2012 or latest available year



Figure…. Magnetic Resonance Image exams (2012 or nearest year)
Per 1000 population

Source: OECD Health Statistics; Eurostat Statistics Database.
Exams outside the hospital are not included in Denmark, UK, Portugal, Ireland, Cyprus, Romania

Source: OECD health data (2015)

Policy responses at national level

Countries can take a wide range of steps to ensure equitable access to medical devices, address problems of under- and over-use and improve efficiency in the use of resources. These include measures to:

- Define national policies on medical devices.

- Establish regulatory agencies and national health technology units. Promote use of HTA for medical devices.

- Ensure careful planning of facilities and big-ticket equipment.

- Improve procurement processes and pricing systems.

- Create specialised medical equipment management units at national, regional and hospital level to ensure appropriate use and maintenance.

- Improve the prescribing and rational use of devices and introduce systematic assessment of variations in use and cost-effectiveness.

- Use devices efficiently (functioning hours) to optimise investment.

- Promote cost-effective ICT solutions to provide services in remote areas.

Policy responses at EU level

Approve the new directives on medical devices and in vitro diagnostic medical devices.

Promote effective coordination between national authorities in implementing the directives.

Reinforce the capacity of EUnetHTA.

Stimulate cooperation between Member States in the development of e-health solutions.

Support Member States in the development of information systems and assessment methods.

Reinforce information systems at EU level to monitor the medical devices sector, including monitoring of infrastructure, procurement, prices, maintenance, utilisation and clinical evaluation, adverse effects, serious incidents and traceability throughout the supply chain.

Promote R&D in medical devices and optimal utilisation strategies.

7. People can use services when they need them

Chapter summary

People may find it difficult to use health services when they need them due to: lack of information about services, especially if information is not provided in the patient's language; low levels of literacy in general and health literacy in particular; factors affecting the convenience of services for the general population, such as the absence of an effective appointments system (recognising that not all have access to the internet) or the limited availability of out-of-hours services, home visits, repeat prescriptions by telephone and email or mobile phone contact with providers; the extent to which services are equipped to meet the needs of people with disabilities; and long waiting times.

Although it is extremely hard to find comparable and robust data in any of these areas, the available data consistently highlight the potential for these types of barriers to exacerbate underlying inequalities in access to health services.

Comparative data on health literacy – available for eight countries only – suggest inadequate health literacy is a widespread problem affecting the general population. They also indicate a clear socio-economic gradient, with lower levels of health literacy concentrated among people with poor health status, high health care use, low socio-economic status, lower education and older age (over 75 years). The evidence base for strategies to improve health literacy is weak and needs to be strengthened.

Waiting time data are notoriously problematic, both in terms of definitions and the scope for manipulation. Data on self-reported unmet need due to waiting lists also need to be interpreted with caution, especially since they do not account for financial hardship experienced by people who seek privately financed alternatives when waiting times for publicly financed treatment are excessive. Many national waiting time initiatives have been criticised for failing to prioritise access to treatment based on severity of illness and, in some instances, for creating perverse incentives to prioritise patients with relatively minor needs. Nevertheless, attempting to specify and adhere to maximum waiting times and efforts to provide the public with reliable information on waiting times can play a role in enhancing transparency, accountability and other dimensions of health system performance.

EU-wide data show how 95% or more of all health facilities are accessible to people using wheelchairs in Sweden, Finland, Spain, Greece, Cyprus and the United Kingdom, in contrast to less than 60% in Austria, Germany, Slovakia and Luxembourg[5] – perhaps a reflection of the dominance of solo office-based practice in these countries. Individual health facilities can and should take a wide range of relatively straightforward steps to make existing services more easily accessible to the general population and to meet the needs of people with disabilities. Countries should also do more to ensure that people have good information about health services in their own language and have access to translation or interpretation services when required.

The European Union can support Member States by harmonising the definition of and collection of waiting time indicators and setting and enforcing standards for accessibility in health facilities for people with disabilities.

---

[5] No data were available for Denmark, Croatia and France.

This chapter focuses on five factors that may make it difficult for people to use health services when they need them: service information; health literacy; service convenience; meeting the needs of people with disabilities; and waiting times.

Service information

Patient organisations report that 19 out of 28 EU Member States provide an interactive, 24-hour, web- or telephone-based health care information service that is publicly available throughout the country (Björnberg 2015). However, such services are not reported to be effective in 6 out of the 19 countries, either because people do not know about it or because it is hard to access (see Table 7.1).

Table 7.1 Availability and effectiveness of interactive, 24-hour web- or telephone based health care information service, EU28, 2014

Status of service	EU Member State
Service exists	Austria, Estonia, Finland, France, Italy, Latvia, Lithuania, Portugal, Spain, Sweden, UK
Service exists but few members of the public know about it, or it is hard to access	Belgium, Malta, Netherlands, Poland, Slovakia, Slovenia
Service does not exist	Bulgaria, Croatia, Cyprus, Czech Republic, Greece, Hungary, Ireland, Luxembourg, Romania

Source: Björnberg (2015)

Languages

A more important consideration may be whether information about health services is routinely provided in people's languages and the availability of translation and interpretation services. Unfortunately, European efforts to capture the quality of the user experience – for example, the Euro Health Consumer Index produced by the Health Consumer Powerhouse – do not focus on this or on other factors relevant to people who may be especially vulnerable where access to health services is concerned.

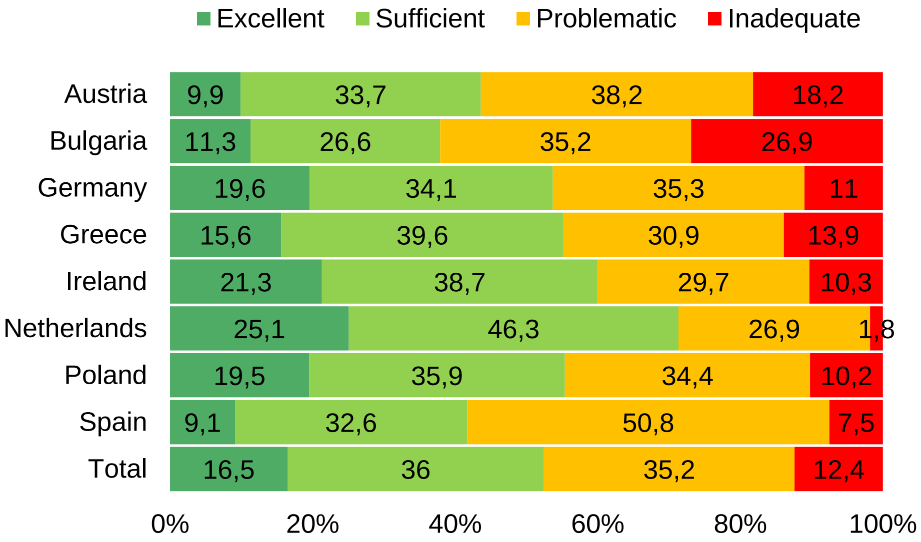
Health literacy

Traditional indicators of health literacy have been criticised for focusing on reading skills, being too clinically focused and not assessing important aspects such as understanding and the ability to assess and use information for health promotion, disease prevention and self-management of health conditions. More comprehensive definitions of health literacy encompass its dynamic interaction with the wider health, education and social systems (Nutbeam 2000; Rudd 2004; Institute of Medicine 2004; WHO 2013).

Recent research in Europe is adopting a population health perspective going beyond individual and clinical dimensions to include interdependencies between health understanding, health attitudes and behaviour, the social determinants of health and the design and delivery of health services (Sorensen et al 2012; Kickbusch et al 2013). This research defines health literacy as 'people's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgments and take decisions in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course' (Sorenson 2012).

Survey results from Europe and north America show that around half of all patients cannot understand basic health care information, which indicates that health literacy is not simply a minority problem. The first European survey of health literacy, carried out in 2011, found that 48% of all respondents had an inadequate or problematic level of health literacy (Figure 7.1). However, this share varied across countries, ranging from around 29% in the Netherlands to around 60% in Bulgaria and Spain.

Figure 7.1 Levels of health literacy in eight EU Member States, 2011



Source: HLS-EU Consortium (2012)

Note: Data for Germany are for one region only (North Rhine-Westphalia)

Low health literacy can increase the risk of medical errors and reduce the success of treatment. It is also likely to be a determinant of inequalities in health, because low levels of health literacy tend to be concentrated among people with poor health status, high health care use, low socio-economic status, lower education and older age (over 75 years) (HLS-EU Consortium 2012).

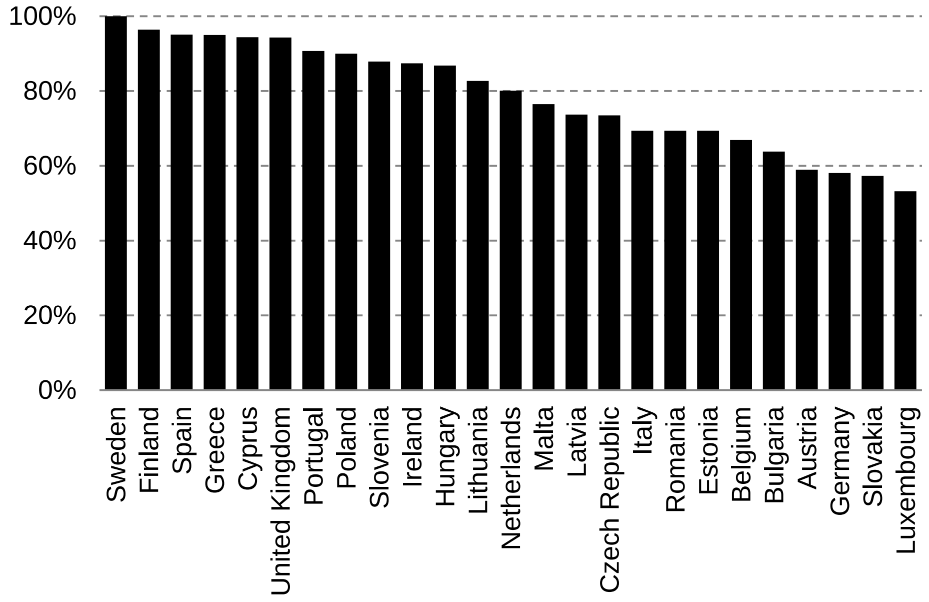
Service convenience

The term 'convenience' covers a wide range of issues around how easily patients are able to make use of available health services and how well services are organised to be as accessible as possible for everyone. The issue of accessibility for people with disabilities is discussed in more detail below. Here, the focus is on the population as a whole and people's ability to access non-emergency services beyond normal working hours; have health professionals visit them at home if they are unable to travel; obtain repeat prescriptions by telephone or some other means so that they do not have to return to the physician's practice or health centre; communicate with the health system in ways that are convenient for them, such as by email or mobile phone; and use non-emergency services without registration.

Meeting the needs of people with disabilities

People with temporary or permanent disabilities may face a range of barriers to accessing facilities. Figure 7.2 shows how the number of primary care facilities accessible to people using wheelchairs varies from 100% in Sweden to less than 60% in Austria, Germany, Slovakia and Luxembourg.

Figure 7.2 Share of primary care practices accessible to people using wheelchairs, EU28, 2013



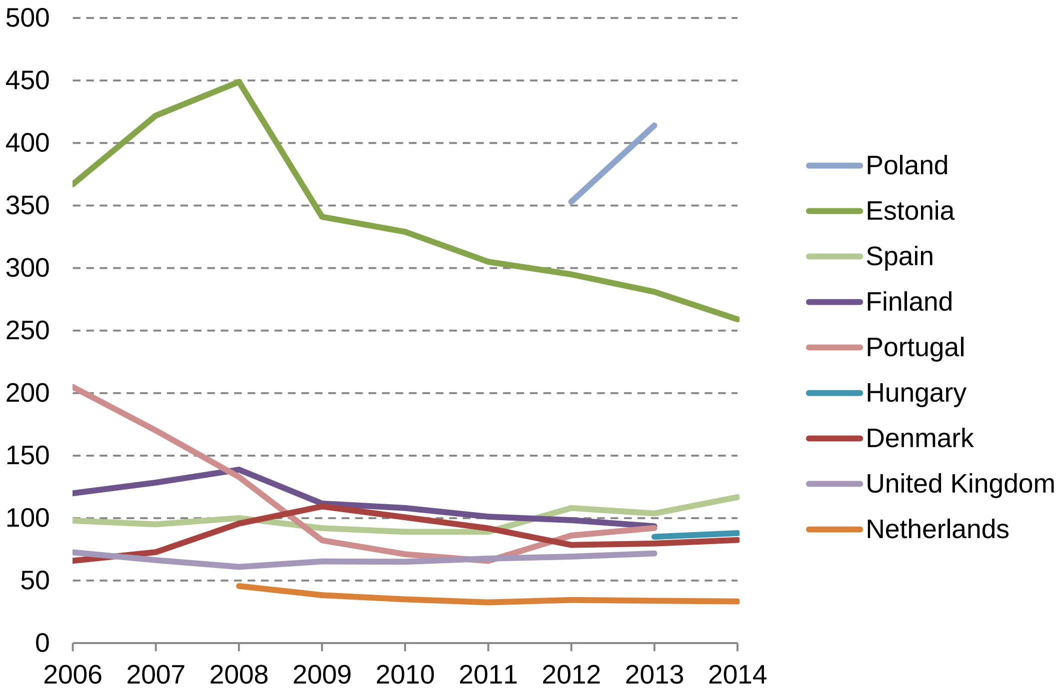
Source: QUALICOPC (2015)
Note: No data available for Denmark, Croatia and France

Waiting times

If services are not readily available due to capacity or funding constraints or inefficient use of resources, people may be required to wait for treatment. Although not all waiting has negative outcomes – some people on waiting lists decide they would prefer not to be treated – there is no doubt that having to wait can involve stress, anxiety and pain and some people may die before being treated. Long waiting times can also lead to financial hardship for people who seek private alternatives and may be damaging for public perceptions about the health system.

There is large variation in the extent to which waiting times for treatment are a problem in EU Member States. Among European OECD countries, long waiting times are not seen as an issue in Belgium, France, Germany and Luxembourg (OECD 2013). Among the very limited number of European OECD countries reporting waiting times, the average waiting time from specialist assessment to treatment for coronary bypass in 2014 ranged from 33 days in the Netherlands to over 400 days in Poland (Figure 7.3).

Figure 7.3 Average waiting time (days) from specialist assessment to treatment for coronary bypass, OECD countries for which data are available, 2006-2014



Source: OECD (2015)

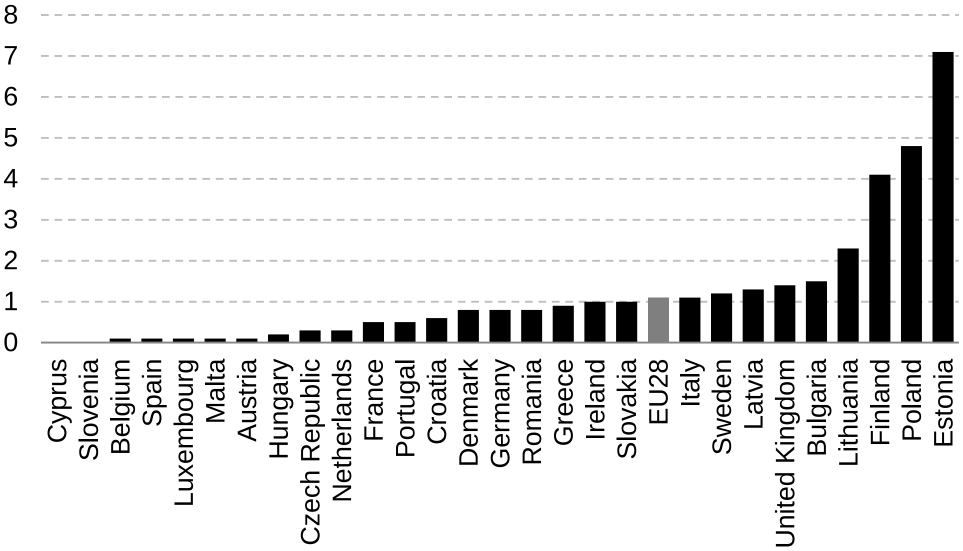
According to patient organisations, most patients would not wait for more than three months for elective surgery in 18 out of 28 EU Member States (see Table 7.2). Comparing this information to reported unmet need due to waiting lists suggests there is no clear link between patient organisation-reported waiting times and self-reported unmet need due to waiting lists. The three countries in which more than 4% of those surveyed reported unmet need due to waiting lists (Finland, Estonia and Poland), as shown in Figure 7.4, experience very different levels of waiting time, as shown in Table 7.2. It is possible that patients in some countries resolve waiting time issues by paying privately for treatment, either through voluntary health insurance or out-of-pocket.

Table 7.2 Extent of waiting time problems for elective surgery, EU28, 2014

Extent of waiting time problem	EU Member State
The vast majority of patients (over 90%) would get the operation within three months	Belgium, Bulgaria, Denmark, Finland, France, Germany, Luxembourg, Netherlands
Most patients (over 50%) would get the operation within three months	Austria, Czech Republic, Estonia, Greece, Hungary, Italy, Lithuania, Romania, Sweden, UK
Most patients (over 50%) would typically wait more than three months	Croatia, Cyprus, Ireland, Latvia, Malta, Poland, Portugal, Slovakia, Slovenia, Spain

Source: Björnberg (2015)

Figure 7.4 Share (%) of the population reporting unmet need for a medical examination due to waiting lists, EU28, 2013



Source: Authors based on EU-SILC (2015)

Waiting time indicators are problematic for several reasons (Pope et al 1991). First, their interpretation, although superficially simple, is actually quite complex (Cromwell 2004). Second, they assume that everyone on the waiting list is actually in need of care, which is not necessarily the case. Third, they may fluctuate in line with supply, so that the threshold for placing someone on a waiting list may vary according to the anticipated capacity for treatment. Put another way, there may be little point in placing someone on a waiting list if there is no prospect of their being treated within a reasonable period.

Policy responses

Health literacy is recognised as a key dimension of population health improvement in the World Health Organization's Health 2020 policy framework. Unfortunately, the European evidence base on the most effective strategies to use for improving population health literacy remains underdeveloped, particularly in the area of the prevention and control of communicable diseases (Barry et al 2013b).

Many actions to make existing services more easily accessible can be taken without detailed evidence but rather by applying basic principles. Individual health facilities can take steps to improve accessibility by strengthening the transport infrastructure, including public transport networks; extending hours of operation to fit in with patients' working lives; introducing measures for people with disabilities, such as wheelchair access, clear signage for those with impaired eyesight and hearing loops for people with hearing problems; and taking account of the very low levels of literacy among some groups of patients (Dani et al 2007).

Other measures include outreach activities, such as locating services in peripheral clinics or using telemedicine. It is essential, however, for these types of strategies to be evaluated before use. For example, numerous systematic reviews of telemedicine have concluded that evidence of cost-effectiveness is lacking and published papers are subject to considerable publication bias (Nordheim et al 2014, Hasselberg et al 2014, Mistry et al 2014).

Strategies to reduce long waiting times used in EU Member States include targets backed up by heavy sanctions for hospital managers, including job loss (England); maximum waiting times organised by the national purchasing agency and negotiated with providers (Estonia); waiting time guarantees set in law (Sweden); waiting time guarantees accompanied by access to treatment in the private sector or abroad (Denmark and Sweden); financial incentives targeting regional purchasers (Denmark and Sweden); using private sector capacity (England); and allocating additional funds to tackle long waits in problem specialties (England, Estonia). Box 7.1 gives examples of maximum waiting times in selected countries.

Many national waiting time initiatives have been criticised for failing to prioritise access to treatment based on severity of illness and, in some instances, for creating perverse incentives to prioritise patients with relatively minor needs. For this reason, the Danish government recently announced plans to abolish the one-month guarantee and replace it with a differentiated guaranteed based on severity.

Nevertheless, attempting to specify and adhere to maximum waiting times and efforts to provide the public with reliable information on waiting times can play a role in enhancing transparency, accountability and other dimensions of health system performance. The waiting time guarantee in Denmark enabled nearly half a million people to obtain treatment in private hospitals between 2002 and 2009, which may have helped to limit out-of-pocket spending and financial hardship for the patients concerned (Denmark HiT 2012). At the same time, it is possible that poorly designed and implemented initiatives will exacerbate inequities in the use of health services.

The European Union can support Member States by harmonising the definition of and collection of waiting time indicators and setting and enforcing standards for accessibility in health facilities for people with disabilities.

Box 7.1 Examples of maximum waiting times in selected EU Member States

Estonia
Maximum wait for a specialist outpatient visit: 6 weeks
Maximum wait for inpatient treatment / day surgery: 8 months
Maximum wait for cataract surgery: 1.5 years
Maximum wait for large joint replacement: 2.5 years

Denmark
Maximum wait from diagnosis to treatment: 1 month

Sweden
Maximum wait for contact with the health system: same day
Maximum wait to see a GP: 7 days
Maximum wait to see a specialist: 3 months
Maximum wait from diagnosis to treatment: 3 months

Source: European Observatory HiT reports for Estonia, Denmark and Sweden, available from www.healthobservatory.eu

8. Services are acceptable to everyone

Chapter summary

People need to be willing to use services, especially in primary care, which is the first point of contact with the health system for many people. When they use health services, their experience should be as positive as possible because user experience shapes expectations and can influence health care-seeking behaviour in the future. Services that fail to be acceptable to people are likely to be under used, with negative implications for health, efficiency in the use of health system resources and equity in use.

User experiences may be sub-optimal due to not having enough time with the provider, communication failures, lack of involvement in care decisions, lack of respect and lack of privacy. These factors may reflect fear on the part of the user; social, demographic and cultural differences between user and provider, potentially resulting in discrimination on the grounds of age, gender, race, ethnicity, religion or other individual characteristic; lack of user participation or consultation; lack of informational continuity (good health records) and service continuity (especially for out-of-hours services); poor management; and poor training of staff (communication skills, cultural competence).

Comparable data on overall user experience of the health system are not available in the European Union. Routinely collected data on the quality of patient-provider interactions are limited to a handful of countries (see Annex 3). The EU-funded QUALICOPC study is the only reliable source of comparable data on aspects of patient-provider interaction across all Member States. The study shows variation across countries, but its results are difficult to interpret. In general, there is a clear socioeconomic gradient in the quality of interaction between patients and physicians. Poorer people, people with less education and people in lower-paid jobs receive less information, explanation and emotional support than others and are less involved in treatment decisions.

Policy responses lie in the following areas:

- Strengthen the development of culturally sensitive and appropriate services (cultural competence).
- Improve the communication skills of health workers.
- Develop e-health systems for better informational and service continuity.
- Conduct regular national surveys of user experience of the health system, building on the experience of regular user surveys carried out in countries such as Denmark, Spain, Sweden and the United Kingdom.

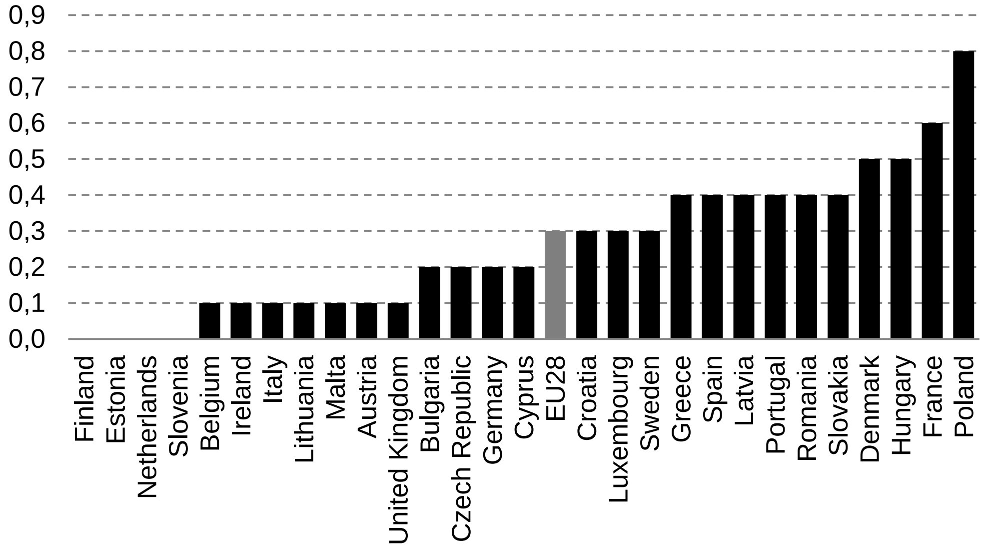
People need to be willing to use services, especially in primary care, which is the first point of contact with the health system for many people. When they use health services, their experience should be as positive as possible because user experience shapes expectations and can influence health care-seeking behaviour in the future. Services that fail to be acceptable to people are likely to be under used, with negative implications for health, efficiency in the use of health system resources and equity in use.

User experiences may be sub-optimal due to not having enough time with the provider, communication failures, lack of involvement in care decisions, lack of respect and lack of privacy. These factors may reflect fear on the part of the user; social, demographic and cultural differences between user and provider, potentially resulting in discrimination on the grounds of age, gender, race, ethnicity, religion or other individual characteristic; lack of user participation or consultation; lack of informational continuity (good health records) and service continuity (especially for out-of-hours services); poor management; and poor training of staff (communication skills, cultural competence).

Tools for monitoring and evidence of variation

Comparable data on overall user experience of the health system are not available in the European Union. Routinely collected data on the quality of patient-provider interactions are limited to a handful of EU Member States (see Annex 3). The only routinely collected data available across all Member States are for unmet need due to fear of the doctor, as shown in Figure 8.1. In general, this is a very minor source of unmet need, although there is some variation across countries.

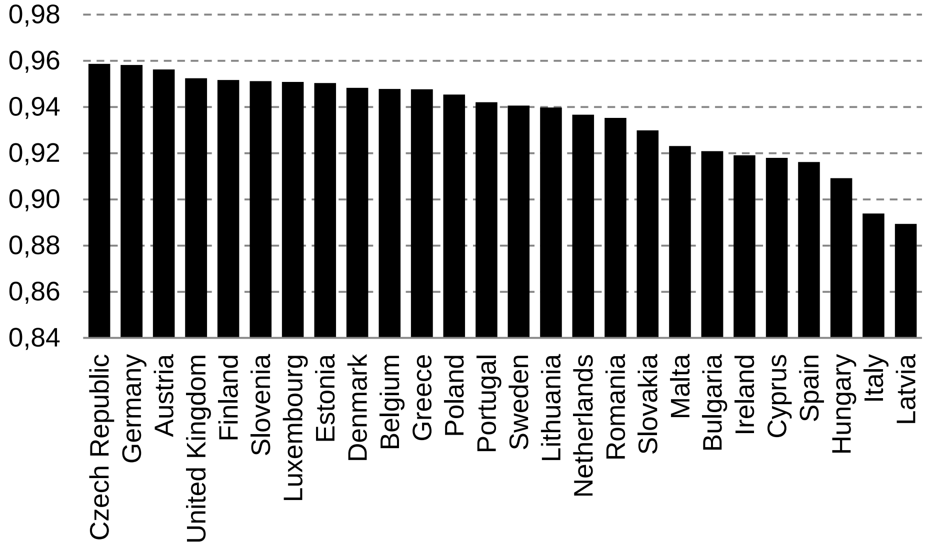
Figure 8.1 Share (%) of the population reporting unmet need for a medical examination due to fear of doctor, hospital, examination or treatment, EU28, 2013



Source: Authors based on EU-SILC (2015)

The EU-funded QUALICOPC study is the only reliable source of comparable data on aspects of patient-provider interaction across all 28 Member States. Figure 8.2 ranks countries on the quality of this interaction in primary care. It shows some variation across countries. These data are hard to interpret, however, as we know very little about the reasons why patients report lower levels of quality.

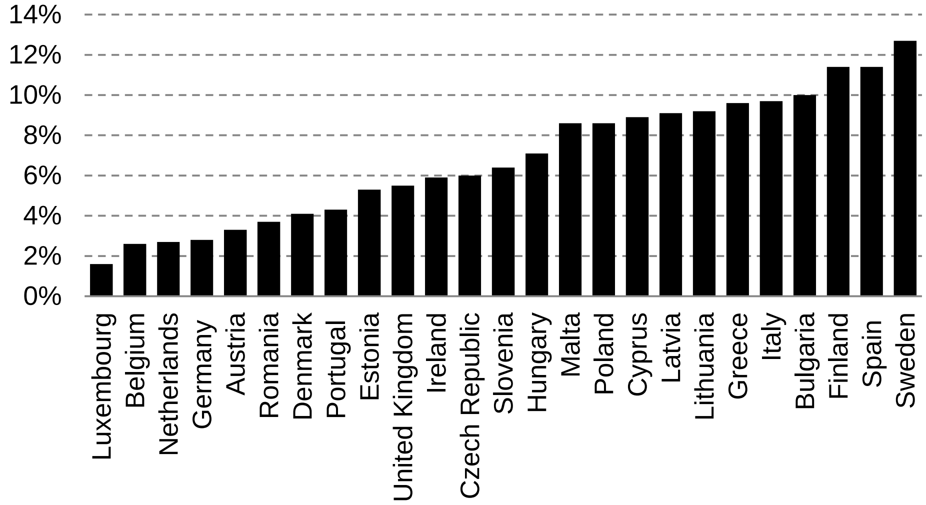
Figure 8.2 Quality of interaction between patient and primary care physician (score), EU28, 2013



Source: QUALICOPC (2015)
Note: A higher score indicates better interaction based on factors such as politeness, attentiveness, eye contact, understandability and asking questions; no data available for Croatia and France.

The same study reports on the share of patients feeling they have been discriminated against in the past year because of their gender, age or ethnic background by health workers in the primary care practice they visit or by other patients (Figure 8.3). Although this ought to provide some explanation in theory, in practice the association between these two sets of results is weak (R^2 = 0.19).

Figure 8.3 Share (%) of people feeling discriminated against by health workers or other patients in their primary care practice, EU28, 2013



Source: QUALICOPC (2015)
Note: No data available for Croatia, France and Slovakia.

Continuity of care – the extent to which a series of health services is experienced as connected, coherent and consistent with a patient's health needs and personal circumstances (Haggerty et al 2003) – is an important factor in determining the quality of patient-provider interaction. While the benefits to patients of always seeing the same physician (relational continuity) are limited, the benefits of informational continuity cannot be overstated, especially the presence of good health records. Continuity of out-of-hours services is also critical.

Resonance for specific people

Studies find a clear socioeconomic gradient in the quality of interaction between patients and physicians. Poorer people, people with less education and people in lower-paid jobs receive less information, less explanation, less emotional support and are less involved in treatment decisions.

Policy responses at national level

Policy responses lie in the following broad areas: strengthening the development of culturally sensitive and appropriate services (cultural competence); improving the communications skills of health workers; and developing e-health systems for better informational continuity and service continuity.

Culturally competent health services require a range of actions, including the definition of agreed standards and frameworks for practice, the development of supportive policies and organisational structures, the provision of education and training for staff, the effective use of cultural mediation to support providers and the recruitment of staff from ethnic or cultural minorities.

Countries should increase efforts to conduct regular national surveys of user experience of the health system, building on the experience of regular user surveys carried out in countries such as Denmark and Sweden.

Access for Roma, undocumented migrants and people with mental health problems

Chapter summary

Some groups of people experience particular difficulties in accessing health services. This chapter focuses on barriers to access among three underserved population groups in Europe: Roma people, undocumented migrants and people with mental health problems. The literature shows that these groups experience substantial problems in accessing health services due to legal, financial and administrative barriers, fragmentation and lack of flexibility in the organisation of services, complex needs, lack of knowledge about health services, fear and mistrust, cultural, language and communication barriers and experience of stigma and discrimination.

Effective policy responses to bridge the gap between need and health service use for these underserved groups of people include the following:

- Guarantee their entitlement and access to health services.

- Provide them with a combination of mainstream and specialised outreach health services.

- Deliver interventions to enhance knowledge about health services and improve health literacy.

- Develop services that are culturally competent to meet the needs of diverse populations.

- Train health service providers to reduce barriers to service uptake.

The European Union can support Member States by funding research into cost-effective approaches to improving access for underserved people and research on the benefits of improved access for these people; promoting the dissemination of good practice; and advocating the implementation of effective policy responses.

Population groups that experience particular difficulties in accessing health services include: people living in poverty, the homeless, long-term unemployed, those without health insurance, with poor education, poor health literacy, people living in rural isolated areas, older people, people with mental disorders and disabilities, ethnic minorities, migrants, asylum seekers and refugees and members of traveller and Roma communities.

Barriers to access may be associated with health policies and the organisation of the health system, including legal restrictions on entitlement to health services for certain population groups as well as financial barriers. In most EU countries, for example, there are legal restrictions on entitlements to access for asylum seekers and undocumented migrants with access to emergency services available in most, but not all countries. Other barriers include special requirements for referral to specialist care e.g., mental health services. Fees for service users and the costs of medicines create inequity in access for many marginalised groups due to their generally lower socioeconomic status. Barriers due to language, communication, sociocultural factors, lack of trust, discrimination and poor health literacy may also be experienced by vulnerable groups.

The stressful and poor living conditions of vulnerable and socially excluded groups and the lack of responsiveness of health services in meeting their complex health and social needs can result in costly patterns of service use (Carr et al 2014). This includes a high reliance on acute services such as Accident and Emergency as opposed to utilisation of primary care, and underutilisation of specialist or outpatient care have also been reported. There are low referral and attendance rates for disease prevention among vulnerable groups, including lower coverage and uptake of screening and immunisation, and difficulties in accessing services related to preventive reproductive health, prenatal care and mental health services. Efforts to improve the accessibility and uptake of health services will contribute to reducing costs associated with the treatment of illness and will improve the health of vulnerable groups.

Studies analysing policies and rights conclude that legal entitlements to health care including emergency care, child immunisations, antenatal care and mental health services, vary considerably across EU Member States (see Table 2.1). However, it is important to note that legal entitlements do not always correspond with access to care as there are country differences in implementation of rights at regional and individual level among health care providers and employers. Similar barriers among different health systems, including communication difficulties, cultural misunderstandings, referral difficulties and delayed or disrupted care, have been reported (Dauvrin et al 2012). The particular barriers experienced by underserved population groups will be explored in the following paragraphs.

An earlier study of differences in access to health care worldwide identified three broad categories of groups (Healy and McKee 2004). These are; i) indigenous populations, such as Native Americans, Australian Aborigines, and New Zealand Maori; ii) migrants, and especially those with cultural characteristics that differ from the majority population and those lacking documentation; iii) others defined by shared characteristics, including location (e.g. rural dwellers), legal status (e.g. prisoners), functioning (e.g. physical or mental disability, or age (older people), among others. In this report we examine the barriers faced by groups representing each of these three categories in Europe: Roma, undocumented migrants, and people with mental health problems.

Much research and many policy responses to inequalities in access to care have focused on groups defined by single characteristics, such as those listed in the previous paragraph. However, many people have multiple characteristics that, while individually important, have even more important consequences when combined. This recognition has given rise to an area of study termed intersectionality (Bauer 2014).[6] So far, most research on inequalities in access to health care using an intersectionality perspective has been undertaken in North America, but similar studies are required to provide a more comprehensive understanding of the determinants of inequalities in Europe.

Roma

Roma are Europe's largest ethnic minority, numbering 10-12 million and comprising up to 12% of the population in some countries. They have long been known to face barriers to health care, including distance to health facilities, unwillingness of health professionals to treat them, fear and mistrust of health professionals and lack of access to statutory health insurance schemes. In the last decade more and more attention has been drawn to Roma in Europe as a vulnerable and marginalised population group. The Roma population is an extremely diverse group that includes several subgroups (Hajioff and McKee 2000; Jarcuska et al 2013). Depending on the place they currently reside they will be referred to as Roma, Romani, Gypsies or Travellers.

The European Commission (2014) published a 'Roma Health Report' which highlighted how Roma still experience a lower life expectancy, up to 20 years fewer. In addition, infant mortality rates are significantly higher in some Roma populations and they are generally more likely to suffer from infectious diseases and communicable diseases (European Commission 2004, 2014). These findings can be explained partly by worse living-conditions (Eurofound 2012) and risk factors. However, the lower health status of Roma can also be explained by their limited access to care and levels of unmet need (ERRC 2006).

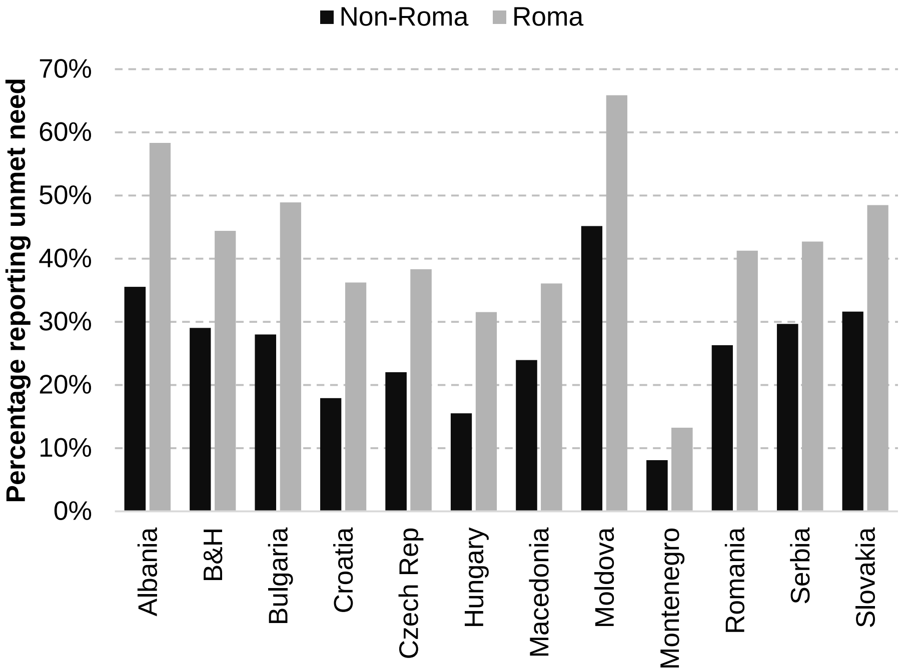
A series of household surveys designed to assess the living conditions of Roma was conducted between May and June 2011 by the UNDP, the World Bank, and the European Commission in 12 European central and eastern European countries. Primary sampling units were drawn randomly from settlements where, according to census data, Roma were more than 50% of the population. Non-Roma populations were sampled from those living in close proximity to the Roma settlements. That study found that Roma were significantly less likely to have health insurance than non-Roma in all countries except Slovakia and Serbia, with the greatest differences in Montenegro, Bosnia and Herzegovina, Croatia, Bulgaria, and Romania. Even after adjusting for employment status and income, the gap between Roma and non-Roma remained significant in Montenegro, Croatia, Bosnia and Herzegovina, Bulgaria, Romania and Moldova.

Further analysis of these data shows that Roma report higher levels of unmet need than non-Roma in each one of the countries studied (Figure U.1).

---

[6] Initially developed by feminist scholars researching the experiences of African Americans, intersectionality seeks to understand the complex challenges faced by those defined by the interaction of different social locations. These interactions occur within the context of connected systems and structures of power, such as laws, policies, religious institutions, and the media. Thus, from an intersectionality perspective, human lives cannot be reduced to single characteristics and social categories such as gender, sexuality, ethnicity, and class are socially constructed, fluid, and flexible while social locations are shaped by interacting social processes and structures that are influenced by time and place.

Figure U.1 Unmet need for health care among Roma and their non-Roma neighbours, 2011



Source: EU-SILC (2015)

Both higher unmet need and lower access can be explained by the barriers that Roma experience in their search for care. Some of these barriers, such as lack of financial resources and geographical remoteness, are relatively common and are also prevalent barriers for other vulnerable groups (ERRC 2006; Jarcuska et al 2013). However, the European Roma Rights Centre (2006) identified barriers which are particularly critical for the Roma population. One such barrier is the systematic exclusion of Roma from health-insurance schemes (ERRC 2006). Not only are the insurance contributions usually unaffordable for this population, they often lack the necessary documents and identification required to join an insurance scheme. A recent study by Kühlbrandt et al (2014) has shown that in almost all central and east European countries Roma are significantly less likely to be insured than Non-Roma, with the biggest differences being found in Montenegro, Bosnia and Herzegovina, Croatia Bulgaria and Romania. The absence of personal documents and citizenship is not only problematic in obtaining an insurance but also in receiving fundamental rights and social benefits such as pensions, social assistance, and basic care (ERRC 2006).

In addition to actual lower access, information of how to access relevant care is mostly absent in Roma communities (ERRC 2006). This is true for Roma in their native country as well as for those who migrated to another country in Europe. In both cases Roma often live outside the mainstream society and have little knowledge about their rights or the possibilities to gain access to medical care. Apart from the lack of knowledge on health services, (il)literacy and language differences also hinder Roma in accessing and obtaining health care.

The barriers mentioned above are enforced by the direct and indirect discrimination by health care providers and government policies (European Commission 2004). In 2012 a survey in 11 EU-Member States revealed that the proportions of Roma who felt discriminated ranged from 25% in Romania to 60% Czech Republic, Greece, Italy and Poland (FRA 2012). Discrimination can occur in an indirect way by excluding Roma from the labour market, education or even denying them citizenship (ERRC 2006) and forcing them to migrate to neighbouring countries where they often remain permanent illegal. More overt forms of discrimination have also been reported, including the denial of emergency aid, refusal to treat Romani patients, segregation in hospital facilities and even extortion of money from Romani patients by health care providers have been documented (ERRC 2006; European Commission 2014).

In response to these problems several European countries have implemented new policies to address the situation of the Roma in their country (ERRC 2006). Outreach programmes using trained members of the Roma and Traveller communities are documented in the literature (Carr et al 2014). Examples include the Pavee Point Primary Health Care Project in Ireland (Murphy 1999) and the Roma health mediators programme in Eastern Europe and Finland (Open Society Institute 2005). In 2005, a new platform called 'Decade of Roma Inclusion' was launched. In its statement 14 European countries declared to: "work toward eliminating discrimination and closing the unacceptable gaps between Roma and the rest of society." (Decade of Roma Inclusion 2005). These countries have developed different projects to achieve Roma inclusion, which include strategies such as immunisations campaigns targeted specifically at the Roma communities, health education, communication-training for personnel working with Roma (European Commission 2014), and the use of Roma health mediators (see also Box U.1). Since the launching of this platform, much attention has been given to the health-improvement of the Roma-community in Europe. Meanwhile, the European Council continues to stimulate the European Member States to develop and implement policies that improve Roma-integration and inclusion (European Commission 2014).

Box U.1 Mediators in care for Roma

In 1987, a non-governmental organisation implemented the 'Health Promotion among Navarre Ethnic Minorities'- programme (Jarauta et al 2010). This programme targeted the deplorable health of the Roma-community by using mediators from within the Roma-community. They received extensive training in the health needs of Roma, aspects of personal empowerment, the functioning of health care services and other services used by the Roma, etc… . The mediators function as an intermediary between the Roma community and policy, by assessing their needs and expectations, developing a local strategy for that particular community and the implementation of the plan. The programme succeeded in achieving higher levels of primary health care coverage, better maternal and child care, increasing participation of Roma in various health care and prevention programs and increased school attendance of Roma-children. Since its success similar programs were implemented in e.g.: Belgium, France and Romania (European Commission 2014).

Undocumented or irregular migrants

Undocumented or irregular migrants are regarded as one of the most socially marginalised groups in Europe. Policies exist at a European level to improve health care for migrants in general; however, the actual implementation of these in practice is highly variable (Cuadra 2011). In the EU context, 'undocumented migrants' or 'irregular migrants' refers to "third country nationals without a valid permit authorizing them to reside in EU Member States" (Cuadra 2011), covering rejected asylum seekers, those who have violated the terms of their visas, as well as those who have entered the country illegally. It is estimated that 1% of the entire population in the EU and circa 10% of the foreign-born population is undocumented (Duvell 2010 cited in Cuadra 2011).

Box U.2 Access to health care by undocumented migrants in the UK

In 2014 the United Kingdom government imposed major restrictions on the ability of undocumented migrants to access health care. This was despite evidence that, even before this, they faced many obstacles because of difficulties in navigating the system. As a consequence, when they were treated, it was often at a late stage in their illness. A number of qualitative studies seeking to understand their experiences have highlighted the scale of the challenges they face (Poduval et al 2015, Britz and McKee 2015). They also show that the claims by politicians that migrants come to the United Kingdom purely to obtain health care, a phenomenon pejoratively termed health tourism, has no basis in evidence. Moreover, these studies raise serious questions about the risk posed to the population in general as a result of late diagnosis of communicable disease.

In the Council of Europe Resolution 1509 (2006) on Human Rights of Irregular Migrants - Article 13.2 states that as a minimum right, emergency care should be available for irregular migrants and that Member States should seek to provide more holistic health care, in particular for vulnerable groups such as pregnant women, children, people with a disability, older migrants etc. However, these human rights obligations appear to be only partially met, or not at all in the majority of Member States. A comparative study of national policies regarding the right to access to health care for undocumented migrants in the 27 EU Member States found that there are wide differences in the entitlement to health care in the EU (Cuadra 2011) (see Table 2.1). However, the authors comment that there are gaps in the implementation of these policies in practice, whereby health care staff may refuse access where they do not know the rules or may grant access in spite of restrictive regulations. These variations were found to be independent of the system of financing or the number of undocumented migrants present in the country, but were rather related to categories or types of undocumented migrants and country level strategies for controlling migration.

Box U.3 Access to health care for undocumented people in Belgium

Since 1996, a royal decree organises the access for Undocumented People to "urgent medical care" in Belgium. Originally, this system was organised in the framework of the Public Centres for Social Welfare, run by the local authorities. Undocumented People had access to care providers (physicians, nurses,) where they received "free care" for "urgent" health conditions. They also had access to those medicines that were integrated in the official reimbursement-scheme of the health insurance system. The providers had to fill in administrative documents in order to be paid by the Public Centres, that then had to ask for reimbursement at the federal government.

Certainly at the primary care level and in the emergency departments, care providers tried to help Undocumented People, broadening the scope of "urgent medical care" to follow-up of chronic conditions, prevention, family planning, pregnancy. The system was quite complex, required a lot of instruction for the stakeholders at the different levels and created frustration as reimbursement was sometimes delayed. Moreover, it was not always easy to assess the entitlement to free "urgent medical care" for different groups of "Undocumented People": asylum seekers, political refugees. The strategy to "distribute" the undocumented people over all the cities and villages in Belgium, required an important effort in terms of information sharing, competency building and development of skills. After more than 10 years the system was optimised, in this sense that the Undocumented People who had free access to "urgent medical care", had to first collect a "medical card" at the Public Centre for Social Welfare. The administrative overhead and frustration at the level of care providers and administrative staff was huge and contrasted with the limited amount of the budget spent for the reimbursement (+/- 41 million euros a year). Moreover, the "medical card" had frequently to be renewed, not all groups of undocumented people were included, and there was a need for an official address (domiciliation).

Recently, a proposal to integrate the system for medical care for Undocumented People in the broader social insurance system was developed and one of the sickness funds was asked to provide membership for Undocumented People so that they could access health care as other citizens do. The transition from a selective approach to a more universal strategy is under assessment.

Measures adopted by the Spanish government in 2012 have resulted in further restrictions in access to health care for undocumented migrants (Council of Europe 2014 - report of the European Committee of Social Rights) with a loss of health coverage previously granted (MINECO 2013). The Spanish Government has recently announced a partial coverage for primary care consultations. In contrast, Sweden passed a law in July 2013 which has broadened access to health services for undocumented migrants, leading to improved access to a range of primary and secondary health services and with no evidence of an increase in migration following the health care reforms) It would appear that the problems that undocumented migrants experience are related to both the laws governing access and to the variable implementation of these laws in practice. As international and national migration policies are becoming more restrictive, urgent attention is needed to avoid worsening the current situation.

The stressful environments in which undocumented migrants live and work are not conducive to good health, particularly mental health. Mental health is one of the most frequently reported health needs of undocumented migrants in EU countries (PICUM 2010) and findings also indicate that infectious diseases such as HIV, TB and chronic Hepatitis B rates may be relatively high, while access to screening, immunisation and treatment is relatively low (Chauvin et al 2009, 2015). Effective public health care needs to reach all, including those without documentation. The lack of reliable data on the health of undocumented migrants remains a problem, especially those not seeking care, and leads to their invisibility in health service planning (Mladovsky 2007; PICUM 2015).

The literature on health and access to health care for undocumented migrants in the EU is limited, although increasing, in part because of increasing restrictions on entitlement to care being imposed in several countries. A scoping review by Woodward et al (2014) identified several studies, which were mainly qualitative in approach, that described poor self-reported health among undocumented migrants with increased stress and mental health problems being reported. Access to health care was described as variable and unpredictable depending on choices of health care workers. Barriers to health care access were found at primary, secondary and tertiary level. Primary care access was often delayed with the continuum of care disrupted /delayed for pregnant undocumented migrants. Hospital referrals were limited and several studies raised concerns about mental health services access (Strassmayr et al 2012).

Preserving the health advantage of newly arrived migrants has been identified as an important preventive strategy (Mladovsky 2007), however, there is a paucity of research on access to prevention and health promotion for undocumented migrants in Europe. Particularly vulnerable undocumented migrant groups include children, pregnant women and detainees. Studies describe the lack of, or delays in antenatal care (van den Muijsenbergh 2007, PICUM 2014, Mladovsky 2007) with women facing payment barriers at hospitals and lack of referrals to gynaecologists. Delayed health care seeking and practical financial and administrative barriers to health service access among undocumented migrant children and their parents is frequently reported (PICUM 2014, 2015). Access to dental, HIV, and TB services are also reported as limited. The Platform for International Cooperation on Undocumented Migrants (PICUM) argue that for services to be accessible in practice, there needs to be a clear separation or ‘firewall’ between service provision and immigration enforcement so that the personal information of undocumented service users is not shared with immigration authorities.

Major access barriers reported in the literature include:

- Lack of awareness of legal entitlements among undocumented migrants and health care providers.
- Fear of being reported to the authorities was cited as an important barrier to care seeking.
- Financial obstacles limited access to secondary care, with access to primary care also affected. Costs prevented undocumented migrants from accessing care and medicines.
- Cultural and language barriers were described as reducing undocumented migrants’ ability to negotiate treatment options, compounded by limited socio-cultural skills among providers, potentially compromising quality of care.
- The complexity of the social needs and health problems of undocumented migrants lead to difficulty in providing adequate treatment and reduced quality of care.

Access appears to be improved by the presence of voluntary health organisations, which play a role in referring undocumented migrants to accessible primary and secondary care providers and provision via outreach clinics. Some NGOs also provide advocacy and legal support. However, there is concern that the responsibility for delivery should not rest solely with non-governmental organisations. Closer cooperation between governments and NGOs is needed, including user involvement in the design and provision of accessible services.

People with mental health problems

Mental health problems are estimated to account for up to 30% of the burden of ill-health across Europe as measured by Years Lived with Disability (WHO 2014), with suicide being one of the ten most common causes of premature death (European Commission 2010). In any one year, some 38% of the EU's population experience a mental disorder (Wittchen et al 2011) and the rate remains persistently high. Access to mental health care for those who need it is critical, yet the gap between need and utilisation of mental health care services is wide in many countries in Europe (Alonso et al 2007). There is a need to improve access for the treatment of common and severe mental disorders, and the delivery of early intervention, prevention and mental health promotion adapted to the needs of diverse population groups, especially those who are vulnerable and socially disadvantaged (WHO 2013). On foot of the economic crisis in Europe, mental health care budgets, already operating from a low base, have been cut in many countries, giving rise to serious concerns regarding the adequate provision of mental health care.

People with mental disorders are at greater risk for poorer physical health and have higher levels of disability and earlier mortality, as they die on average 20 years earlier (Brown et al 2010). There is also evidence that people with severe mental disorders and comorbid physical health problems are less likely to receive standard level of heath care for metabolic, cardiovascular, viral, respiratory and other disorders (De Hert et al 2011). On average 26% of people with mental disorders in Europe are provided with treatment, which compares with over 75% for those with physical illnesses (Wahlbeck and Huber 2009). Health professionals have more difficulties when diagnosing and treating physical health problems in people affected by mental disorder and stigma and discrimination are recognised as being detrimental to the provision of good quality care. Specific strategies are needed to improve the access to appropriate health services for people with mental disorders, including improving the prevention and early detection of mental health problems, and the effective delivery of mental health promotion and primary prevention for both children and adults (Campion et al 2012, Barry et al 2013a).

People who experience social exclusion and marginalisation are more likely that than the rest of the population to experience mental health problems (Friedli 2009) and are also more likely to be over-represented in psychiatric hospital admissions (Priebe et al 2012). However, it is not clear what actions have been taken by governments in different Member States to address social exclusion as a determinant of mental health or how much priority has been given to targeted mental health promotion and strategies to improve access to appropriate health services. If mental health services are organised separately from other health care services, gaps arise in the provision of comprehensive services to people with multiple and complex problems, including mental and physical health needs, addiction and social needs such as homelessness (Canavan et al 2012). The integration and co-ordination of services across the health and social care sectors is of vital importance, as is ensuring good coordination between primary health care and mental health services. The co-occurrence of mental disorders with substance use disorders has given rise to the integration of specialised mental health and addiction treatment in several European countries (Wahlbeck 2010). Although the evaluation of integrated care models for people with mental health problems and /or addictions is limited, existing evidence is encouraging concerning their positive outcomes (Wahlbeck 2010).

The EU-funded PROMO project (DG Sanco: 2007-2010), assessed and described services in 14 EU capital Member States in order to identify good practice in mental health care for socially marginalised groups in Europe (Priebe et al 2012). The focus was on the delivery of health and social care for people with mental health problems who belong to one of the six following groups: long-term unemployed; homeless; street sex workers; asylum seekers/refugees; undocumented migrants; travelling communities. The quality of care provision was investigated and the components of good practice identified. The relevant policies and legislation in the participating countries were also identified and reviewed.

The most important barriers to care for these socially marginalised groups across all 14 countries were grouped into seven categories:

- Limited entitlements and administrative barriers to obtaining health care, particularly for asylum seekers and undocumented migrants, but also for the other groups who may be without health insurance.
- Complexity of needs and limited ability to engage, because marginalised people often live in poor socio-economic circumstances, inadequate housing, and social isolation, having chaotic life styles and lack information on health services.
- Language barriers and cultural differences between clients and staff in services, with a shortage of resources for trained interpreters (and a reluctance to use them where available) and often very different explanatory models for mental health problems.
- Lack of flexibility in the organisation of services and administrative procedures.
- Poor co-ordination and collaboration among services in the same area.
- Negative attitudes and discrimination towards some of the marginalised groups (particularly travelling communities, street sex workers, and the homeless).
- Clients from marginalised groups often mistrust or fear staff in services, which may be associated with previous negative experiences.

The collected evidence from this project suggested four components of good practice that apply across all marginalised groups:

- Establishing outreach programmes for marginalised groups to identify, engage with and help individuals with mental health problems.
- Facilitating access to general health services that include expertise and treatment programmes for mental disorders (providing different aspects of health care in one service and reducing the need for further referrals).
- While practice in mental health care for socially excluded and vulnerable groups varies substantially across Europe, there are some common barriers to good care for these groups. PROMO identified components of good practice, based on what is already in place or has been suggested as improvements, that apply across health and social care systems in Europe. These practices may guide future policies to improve mental health care for socially marginalised groups. In addition to sufficient financial and human resources, this requires the appropriate organisation of both individual services and the way services are co-ordinated, training programmes for staff in different services, the provision of information material, and improving the attitudes of health and social care professionals towards socially excluded groups.
- Disseminating information on health services available to marginalised groups to both the marginalised groups themselves and other services.

Box U.4 Good practice for different marginalised people with mental health problems

Homeless people

- Reducing administrative barriers to access mental health care (especially for those without insurance or without a permanent address).
- Including mental health expertise in outreach teams for appropriate assessments and referrals.
- Training mental health professionals to use a flexible and non-intrusive approach.
- Training staff in frontline services for homeless people, including accommodation/housing services, to increase awareness of mental health problems.

Asylum seekers/refugees

- Funding of and facilitating access to competent interpreting services.
- Providing culturally appropriate mental health care services.
- Developing good collaboration between mental health services and other organisations involved in the care for asylum seekers/refugees such as migrant organisations, not-for-profit organisations, asylum authorities and social welfare organisations.
- Clear information for mental health services on the entitlements of asylum seekers and refugees to care.

Street sex workers

- Including mental health expertise in the outreach services for sex workers.
- Establishing effective collaboration between specialised outreach services and mental health services to facilitate access to care.

Undocumented migrants

- Funding of and facilitating access to competent interpreting services.
- Providing clear information to migrant organisations on available services and on the entitlements of undocumented migrants to use them.

Long-term unemployed

- Training staff in unemployment agencies (e.g job centres) to be aware of the prevalence and implications of mental disorders.
- Establishing close collaboration of unemployment agencies (e.g. job centres) with mental health and social care services.
- Providing long-term and flexible training and employment schemes to accommodate the specific needs of people with mental disorders.

Travelling communities

- Providing a specialised point of entry into health care either with mental health expertise (eg cultural mediators, specialised health care staff) or close collaboration with a mental health service.
- Fostering cooperation between mainstream mental health services and non-governmental organisations specialising in care for travelling communities.

Policy responses

It is clear from this brief review that entitlement to health care does not always translate into access or uptake of services. The literature on barriers to access for underserved population groups shows that there is some consistency across the groups in relation to the main barriers experienced. There is also some consistency regarding examples of good practice in reducing inequalities in health access. These include strategies to:

- Guarantee access for underserved groups, incorporated explicitly into health policies and supported by adequate resources and service user involvement in the design and planning of services to meet their specific needs.

- Underserved groups should use ‘mainstream’ services, which should be organised in such a way as to ensure uptake among these groups.

- Establish outreach services for underserved and socially excluded groups with trained peer health workers who will help bridge the gap between specific needs of excluded groups and mainstream health service provision.

- Increase knowledge related to access and health literacy for vulnerable and underserved groups, supported by the provision of services and material developed for specific ethnic and linguistic groups, taking into account levels of education and literacy.

- Develop culturally competent health services that will meet the health needs of diverse population groups, through the use of qualified interpretation services, multilingual staff, cultural mediators and other organisational supports and practices, that will provide culturally accessible, acceptable and effective services.

- Train health care providers to enable the participation of services users in the planning and delivery of services. Includes, advocacy, informal support and advice in empowering both providers and patients in reducing barriers to service uptake.

Further research is needed to determine the most effective and efficient approaches to improving access to health service for underserved population groups, including research to inform policy decisions about the optimal balance of specialised and mainstream services and the effectiveness of different outreach service models for different groups.

The provision of effective prevention and health promotion services for these groups is important to ensure tailored support and interventions are provided before health problems emerge and become severe and intractable.

Accessible and good quality health care for vulnerable underserved population groups needs to be defined and developed in a participatory way based on the active involvement of group members in determining levels of needs and the planning and delivery of appropriate models of service provision. A combination of research-based information and user participation is critical.

Ensuring equitable access: EU and Member State responsibilities and responses

Chapter summary

The EU Charter, the EU Treaty and the International Covenant on Economic, Social and Cultural Rights all establish a right of access to core health services for everyone, especially vulnerable and marginalised groups of people, with an equitable distribution based on need. Interpretation of these documents suggests there should be progressive realisation of the right to health, requiring countries to move forward and, by implication, not to adopt measures that are regressive. In addition, core obligations constitute a universal floor, not a ceiling. This has particular resonance in light of health system responses to the financial and economic crisis in Europe.

Assuring this right is primarily the responsibility of Member States. Nevertheless, the European Union has a mandate to complement national policies towards improving public health, preventing physical and mental illness and diseases and removing sources of danger to physical and mental health.

Overall, there is need for *better monitoring* to identify the magnitude of access problems in a timely manner, to measure changes over time and across groups of people and to enhance international comparability. There is also a need for *more policy analysis* to enable a deeper understanding of the causes of access problems and to identify cost-effective policy responses.

The indicators routinely used to monitor access in the European Union are limited in scope and relevance (see Annex 3): very few are available across all 28 Member States, almost none is available at sub-national level and only a handful can be broken down by population sub-group. Stronger and more accountable health systems call for a new generation of data collection in which indicators are robust, comparable across countries and relevant to European and national contexts; data are collected and disseminated in a timely and visible manner; and disaggregated at sub-national levels and by sub-groups in the population.

For inspiration, the European Union should look to the United States, where the National Center for Health Statistics provides a wealth of up-to-date information and analysis for the nation as a whole and across its 50 states.[7] To match the quantity and quality of data available to health policy makers in the United States, the European Commission will need to:

- Develop a robust framework of indicators relevant to access issues that can be tailored to national contexts.
- Harmonise data collection and classification across national statistical offices and ensure adequate funding for national data collection, especially during economic downturns.
- Safeguard privacy in data collection, particularly where record linkage is required.
- Gather information from hard-to-reach groups, who may experience the worst barriers to access.
- Co-ordinate initiatives across countries.

---

[7] http://www.cdc.gov/nchs/

The most important areas requiring better data collection, and those where the information gaps are largest, are unmet need (better comparability across countries), utilisation of health services (disaggregated by region and population groups), user experience of the health system, financial protection and links between access barriers and health outcomes. Improving the availability and transparency of data on pharmaceutical costs and prices and finding a more efficient way to fund R&D should also be priorities, so that people living in the European Union can benefit from access to needed medicines and medical devices that are fairly priced.

The causes and consequences of poor access to health services are diverse. Because of this, monitoring, policy analysis and actions to improve access need to be tailored to a specific context. In this report we have identified actions in eight policy areas, at national and EU level. The actual policy responses required in a given context will depend, to a large extent, on the current state of the health system.

Evidence on unmet need clearly indicates the magnitude of financial barriers to access: cost is the single most important factor behind self-reported unmet need. Ensuring health services are affordable for everyone should therefore be a priority for the Member States. Improving affordability requires identifying and addressing gaps in publicly financed coverage to keep out-of-pocket payments as low as possible. It also has particular resonance when it comes to access to medicines, especially (but not only) new and innovative medicines, which are increasingly priced beyond the reach of many countries, including countries in the European Union.

The report has pointed out that promoting access does not mean making everything available to everyone at all times. Rather, it involves efforts to ensure access to health services that are relevant to people’s need, appropriate and as cost-effective as possible. This is an area that will require added attention as evidence of unwarranted variation in clinical practice increases and if health budgets do not grow in line with population health needs. The report has also emphasised the importance of service availability – well-equipped facilities within easy reach; enough health workers, with the right skills, in the right place; and stimulating research and development in areas of significant clinical need, such as antibiotics.

A final area the report has covered is user experience. Whether people have the information and skills needed to navigate complex health systems; whether they can obtain appointments with ease and treatment without excessive waits; whether they are treated with respect and dignity, are able to avail of services in their own language and are sufficiently involved in decisions about their treatment – these are questions that are often overshadowed by issues of affordability and availability and yet they may have a critical impact on access to health care, especially for systematically underserved groups of people.

In covering all of these different areas, the report has aimed to show how ensuring equitable access to health services is a multi-dimensional challenge. There are very few simple or quick fixes. It is also a permanent challenge, requiring sustained effort on many fronts. Better monitoring, context-specific policy analysis and research targeting hard to reach groups of people can contribute to this effort. However, real progress will only be made – and felt – when Member States are ready to act in response to what the available data already clearly demonstrate.

This report has tried to illustrate the extent of variation in access to health care between countries in the European Union. Demographic changes, increasing migration, ethnic diversity and the high price of some medicines are creating new challenges for EU health systems. More inclusive and accessible health systems are needed to prevent inequities in health from growing.

The focus of this chapter is on the roles and responsibilities of the European Union and its Member States in ensuring equitable access to health services. It focuses on the need for a new generation of data collection for effective, accessible, resilient and accountable health systems; summarises the policy responses identified in previous chapters; and comments on the challenges and opportunities these actions entail.

The roles and responsibilities of the European Union and its Member States

As noted in Chapter 1, the right to access health services is set out in the European Union's Charter of Fundamental Rights, which states that:

> Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities. (Article 35)

The Charter does not specify where responsibility lies for ensuring these rights. For this it is necessary to look to the Treaty on the Functioning of the European Union, which makes clear that the competence of the European Union is strictly limited with respect to the first part of Article 35 of the Charter:

> Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. (Article 168.7)

The Treaty also notes that Union action to ensure health protection:

> …shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health. (Article 168.1)

EU Member States have other obligations under international agreements. The primary instrument in this respect is the International Covenant on Economic, Social and Cultural Rights. The Covenant has been interpreted by the Committee on Economic, Social and Cultural Rights, an international body tasked with monitoring compliance with Covenant, giving rise to a body of jurisprudence and authoritative interpretation of international human rights law that identifies the rights of individuals and the obligations of those who should secure their rights. Several principles flow from this body of material.

All states, no matter how poor, should offer a minimum core level of provision, which should include at least the following obligations:

- To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups
- To provide essential drugs, as from time to time defined under the [Word Health Organization] Action Programme on Essential Drugs
- To ensure equitable distribution of all health facilities, goods and services [based on need]
- To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population

Right of access to core health services, with an equitable distribution based on need, therefore lies at the heart of Member States' responsibilities.

There should be progressive realisation of the right to health. This requires countries to move forward towards the right to health and, by implication, *not to adopt measures that are regressive*. This has particular resonance in light of health system responses to the financial and economic crisis in Europe. In addition, each state should make progress "to the maximum of its available resources", which implies an explicit comparison of what is being provided and available resources. If states claim they cannot provide health care to the level seen elsewhere, they are obliged to demonstrate why. And if states are able to move beyond their core obligations, they have a legal obligation to do so: core obligations constitute a universal floor, not a ceiling. One clear implication of this principle is that when budget cuts cannot be avoided, they should be implemented selectively, with great care to ensure that cuts first target areas in which they will do least damage to equitable access to health services and to population health.

Interventions should be cost-effective to maximise the benefit from available resources, derived from non-discrimination. The Committee has noted that 'expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population' are an '[i]nappropriate health resource allocation [that] can lead to discrimination that may not be overt'. In countries with relatively generous entitlement for the whole population, the same principle applies, but the divide is not so much between privileged and poor as between different illnesses. Non-discrimination therefore takes a broader perspective.

There should be shared responsibility among states. When the Committee elaborated states' core obligations arising from the right to health, it explicitly referred to international assistance: 'For the avoidance of any doubt, the Committee wishes to emphasise that it is particularly incumbent on State parties and other actors in a position to assist, to provide 'international assistance and co-operation, especially economic and technical' which enable developing countries to fulfil their core and other obligations'. Thus, there is an obligation on richer states to prioritise equitable access to health care in their international assistance programmes.

There is an imperative for participatory decision-making, derived from the principle of non-discrimination. The Committee believes that national public health strategies and plans of action that states are required to adopt and implement 'shall be devised, and periodically reviewed, on the basis of a participatory and transparent process'. Thus, the health concerns of the whole population should not simply be assessed from epidemiological data but should incorporate people's expressed priorities.

The needs of vulnerable or marginalised groups should be addressed explicitly, the last derived from non-discrimination. Participation in the process of developing and monitoring national plans must specifically include marginalised populations in a meaningful way. Where particular health concerns disproportionately affect vulnerable or marginalised populations, it may be incumbent on the state to include interventions in its benefit package, even where the interventions needed are not considered cost-effective overall. This presents an explicit trade-off between the different objectives of a health system, in which improving access for disadvantaged groups may receive more weight than improving access for more advantaged groups.

In summary, the EU Charter, the EU Treaty and the International Covenant all establish a right to health care. They indicate that its assurance is primarily the responsibility of Member States. Nevertheless, the European Union has a mandate to complement national policies towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. The following section indicates areas and ways in which this might be possible.

A new generation of data collection for effective, accessible, resilient and accountable health systems

Ensuring equitable access to health services across and within countries in the European Union requires action at EU and national levels:

- *Better monitoring* to identify the magnitude of access problems in a timely manner, to measure changes over time and across groups of people and to enhance international comparability.

- *More policy analysis* to enable a deeper understanding of the causes of access problems and to identify cost-effective policy responses.

The tables in Annex 3 list the indicators that are routinely used to monitor access in the European Union. On one hand, these indicators have the advantage of being consistently defined and collected over several years. On the other hand, it is evident that they are limited in scope and relevance. For example, none of these indicators is available at sub-national level, only a handful can be broken down by population sub-group and, with the exception of health expenditure data and unmet need data from EU-SILC, none are available across all 28 Member States.

Goals, principles and governance for better monitoring and analysis

If the European Union is serious about promoting effective, accessible and resilient health systems, there is an urgent need to invest in improving the health information infrastructure. Stronger and more accountable health systems call for a new generation of data collection based on the following principles:

- Indicators that are robust, comparable across countries and relevant to European and national contexts.

- Data collected and disseminated in a timely and visible manner.

- Data disaggregated at sub-national levels, so that it is possible to identify regions requiring particular attention; analysis shows that variations within countries are sometimes greater than variations across countries.

- Data disaggregated by sub-groups in the population, so that it is possible to identify differences between groups of people based on socio-economic status, health status, age, gender, ethnicity, residence in urban vs rural areas or other relevant characteristics.

The governance of this new data collection system will require greater involvement by the European Commission in the way in which relevant data are identified and collected, in line with the European Union's mandate to ensure a high level of human health protection. For inspiration, the Commission can look to the United States, where the National Center for Health Statistics provides a wealth of up-to-date information and analysis for the nation as a whole and across its 50 states.[8]

To match the quantity and quality of data available to health policy makers in the United States, the Commission will need to engage in a number of areas:

Develop a robust framework of indicators relevant to access issues that can be tailored to national contexts. This is something the EU Social Protection Committee identified as a key priority in 2013. Since then it has been working on a Joint Assessment Framework for Health, which includes indicators measuring access to health services.

Harmonise data collection and classification across national statistical offices. The Commission has been reluctant to require national statistical offices to adhere to EU standards, seeing its role as co-ordinating rather than imposing standards. However, this stance no longer seems appropriate in an era in which the Commission and EU Member States are committed to systematic assessment of health system performance. International and national statistical offices need to use standard definitions and make sure that indicators capture the same dimensions in a consistent fashion across countries and account for cultural differences.

Safeguard privacy in data collection, especially where record linkage is required. Monitoring access more effectively means developing national information systems that allow countries to link patient records across datasets using unique patient identifies (see below). Few countries are able to link records at present, but the need to do so is growing and, as it grows, the need to safeguard patient rights also increases.

---

[8] http://www.cdc.gov/nchs/

Gather information from hard-to-reach groups, who may experience the worst barriers to access. Vulnerable or marginalised groups of people are often least likely to participate in surveys targeting the general population, making them invisible to researchers and health systems. None of the European Union's survey instruments that can offer insights into access – EU-SILC, SHARE (Survey of Health, Ageing and Retirement in Europe), Health interview and Health Examination Surveys – is likely to adequately capture the experience of people who are systematically underserved by the health system. This failure wastes resources. The Commission should develop specific methods to improve data collection among hard-to-reach groups of people, some of whom may actively avoid contact with researchers and bureaucrats.

Ensure adequate funding for national data collection. At the start of the crisis, Greece stopped collecting SHARE data due to the severe fiscal constraints it faced – a move that has undermined its ability to monitor the effects of the crisis on a vulnerable group of people. The European Union could draw on structural funds to provide matching funding for national statistical offices that agree to adhere to EU-defined standards and to enable Member States to invest in vital data collection when it is most needed.

Ensure national data collection results are easily accessible. Some countries – the Netherlands, for example – charge individuals and institutions relatively large sums of money to access routinely collected household budget survey data, while others (the United Kingdom) make it freely available and easily downloadable, at least to anyone based in a university. The Commission could address this by requiring more data to be made available centrally, through Eurostat.

Co-ordinate initiatives across countries. Some EU health systems are making rapid progress in the design and use of access measures such as surveys of user experiences and outcomes. Reaping the benefits of these innovations, and making them more internationally comparable, requires an international framework.

EU Member States should not see the collection of EU-wide data as a burden. A stronger system of data collection will benefit individual Member States by enhancing their ability to identify and respond to problems. It will also benefit the European Union as a whole.

The content of better monitoring and analysis

There are many areas that could be strengthened. Here, we focus on what we regard as the most important and those where the information gaps are largest.

Unmet need: Throughout the report we have highlighted both the importance and the limitations of EU-SILC data on unmet need. These critical data are less useful than they could be because they lack international comparability and explanatory power. Additional research is needed to understand how the survey question is understood by different people in different countries.

Utilisation of health services, disaggregated: Countries should be required to collect standardised administrative data on the use of health services, to help identify and interpret evidence of unmet need. Administrative data on utilisation need to be linked to data on individual characteristics, including socio-demographic information and measures of deprivation within geographically defined communities. Such systems are currently rare within Europe, but should be encouraged to become the norm in the next few years, accompanied by appropriate safeguards.

User experience of the health system: Data on user experience would also help to identify and interpret evidence of barriers to access. Some countries are beginning to invest in regular national surveys – notably Denmark and Sweden – and now is the time for the Commission to build on their experience and facilitate better collection of this important indicator across more countries.

Financial protection: A limitation of unmet need data is that they do not tell us about financial hardship patients experience when using health services, which might be significant enough to present a financial barrier to access in the future. Two routes need to be explored. First, EU-SILC should be adapted to include proxy measures of financial hardship. In 2014, suggestions were made to and considered by the EU Social Protection Committee's Joint Assessment Framework for Health. Second, the Commission should invest in better and more regular collection of household budget survey (HBS) data – for example, developing a standardised health module with a detailed set of questions on households' use of and spending on health services and requiring countries to use this at regular intervals. At present, the minimum requirement for household budget surveys is one every five years. HBS can be used to estimate the extent to which people are pushed into (or further into) poverty by out-of-pocket spending on health and the extent to which out-of-pocket payments prevent people from spending on other essential items such as food, shelter and utilities (gas, electricity etc). The WHO Regional Office for Europe is currently working to provide new and more robust estimates of financial protection in a range of EU Member States, but the lack of appropriate data is an obstacle.

Links between access barriers and health outcomes: More research is needed into how typical indicators of access – for example, health workforce shortages, time spent with health professionals, waiting times etc – affect health outcomes.

Actions to ensure equitable access: a summary of national and EU policy responses

The causes and consequences of poor access to health services are diverse. Because of this, monitoring, policy analysis and actions to improve access need to be tailored to a specific context. Here, we identify a broad set of actions in the eight policy areas covered in the report. For each area we summarise actions to be taken at national level, by the Member States, and supporting actions to be taken at EU level, by the European Union. The actual policy responses required in a given context will depend, to a large extent, on the current state of the health system.

1 Financial resources are linked to health need

National policy responses	EU support
▪ Link the availability of public funding for health to population health needs, especially during economic downturns. ▪ Countries with low levels of public spending on health should allocate a higher share of the government budget to the health sector. ▪ Ensure public funding is used effectively, rather than simply driving up the prices of technology or highly specialised staff. ▪ Introduce and improve sub-national resource allocation formulas. ▪ Move away from provider payment that links payment solely to inputs.	▪ Routinely collect data on sub-national health care expenditure patterns. ▪ Identify regions in need of additional public spending on health. ▪ Ensure unmet need is accounted for in country-specific recommendations made as part of the European Semester. ▪ Help countries develop secure systems of record linkage, including unique patient identifiers.

2 Services are affordable for everyone

National policy responses	EU support
▪ Ensure most health system funding comes from public rather than private sources. ▪ Keep out-of-pocket payments as low as possible. ▪ Identify and close gaps in publicly financed coverage of cost-effective services. ▪ Broaden the basis for entitlement to encompass everyone living in a country. ▪ Eschew discriminatory approaches such as entitlement linked to employment status or payment of contribution or situations in which people with different diagnoses are entitled to different benefits. ▪ Improve user charges so they do not create financial barriers to cost-effective services or undermine financial protection. ▪ Ensure efficient use of public resources. ▪ Address informal payments using a	▪ Prohibit discriminatory approaches such as entitlement linked to employment status or payment of contributions. ▪ Adapt EU-SILC to include proxy measures of financial protection. ▪ Require countries to carry out household budget surveys on more frequently than every five years and develop a standardised health module to enable better estimation of financial protection.

mix of policy instruments. ▪ Social protection policies are critical to addressing poverty and income inequality.	

3 Services are relevant, appropriate and cost-effective

National policy responses	EU support
▪ Ensure the publicly financed benefits package covers the full spectrum of services, is correlated with population health needs and does not result in inequity by disease. ▪ Take steps to avoid over-medicalisation. ▪ Put in place systematic priority-setting processes to enable HTA-informed, cost-effective coverage decisions for both new and existing technologies. ▪ Develop clinical guidelines and referral systems, adapt guidelines to meet the needs of people with multiple morbidities and monitor adherence to guidelines. ▪ Train and support health workers to deliver services in line with evidence. ▪ Ensure all patients have access to adequate and accessible information about treatment options and outcomes. ▪ Establish information systems to identify (and publicly report on) practice variations and patient outcomes and to support effective decision making by health professionals and patients.	▪ Support the strengthening of activities currently carried out by EUnetHTA.

4 Well-equipped facilities are within easy reach

National policy responses	EU support
▪ Engage in area-level planning to create networks of dispersed facilities feeding into a central one, based on agreed clinical pathways. ▪ Develop mechanisms to facilitate the transport of patients to health facilities or health professionals to patients. ▪ Both responses require administrative structures that can take a population-wide perspective and have the managerial tools required for capacity planning. ▪ In the absence of geographical responsibility for health, instruments such as certificates of need for advanced medical technology can be used.	▪ Continue work to develop European reference networks (ERNs).

5 There are enough health workers, with the right skills, in the right place

National policy responses	EU support
▪ Put in place processes to train adequate numbers of health workers. ▪ Establish working conditions designed to retain staff in underserved countries and areas: remuneration commensurate with skills and attention to broader working conditions, including access to peer support and continuing professional development. ▪ Ensure an appropriate mix of skills is in place. This may require investment in additional administrative or care staff to relieve pressure on specialised health professionals, the development of new roles, such as specialist nurses, or task shifting, with delegation of certain roles to less specialised staff.	▪ Improve data collection on health worker functions, remuneration and working conditions. ▪ Ensure ethical international recruitment. ▪ Promote cooperation on health workforce policies through the Expert Group on European Health Workforce and Joint Action on health workforce planning and forecasting.

6 Quality drugs and devices are readily available

National policy responses	EU support
▪ Ensure fairer prices by identifying more efficient ways to fund R&D, requiring much greater transparency around costs and prices and developing joint procurement agreements for medicines and medical devices. ▪ Define national policies on medical devices. ▪ Systematically use HTA, including cost-effectiveness analysis, to inform coverage decisions and disinvestment for both medicines and medical devices. ▪ Encourage rational prescribing and use of medicines and medical devices through 'wise lists', algorithms, guidelines, capacity planning of big-ticket equipment and specialised medical equipment management units. ▪ Improve information systems and data collection at regional, national and EU level.	▪ Develop more efficient R&D and pricing systems. ▪ Improver information and assessment strategies. ▪ Foster cooperation in HTA and e-health.

7 People can use services when they need them

National policy responses	EU support
▪ Ensure people have good information about health services in their own language and have access to translation or interpretation services when required. ▪ Strengthen the evidence base for strategies to improve health literacy. ▪ Specify and adhere to maximum waiting times; differentiate waiting times by severity of illness; provide the public with reliable information on waiting times. ▪ Individual health facilities can and should take a wide range of relatively straightforward steps to make existing services more easily accessible to the general population and to meet the needs of people with disabilities.	▪ Harmonise definition and data collection for waiting time indicators. ▪ Set and enforce standards for disabled access in all health facilities.

8 Services are acceptable to everyone

National policy responses	EU support
▪ Strengthen the development of culturally sensitive and appropriate services (cultural competence). ▪ Improve the communications skills of health workers. ▪ Develop e-health systems for better informational and service continuity. ▪ Conduct regular national surveys of user experience of the health system, building on the experience of regular user surveys carried out in countries such as Denmark, Spain, Sweden and the United Kingdom.	▪ Support the sharing of good practice regarding methods to assess user experience.

Challenges and opportunities

In discussing ways of ensuring equitable access to health care, this report has focused on eight policy areas, identifying key issues, highlighting evidence of variation within and across countries where available and suggesting policy responses at national and EU level.

Evidence on unmet need clearly indicates the magnitude of financial barriers to access: cost is the single most important factor behind self-reported unmet need. Ensuring health services are affordable for everyone should therefore be a priority for the Member States. Improving affordability requires identifying and addressing gaps in publicly financed coverage to keep out-of-pocket payments as low as possible. It also has particular resonance when it comes to access to medicines, especially (but not only) new and innovative medicines, which are increasingly priced beyond the reach of many countries, including countries in the European Union.

The report has pointed out that promoting access does not mean making everything available to everyone at all times. Rather, it involves efforts to ensure access to health services that are relevant to people's need, appropriate and as cost-effective as possible. This is an area that will require added attention as evidence of unwarranted variation in clinical practice increases and if health budgets do not grow in line with population health needs. The report has also emphasised the importance of service availability – well-equipped facilities within easy reach; enough health workers, with the right skills, in the right place; and stimulating research and development in areas of significant clinical need, such as antibiotics.

A final area the report has covered is user experience. Whether people have the information and skills needed to navigate complex health systems; whether they can obtain appointments with ease and treatment without excessive waits; whether they are treated with respect and dignity, are able to avail of services in their own language and are sufficiently involved in decisions about their treatment – these are questions that are often overshadowed by issues of affordability and availability and yet they may have a critical impact on access to health care, especially for systematically underserved groups of people.

In covering all of these different areas, the report has aimed to show how ensuring equitable access to health services is a multi-dimensional challenge. There are very few simple or quick fixes. It is also a permanent challenge, requiring sustained effort on many fronts. Better monitoring, context-specific policy analysis and research targeting hard to reach groups of people can contribute to this effort. However, real progress will only be made – and felt – when Member States are ready to act in response to what the available data already clearly demonstrate.

Annex 1 Informal care and its impact on access to health services

Although this report is concerned primarily with access to formal care, it is important to recognise that a large amount of care in Europe is delivered by informal carers, such as family and friends of those in need. While there are major gaps in the available data on access to formal care in Europe, the situation is even worse for informal care. Obtaining such evidence is important for several reasons. First, the absence of informal carers may mean that individuals with need for care can only obtain it in formal settings, such as hospitals or care homes that are both more expensive and, in many cases, less acceptable to the individuals concerned, as many of those in need would prefer to be cared for in the familiar setting of their own home. Second, a failure to support informal carers may lead to them becoming patients in their own right.

The most important source of evidence on the situation in Europe is the EU-funded ANCIEN project (Pickard et al 2011). To understand the role of informal care, the researchers first developed a typology of long-term care in European countries, based on two dimensions. The first is organisational depth, characterised by an absence of means testing, clear entitlements, availability of cash benefits, quality assurance mechanisms and integration. The second is financial generosity, characterised by a high share of GDP being spent on long-term care and low user charges. The position of many countries is intuitive, with the post 2004 Member States being relatively less generous, although they vary in organisational depth. However, there is also considerable variation among the pre-2004 Member States on both measures.

Across the European Union, there are large differences in the share of the population receiving informal care, from 21% of those over 65 in France to 43% in the Czech Republic, and from 41% to 60% among those over 85 in the same countries. There are also large differences in the share of the population providing informal care, from just over 10% of those aged over 18 in Denmark to almost 19% in Lithuania. While those providing care are most likely to be female in all countries, there are marked differences among countries in the age distribution of carers and their relationship to those they are caring for.

There are also substantial differences in the support offered to informal carers. In some countries either carers or those in need of care are entitled to financial support. In the Netherlands, those in need of care may be given a personal health budget that can be spent largely as they wish and, while this has provided greater autonomy for some in need of care, there have also been many examples of abuse, with exploitation of vulnerable individuals. A pilot study of a similar initiative in England achieved at best mixed results.

The support available to those in need of care or their carers is often means tested, as in France, Spain and Finland, but not always and, in Belgium, a federal allowance is means tested while another, paid in Flanders, is not. Another form of support, respite care, whereby those receiving care may enter a residential facility for a few weeks to relieve their carer, is also available in many countries but its extent, and the mechanisms involved, including financial arrangements, are poorly documented.

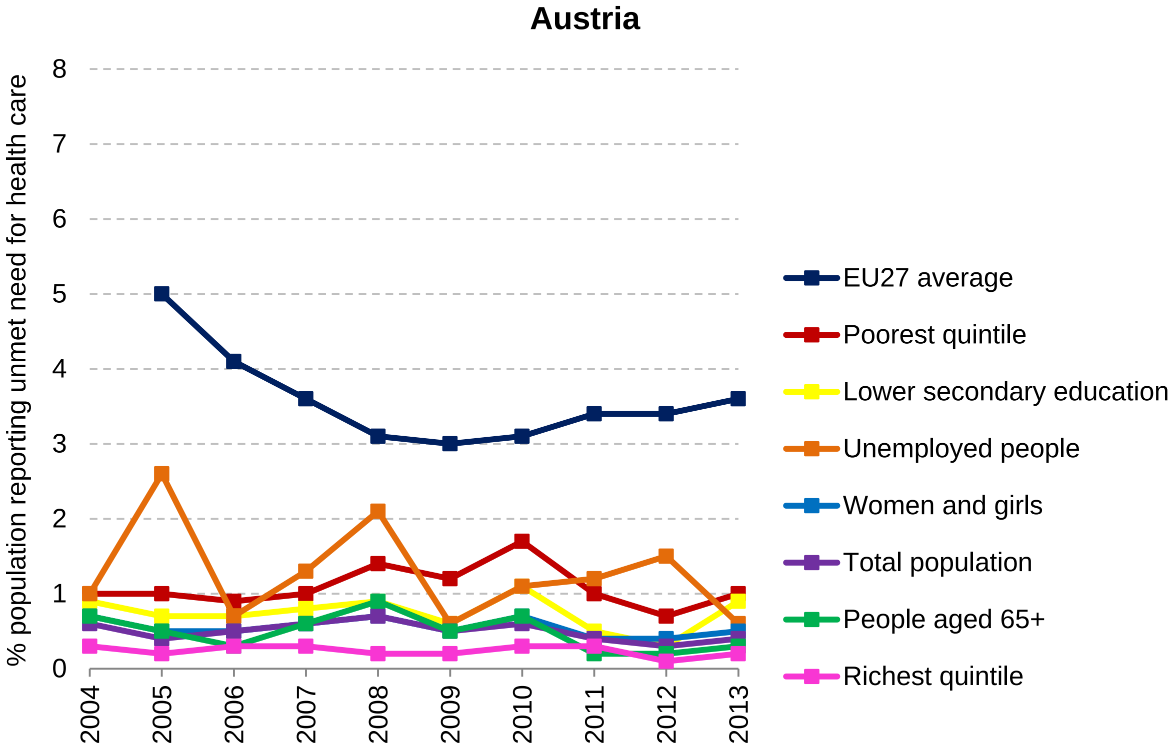
In summary, the volume of informal care provided in Europe is substantial but evidence on the extent of need, both met and unmet, is still very limited.

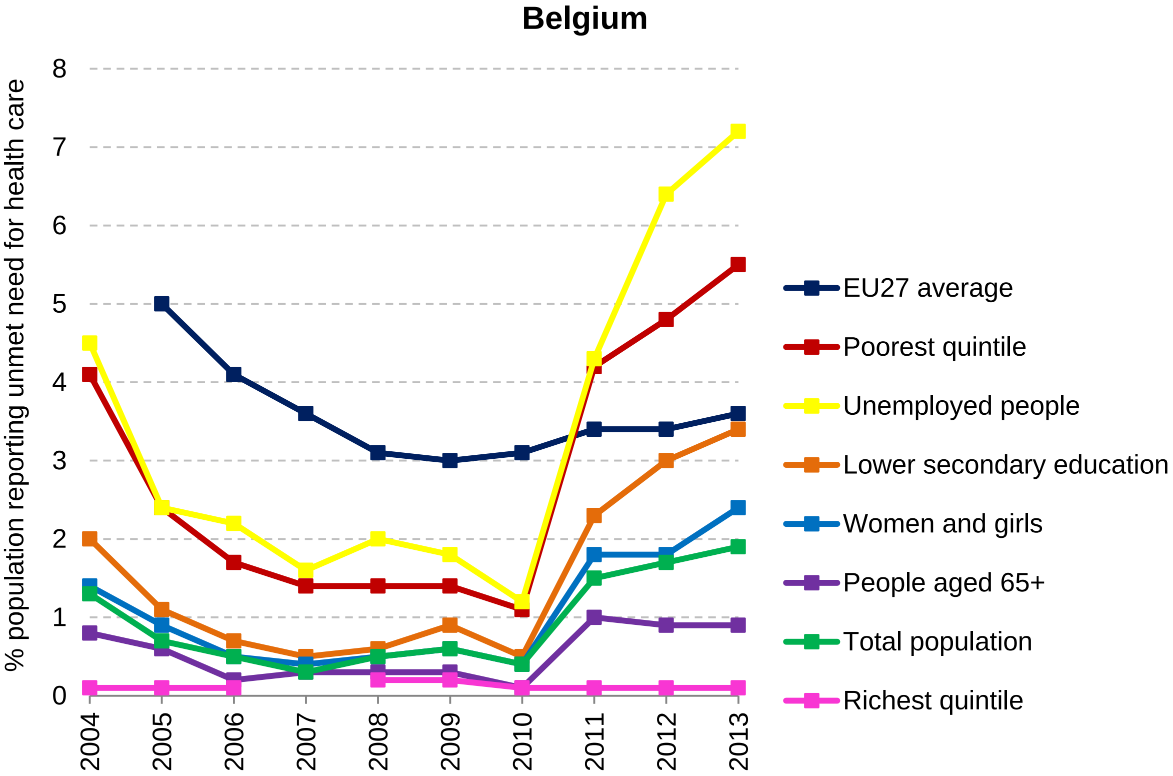
[This page intentionally left blank]

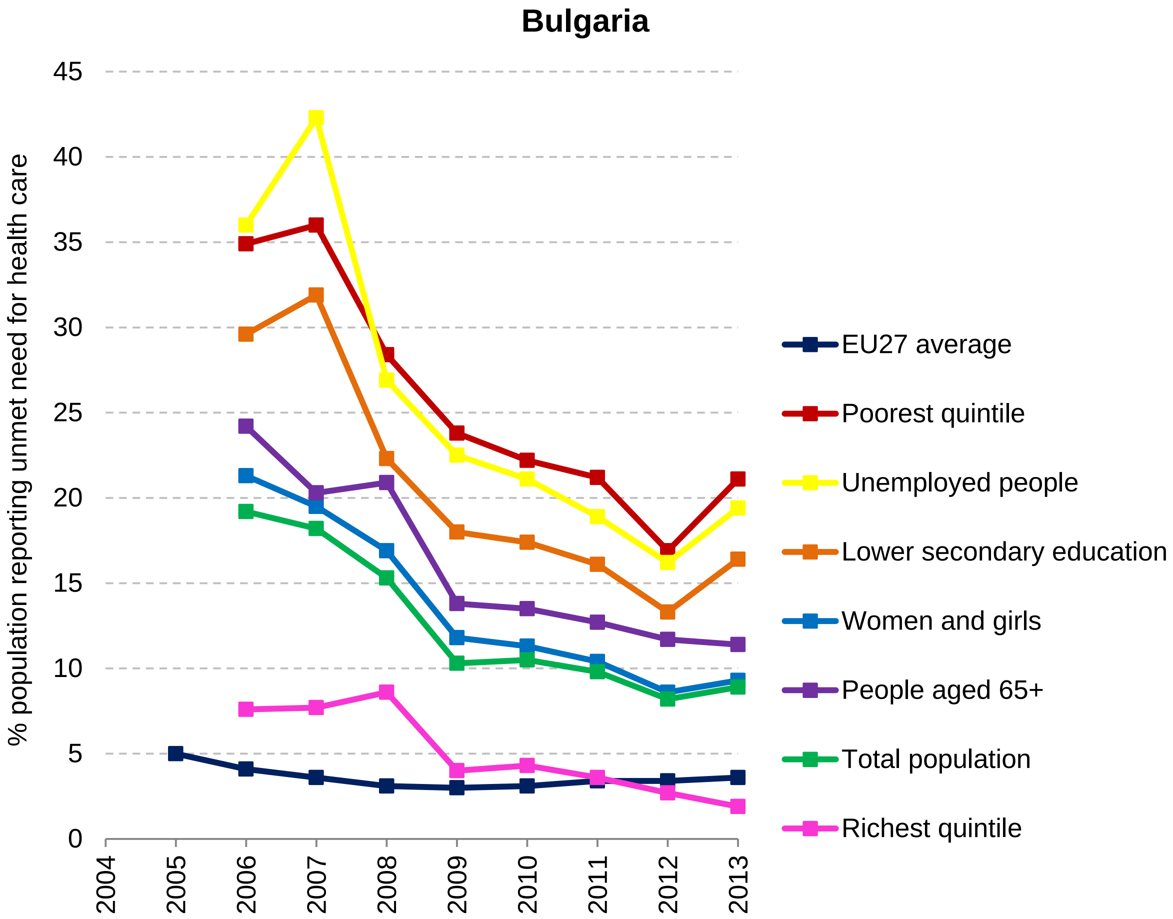
Annex 2 Trends in unmet need for health care in each EU Member State

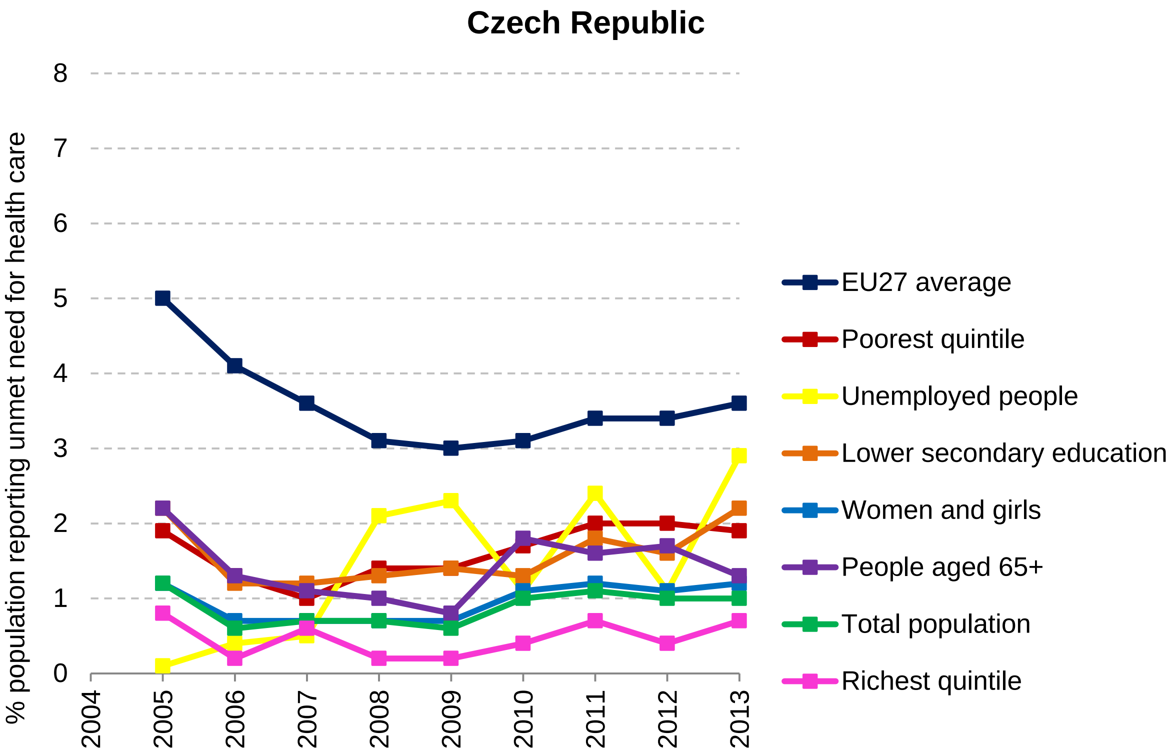
Trends in unmet need for health care due to cost, distance or waiting time by country

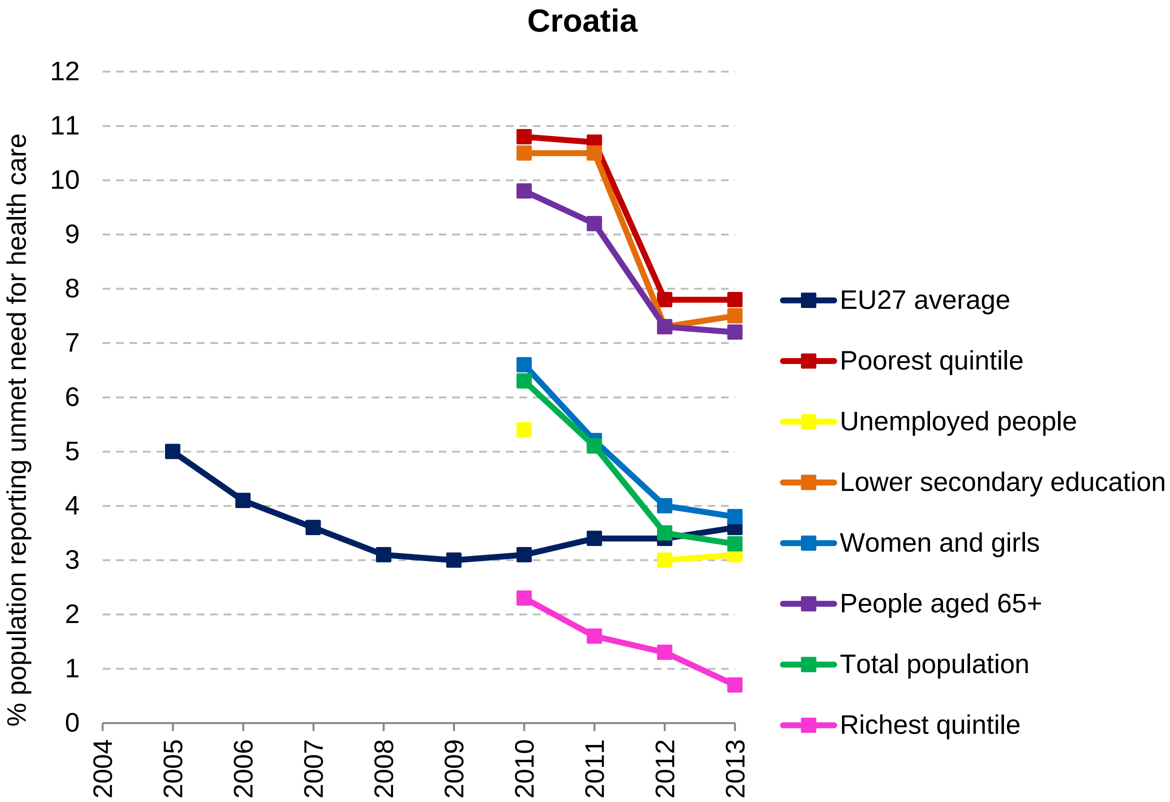
Note: Data are from EU-SILC (2015). Most figures are scaled from 0-8% but some have a larger scale.



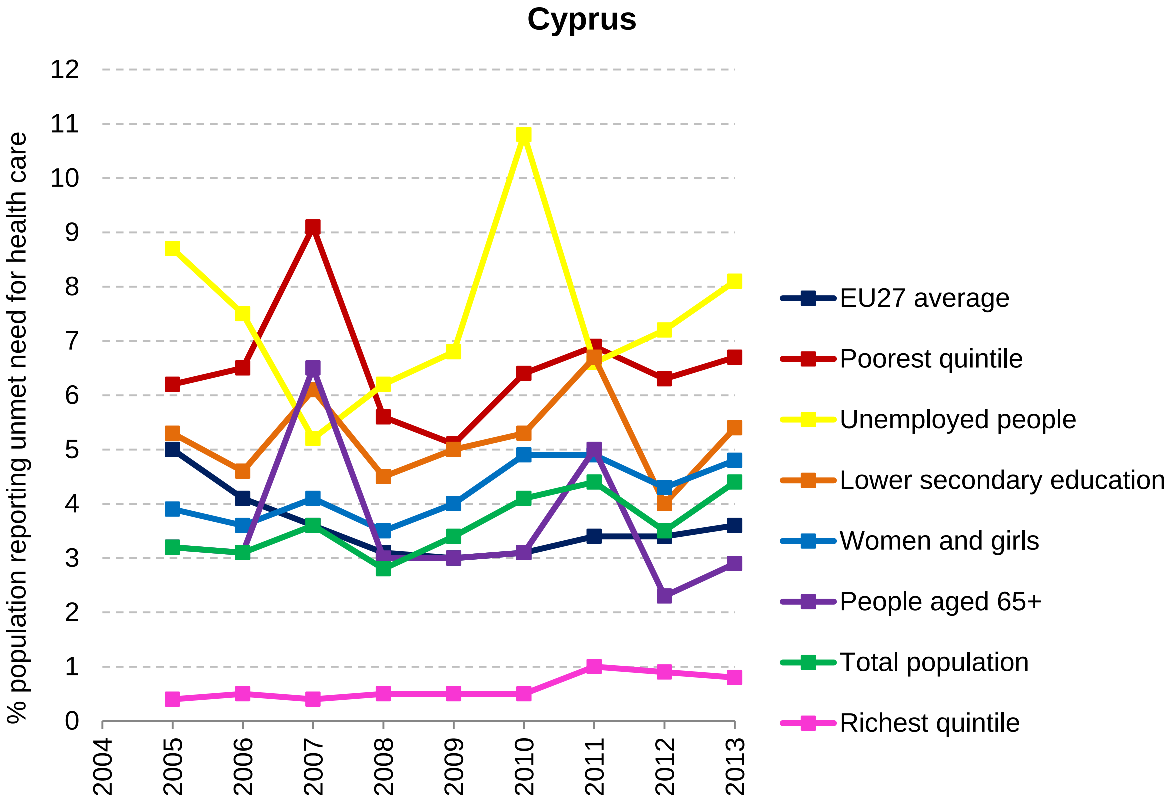



Bulgaria
% population reporting unmet need for health care
45
40
35
30
25
20
15
10
5
0
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
EU27 average
Poorest quintile
Unemployed people
Lower secondary education
Women and girls
People aged 65+
Total population
Richest quintile

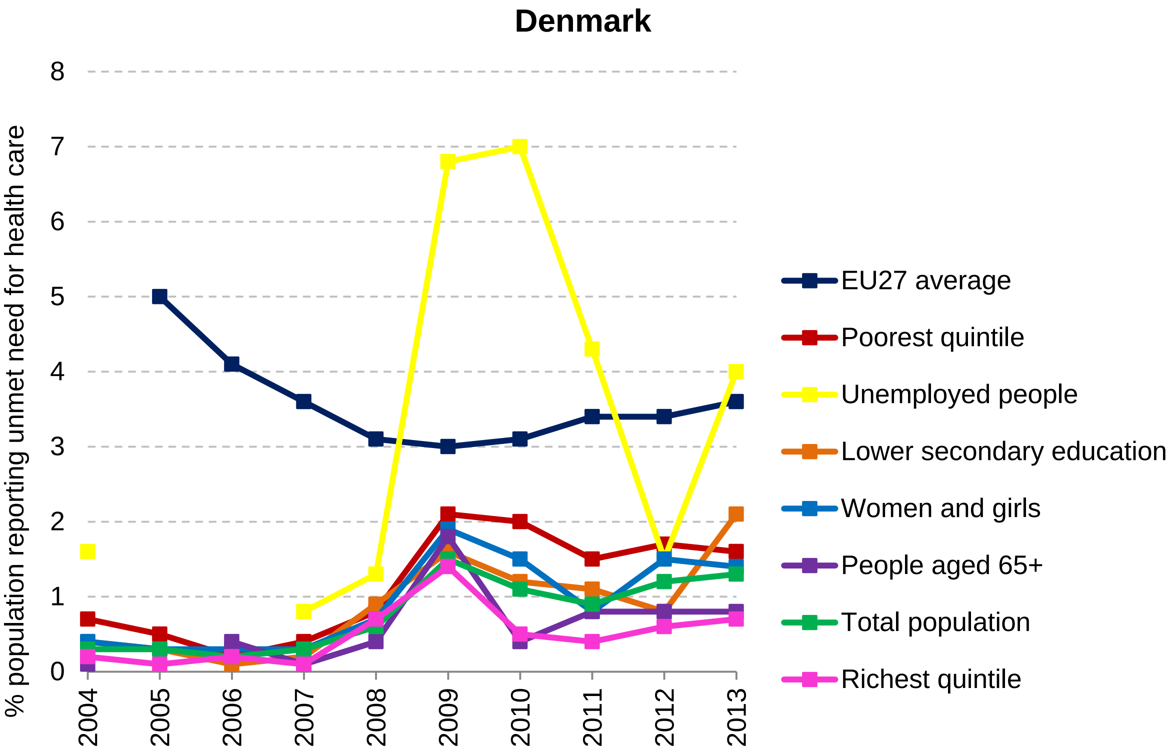

Czech Republic
% population reporting unmet need for health care
8
7
6
5
4
3
2
1
0
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
EU27 average
Poorest quintile
Unemployed people
Lower secondary education
Women and girls
People aged 65+
Total population
Richest quintile



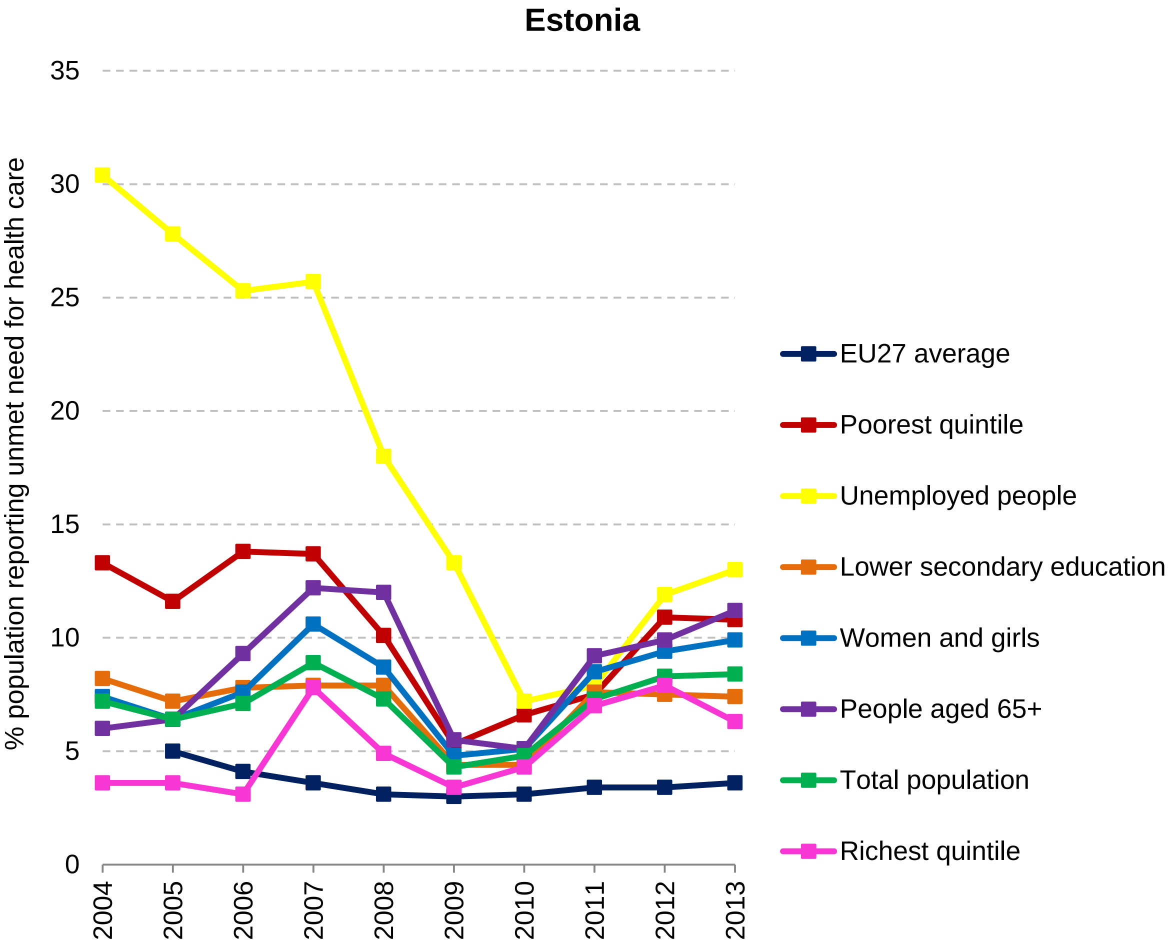
4562



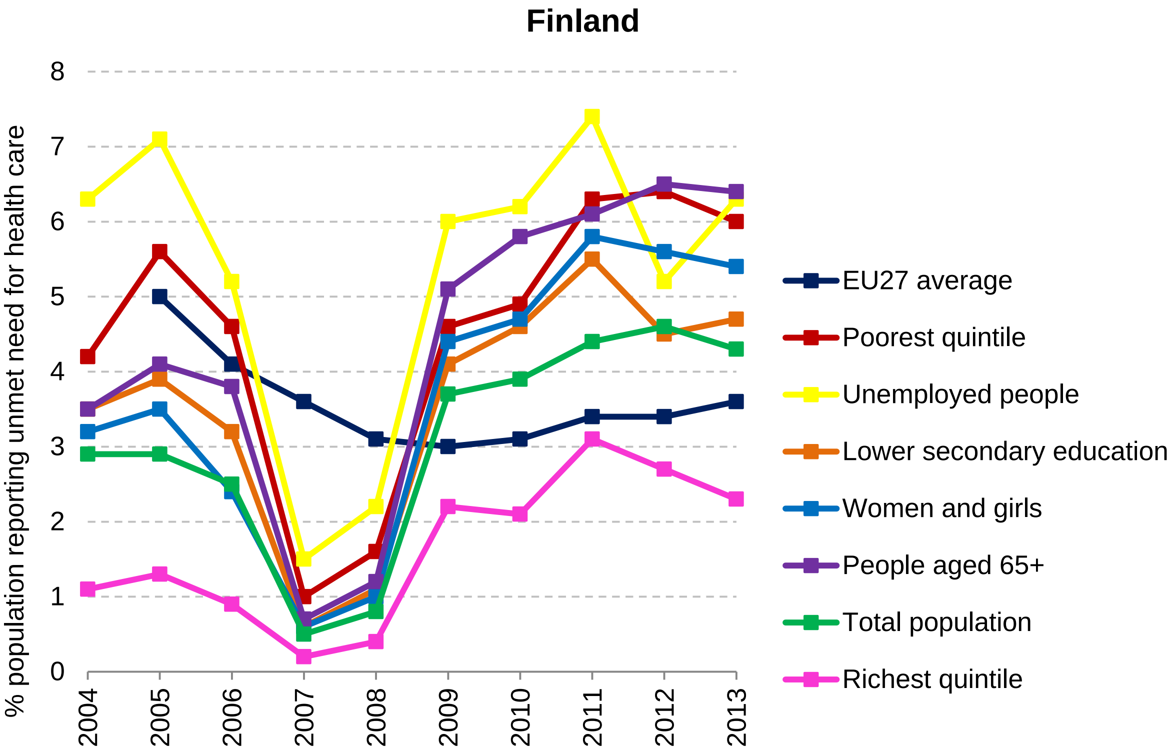
4563
4564



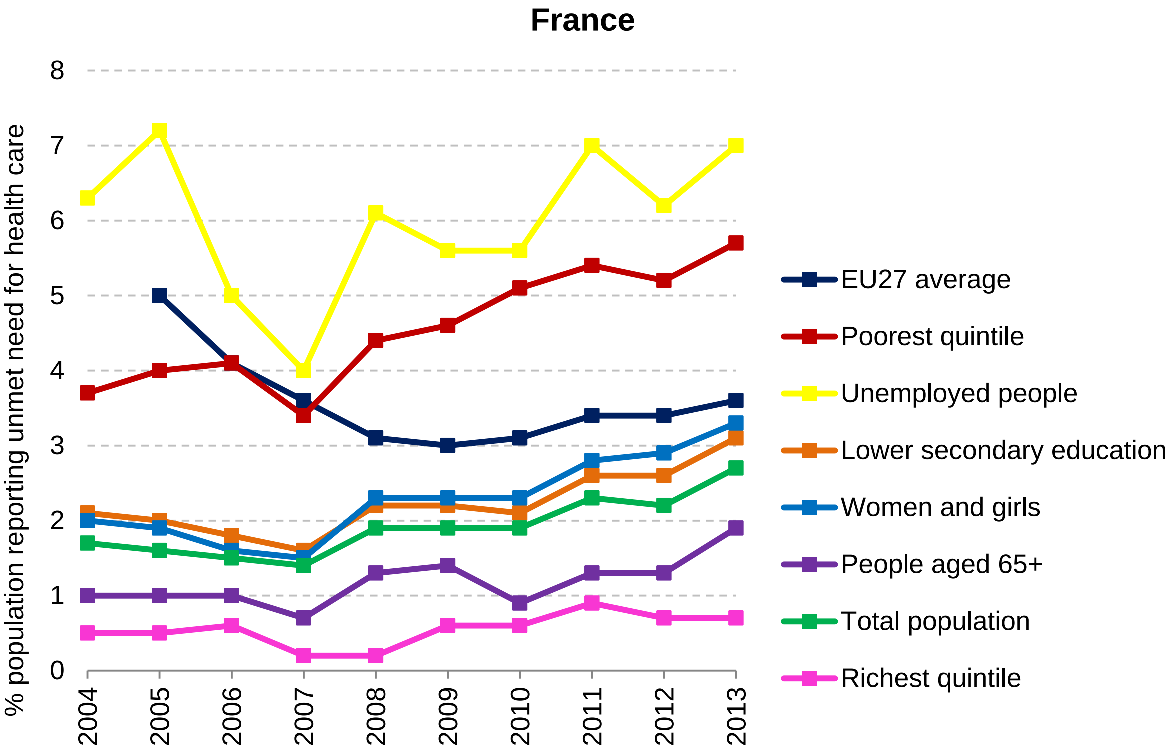
4565



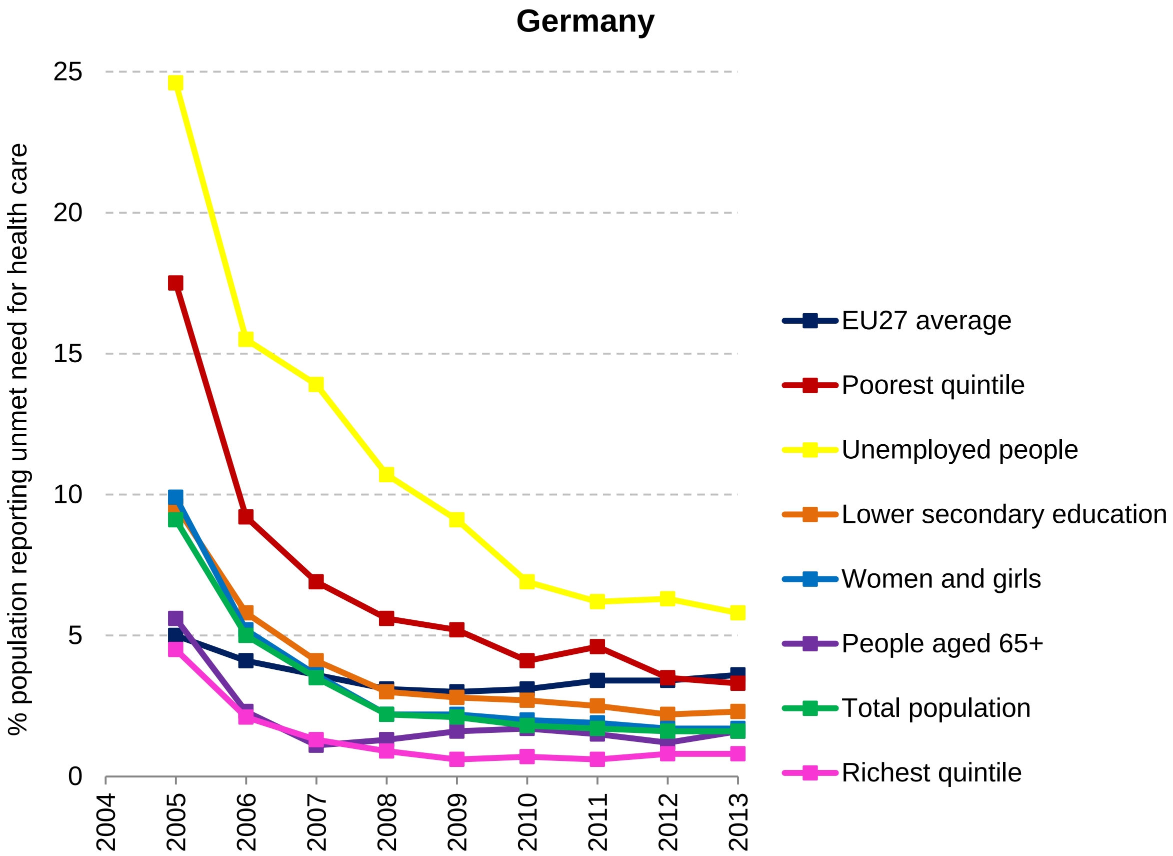
4566
4567

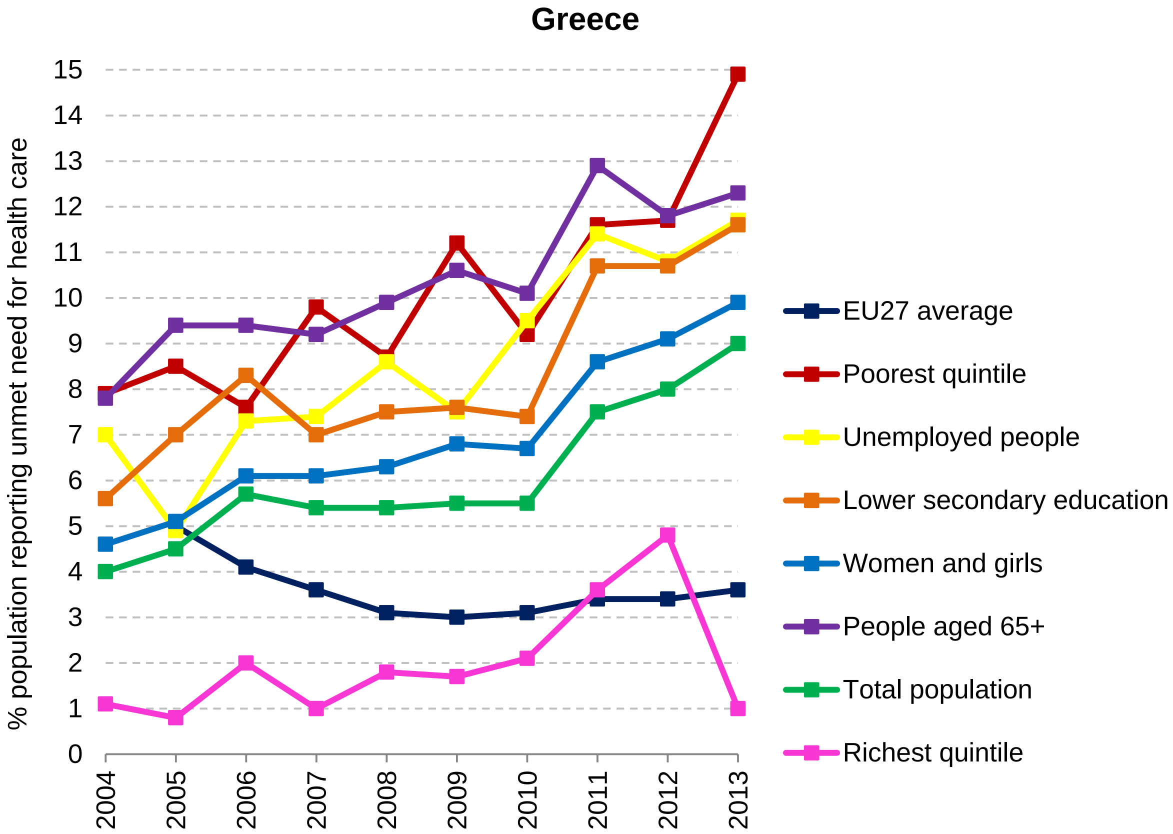


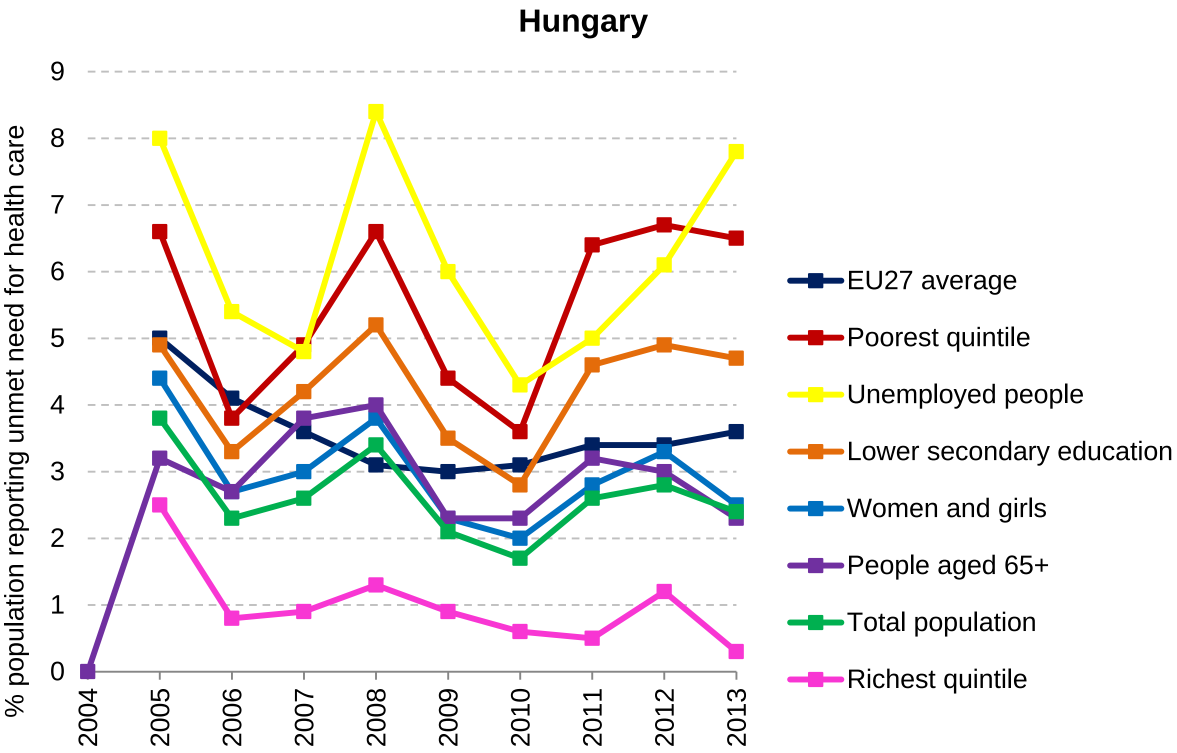
4568



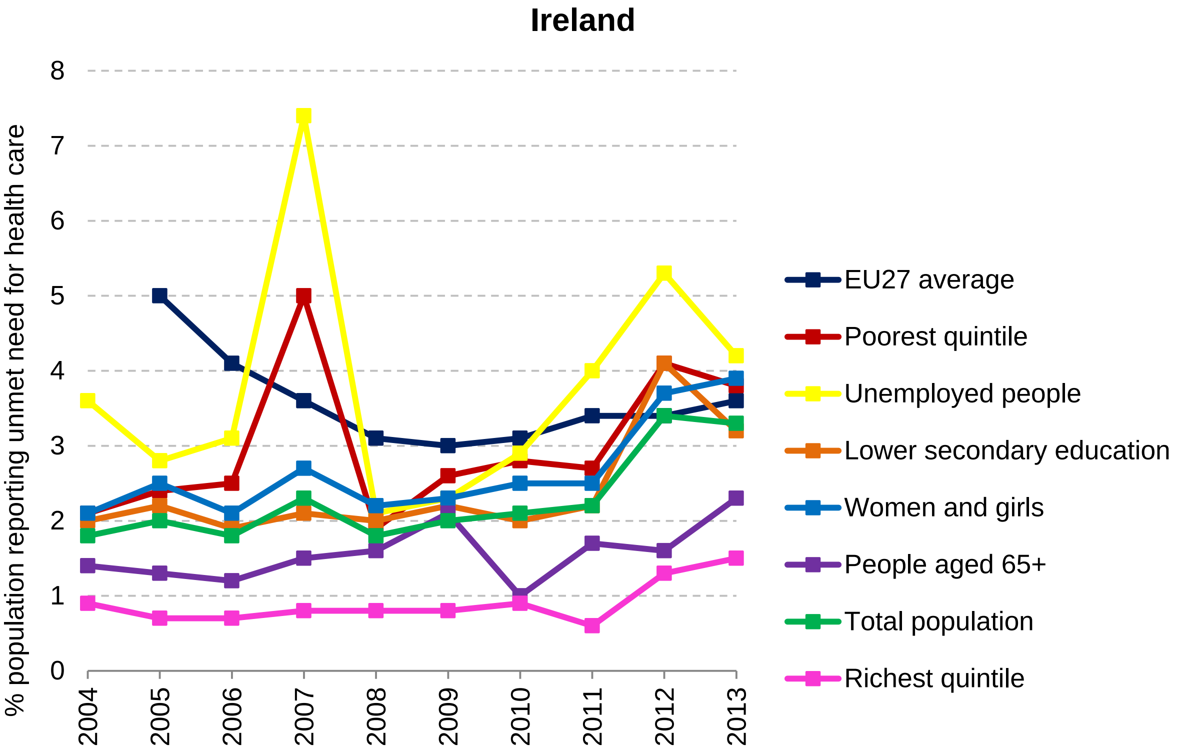
4569
4570


Germany
% population reporting unmet need for health care
25
20
15
10
5
0
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
EU27 average
Poorest quintile
Unemployed people
Lower secondary education
Women and girls
People aged 65+
Total population
Richest quintile

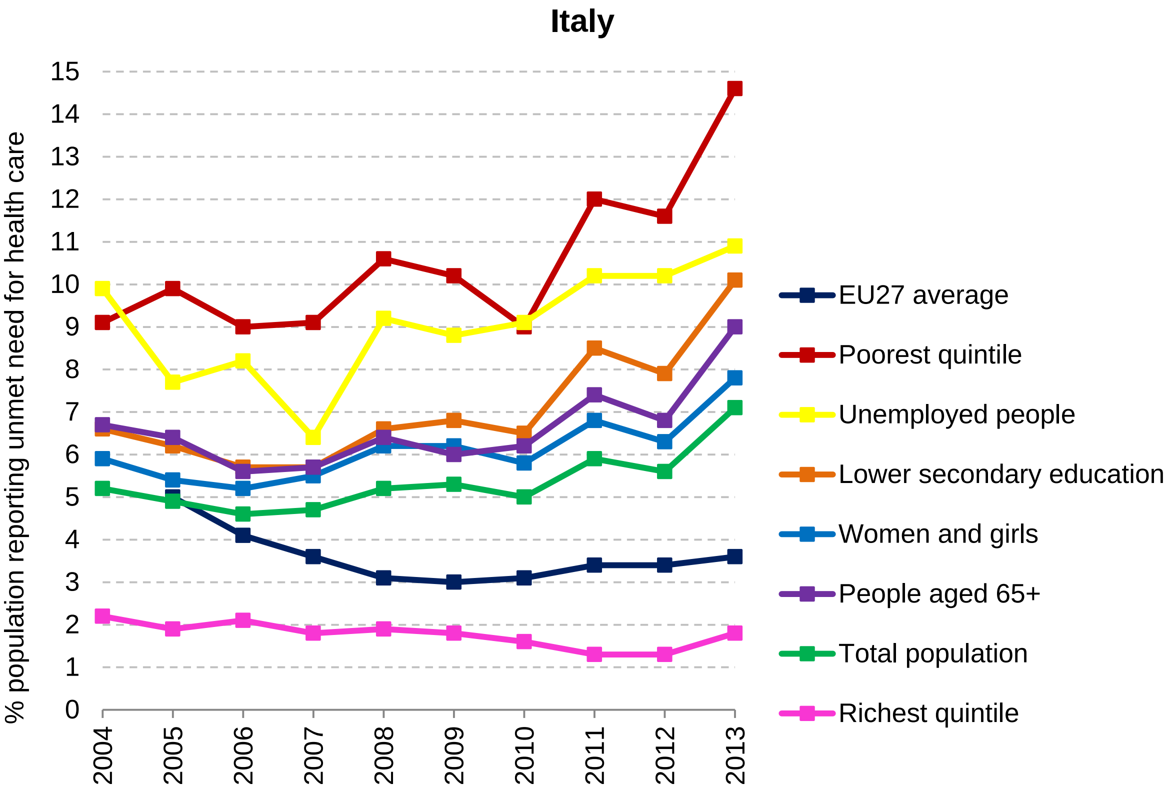

Greece
% population reporting unmet need for health care
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
0
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
EU27 average
Poorest quintile
Unemployed people
Lower secondary education
Women and girls
People aged 65+
Total population
Richest quintile



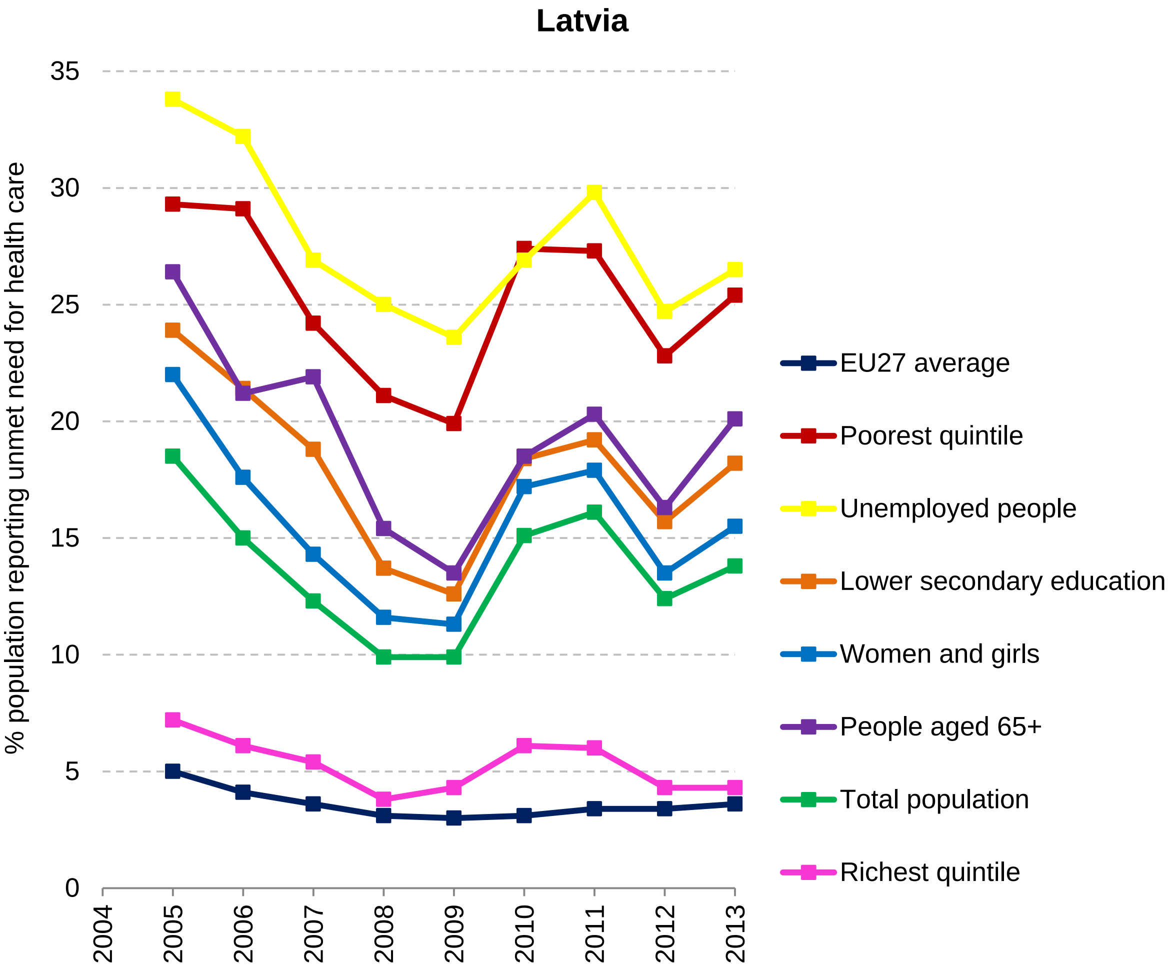
4574



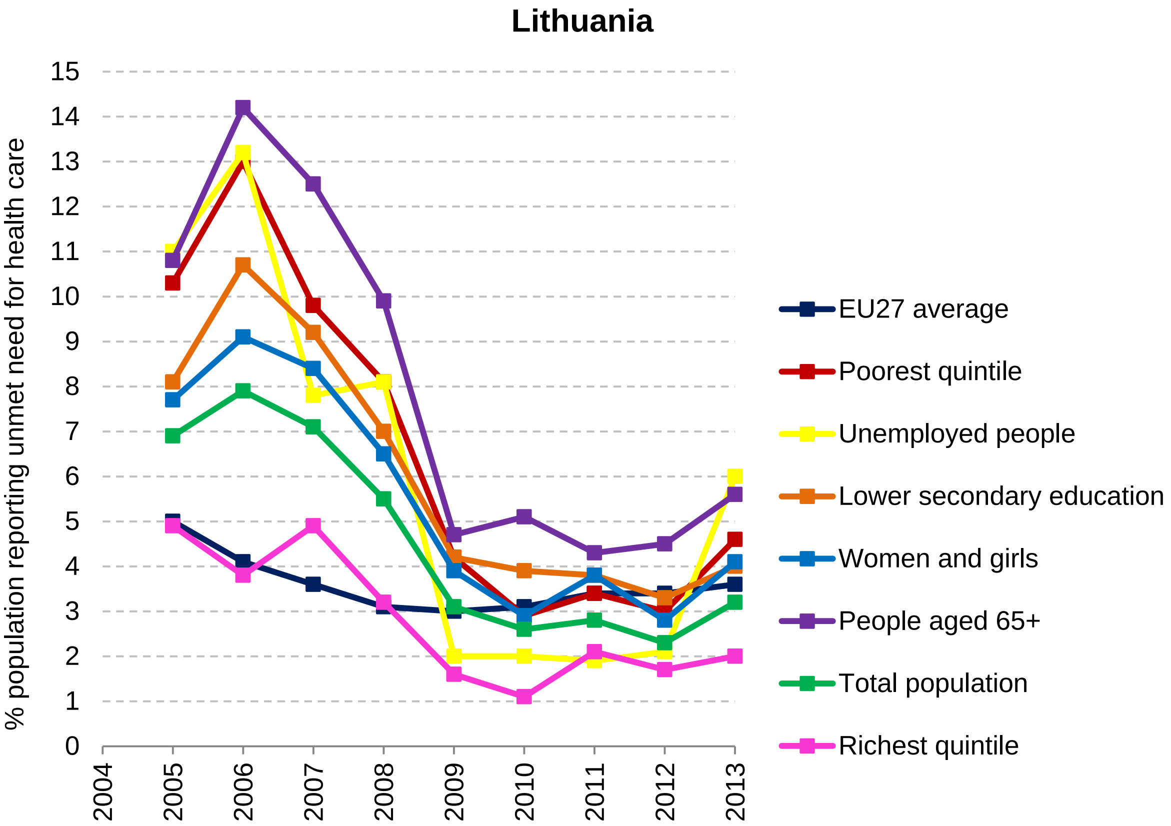
4575
4576


Italy
% population reporting unmet need for health care
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
0
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
EU27 average
Poorest quintile
Unemployed people
Lower secondary education
Women and girls
People aged 65+
Total population
Richest quintile

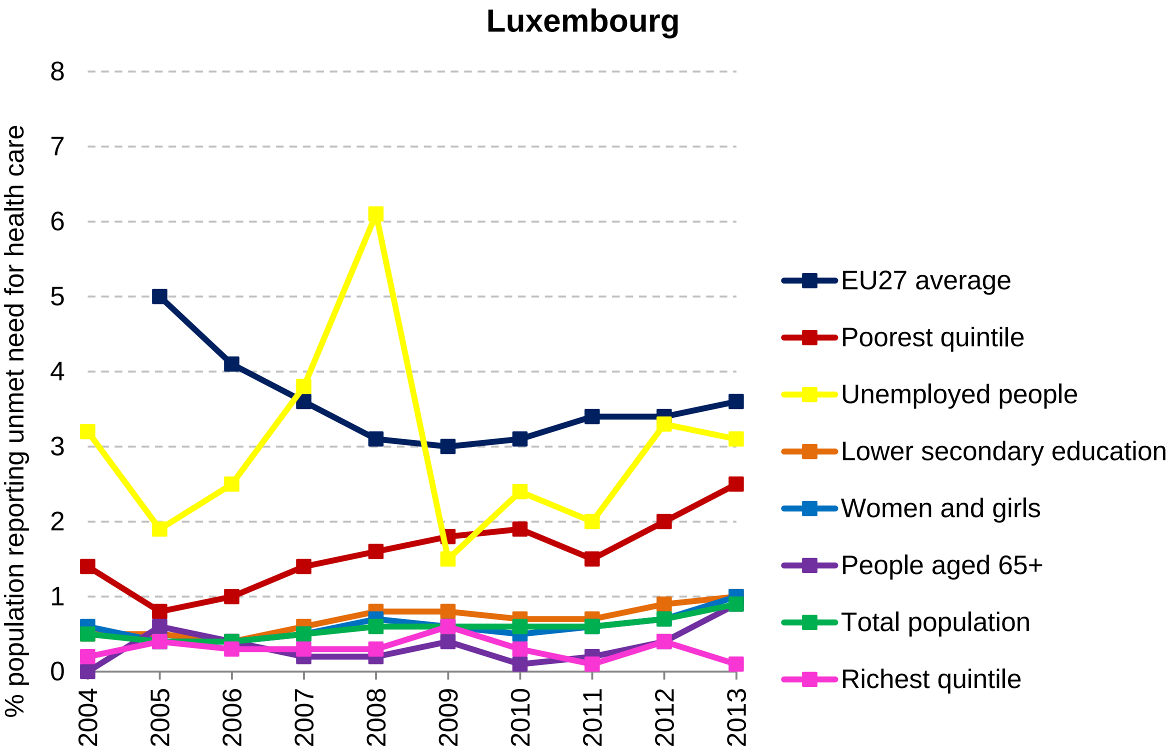
4577


Latvia
% population reporting unmet need for health care
35
30
25
20
15
10
5
0
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
EU27 average
Poorest quintile
Unemployed people
Lower secondary education
Women and girls
People aged 65+
Total population
Richest quintile

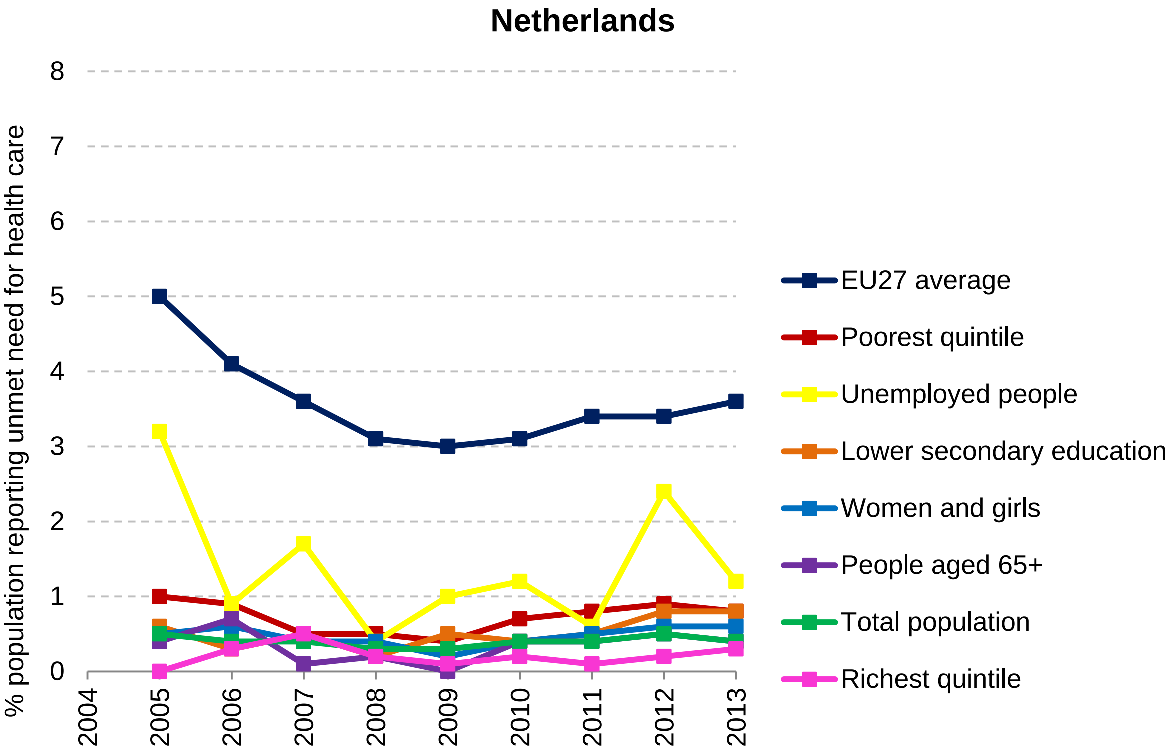
4578



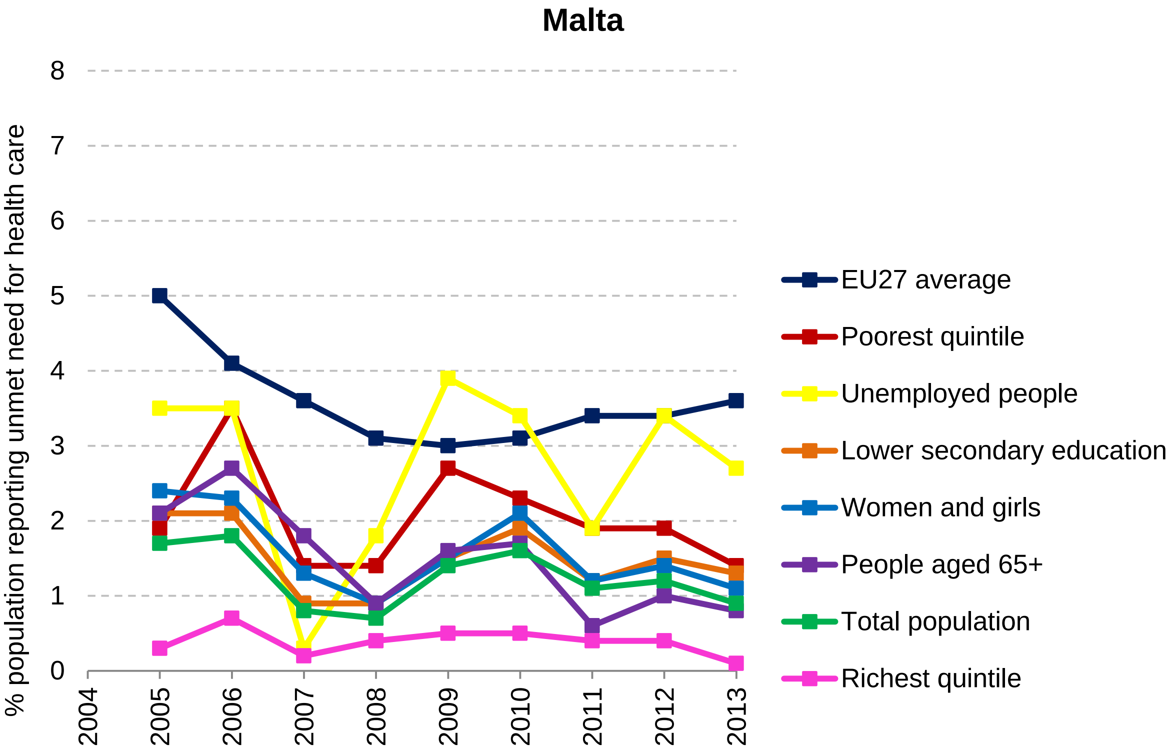
4579



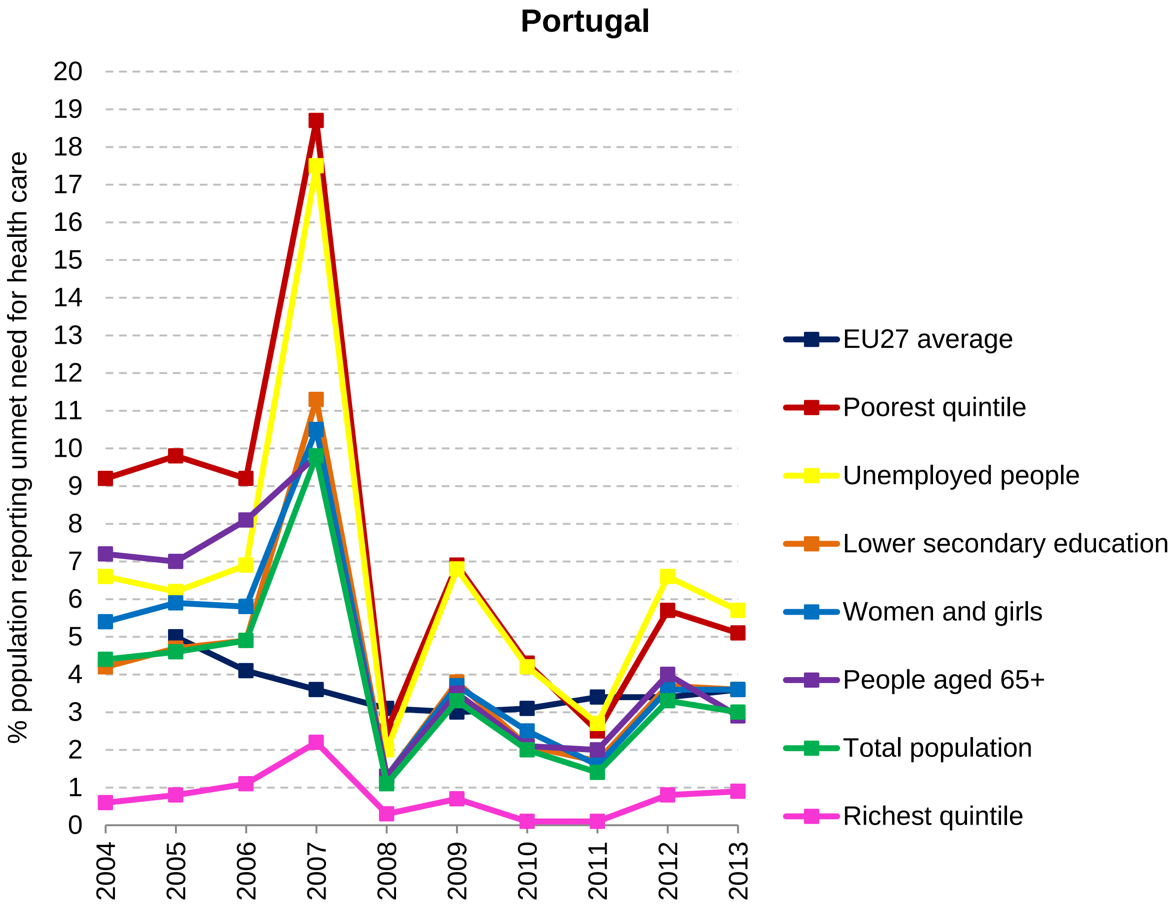
4580
4581



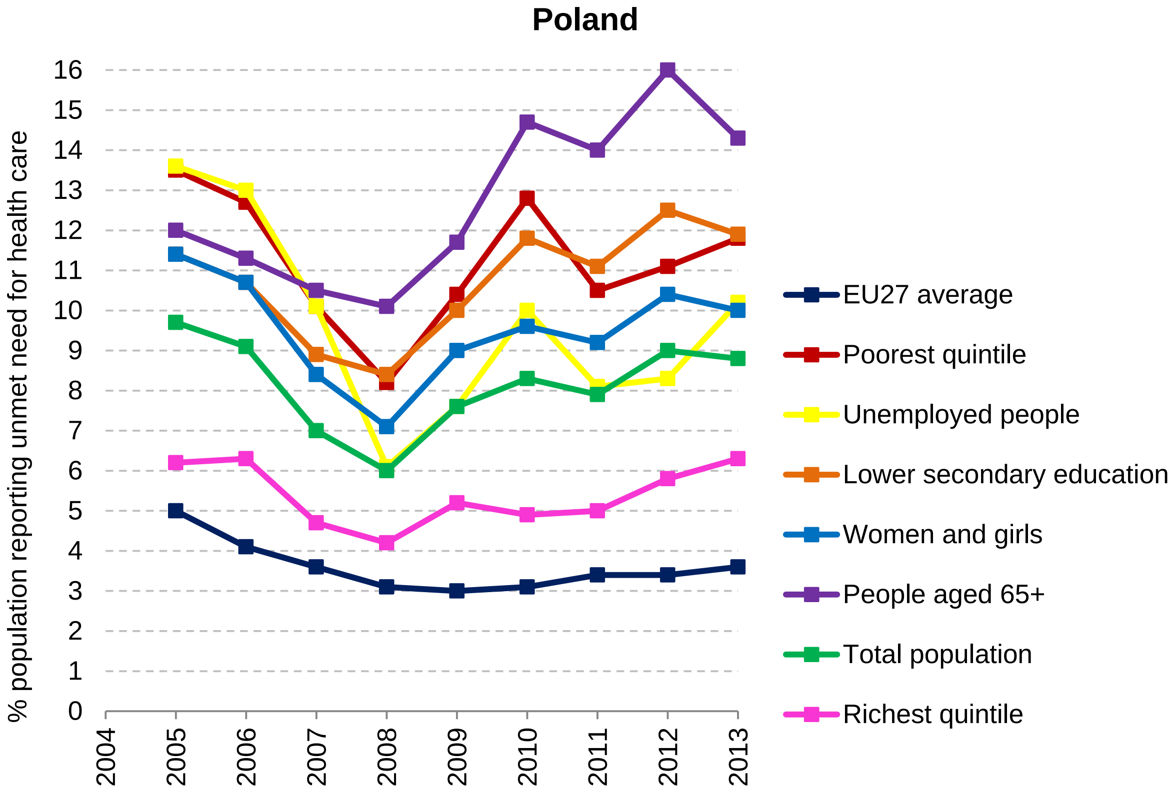
4582



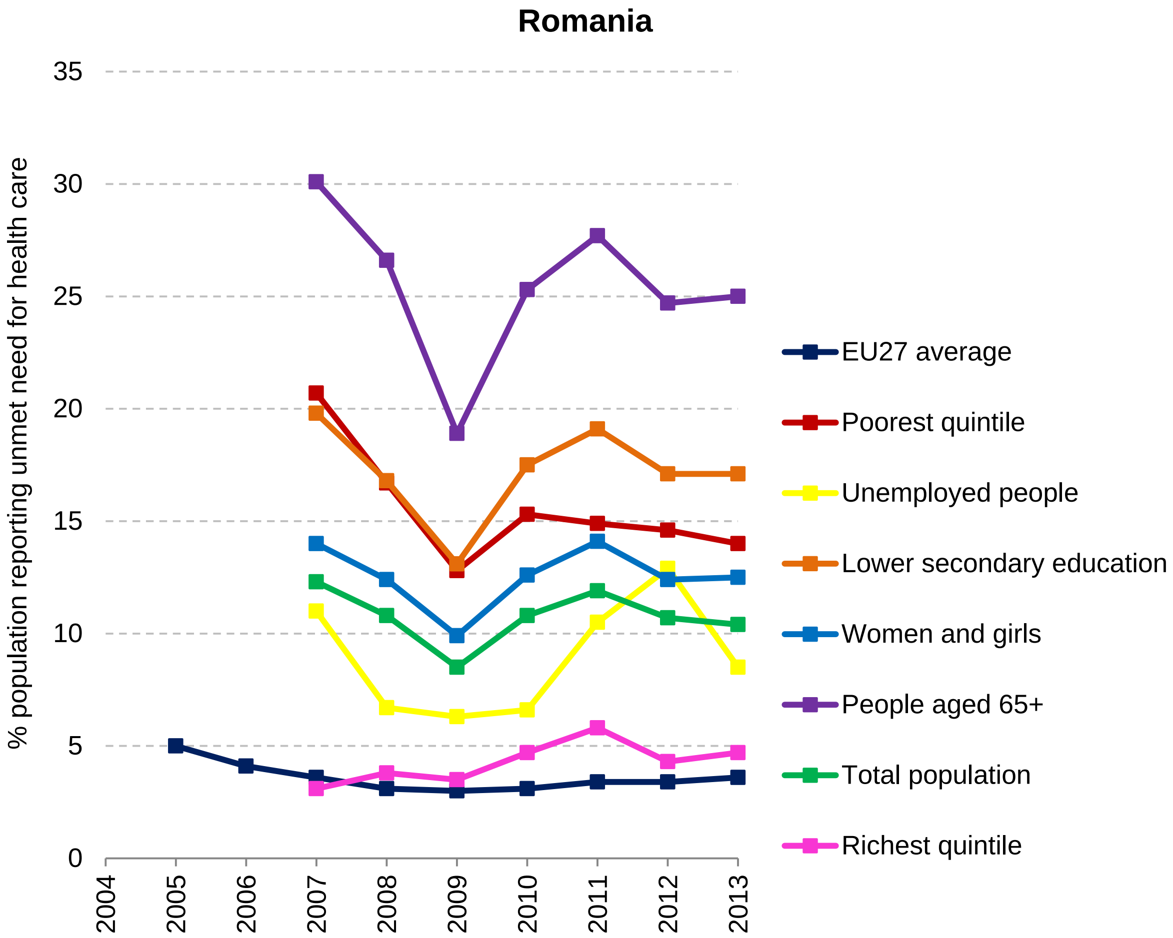
4583
4584



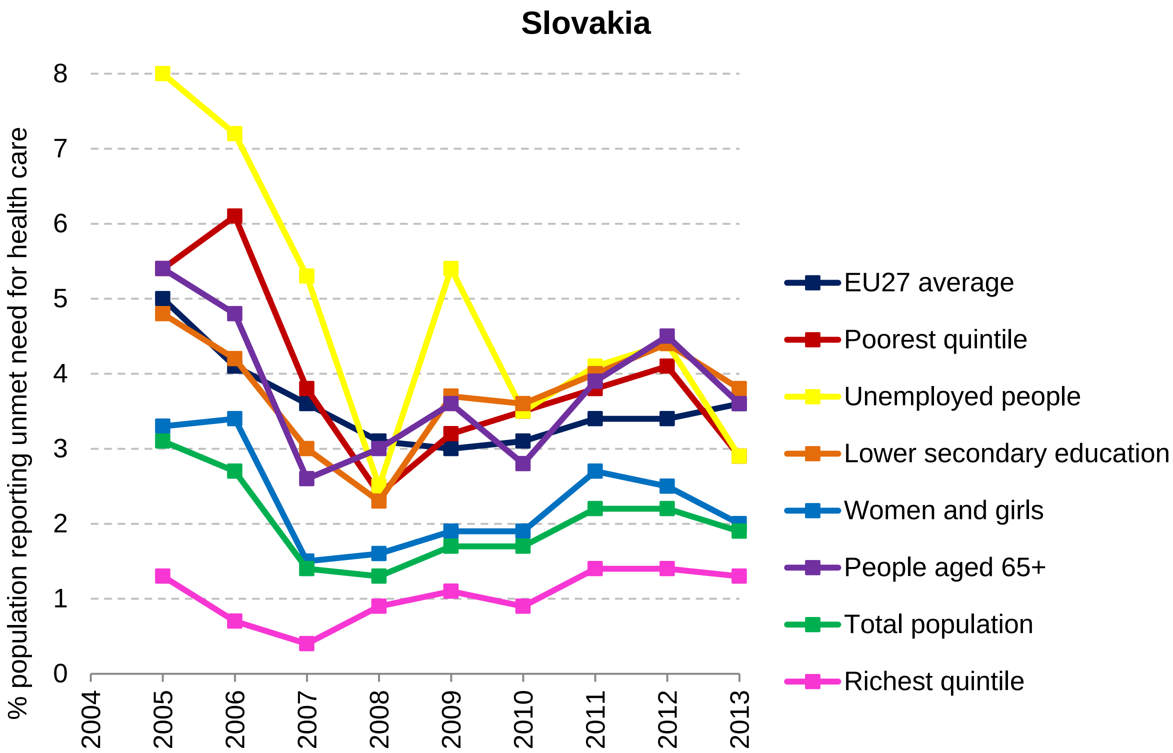
4585



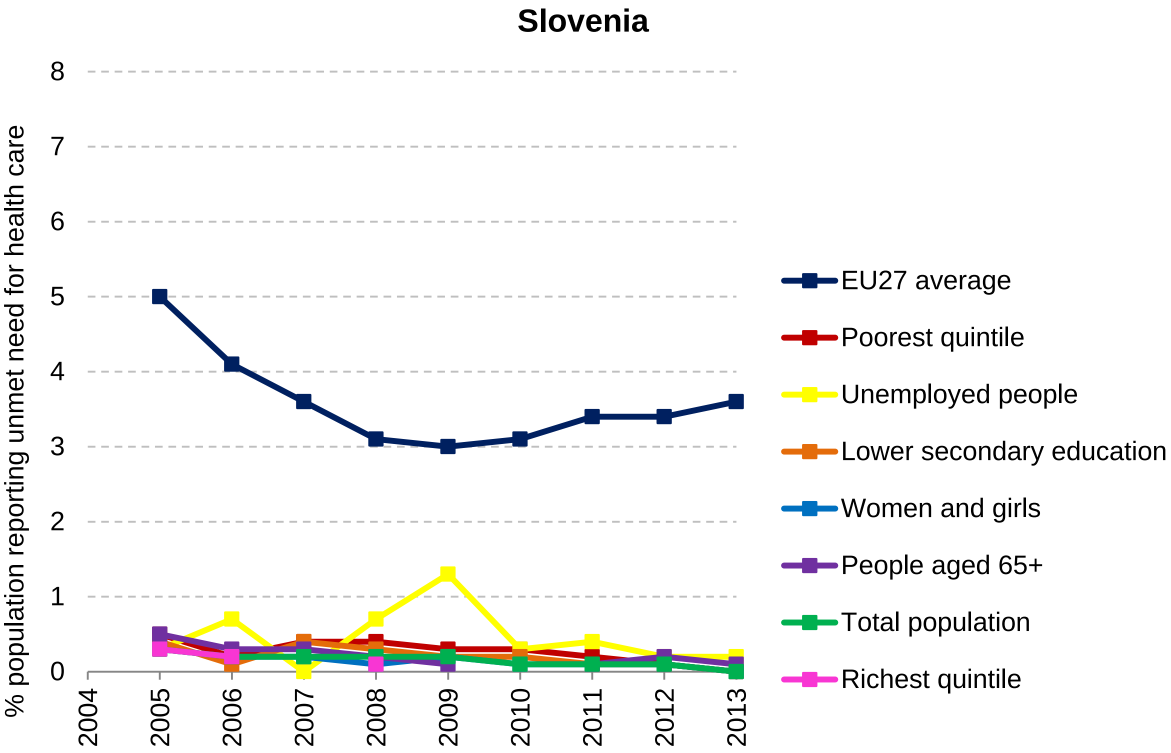
4586
4587



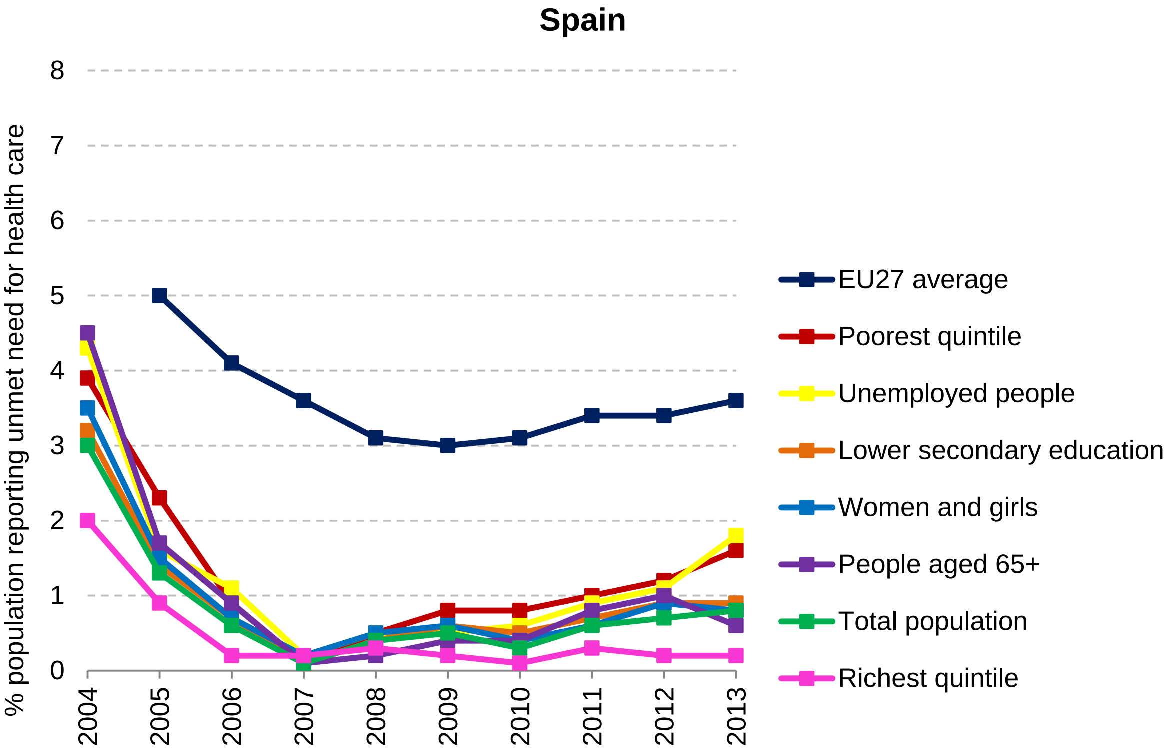
4588



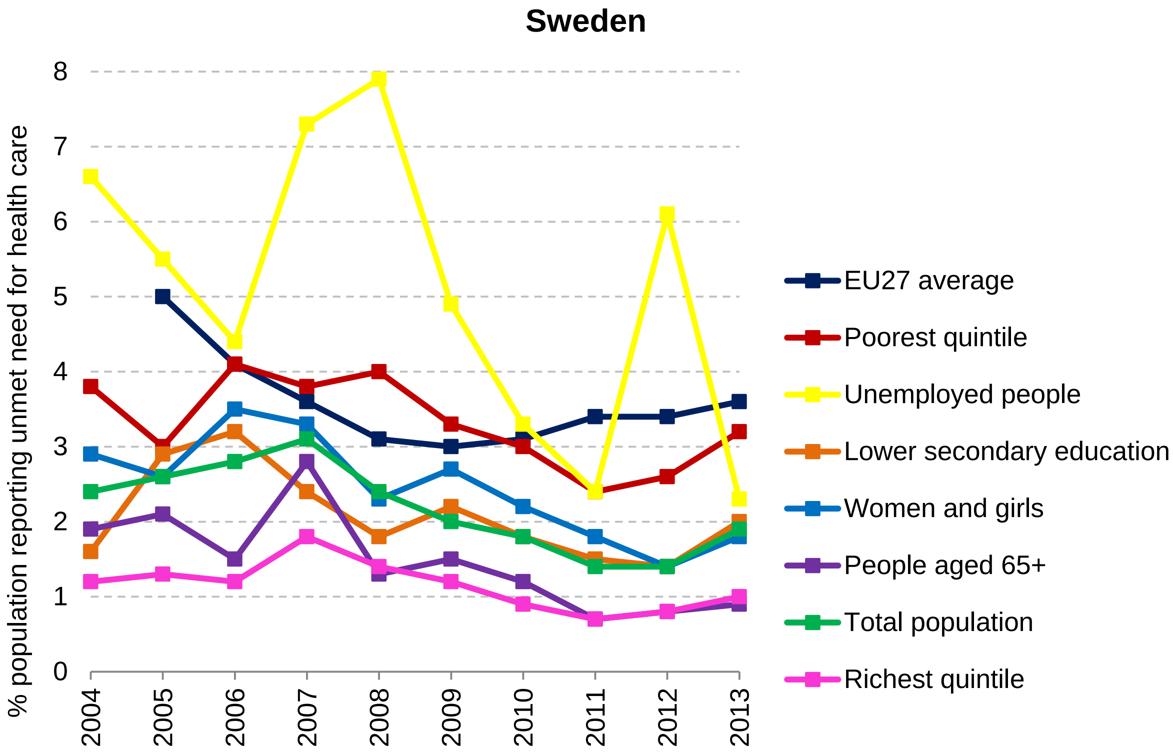
4589
4590



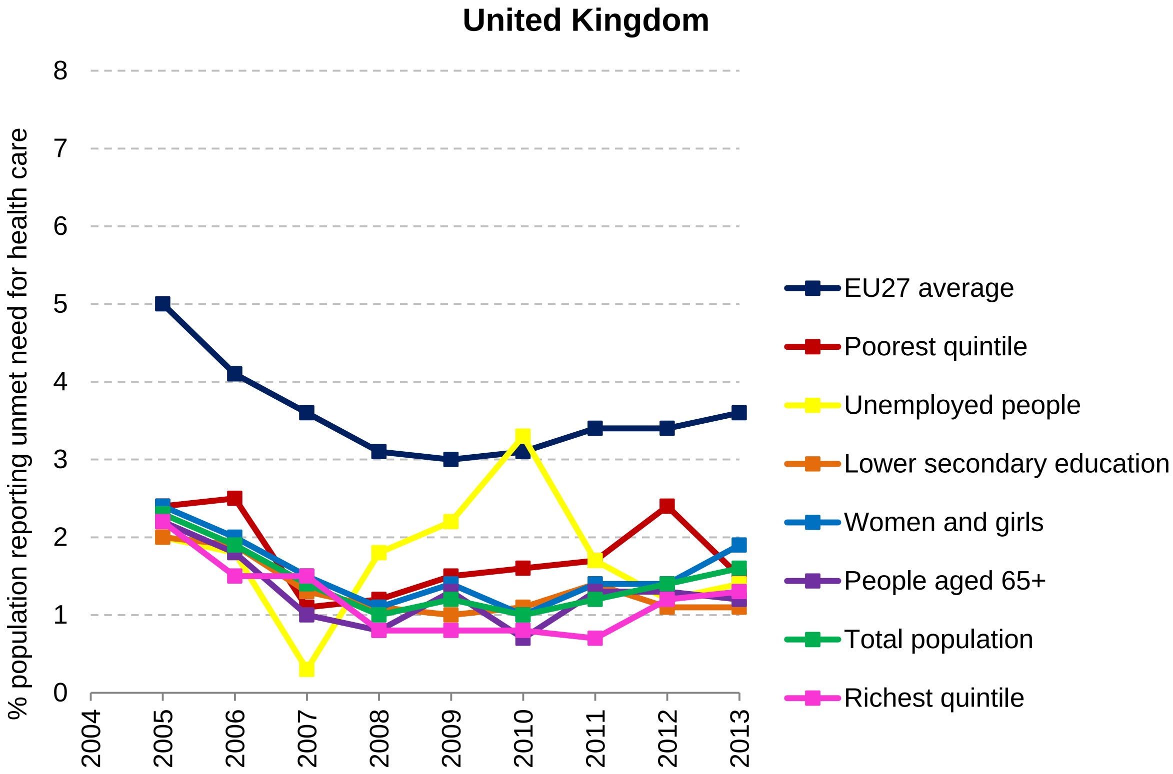
4591



4592
4593



4594



4595
4596
4597

Annex 3 Indicators for monitoring access in Europe

A = age; E = education; I = income; LS = labour market status; MS = Member States; NUTS = Nomenclature of Territorial Units for Statistics; SES = socio-economic status

Table A3.1 Financial resources are linked to health need

Indicator	**Data source**	**No of countries**	**Gender, age**	**SES**	**Sub-national**
Public spending on health as share of GDP	Eurostat	28 EU MS	-	-	-
Public spending on health as share of government spending	Eurostat	28 EU MS	-	-	-
OOP as share of total spending on health	Eurostat	28 EU MS	-	-	-
Public spending on health per capita PPP	Eurostat	28 EU MS	-	-	-

Table A3.2 Services are affordable for everyone

Indicator	**Source**	**No of countries**	**Gender, age**	**SES**	**Sub-national**
Consultation skipped due to cost	OECD	3 EU MS	-	-	-
Medical tests, treatment or follow-up skipped due to cost	OECD	4 EU MS	-	-	-
Prescribed medicines skipped due to cost	OECD	4 EU MS	-	-	-
OOP % of total current expenditure on inpatient care, day care, basic medical and diagnostics, home health care, prescribed medicines, over the counter medicines, other medical non-durables, glasses, orthopaedic appliances, hearing aids, medico-technical devices, other medical durables	OECD/Eurostat	27	-	-	-
Medical examination skipped due to cost	Eurostat	32	Gender, age	A, E, LS, I	-
Dental examination skipped due to cost	Eurostat	34	Gender, age	A, E, LS, I	-

Table A3.3 Services are relevant, appropriate and cost-effective

Indicator	Source	No of countries	Gender, age	SES	Sub-national
Immunisation diphtheria, tetanus and pertussis – share of children	OECD	24	-	-	-
Immunisation measles – share of children	WHO	36	-	-	-
Immunisation hepatitis B – share of children	WHO	28	-	-	-
Immunisation influenza – share of aged 65+	Eurostat	31	-	-	-
Breast cancer screening – share of 50-69	Eurostat	17	-	E	-
Cervical cancer screening – share of 20-69	Eurostat	17	-	E	-

Table A3.4 Well-equipped facilities are within easy reach

Indicator (density per population)	Source	No of countries	Gender, age	SES	Sub-national
Hospitals	OECD	21	-	-	-
Hospitals publicly owned / not-for-profit private / for-profit private	OECD	15 / 14 / 16	-	-	-
General hospitals	OECD	22	-	-	-
Total hospital beds / curative (acute care) / long-term care / psychiatric / other	OECD	24 / 24 / 18 / 24 / 22	-	-	-
Beds in publicly owned hospitals / not-for-profit private / for-profit private	OECD	18 / 15 / 15	-	-	-
Hospital beds	Eurostat	20	-	-	NUTS

Table A3.5 There are enough health workers, with the right skill mix, in the right place

Indicator (worker density per population)	Source	No of countries	Gender, age	SES	Sub-national
Total number of physicians	OECD	22	-	-	-
Generalist practitioners / specialist practitioners	OECD	18 / 24	-	-	-
Obstetricians and gynaecologists / psychiatrists / medical specialists / surgical specialists	OECD	24	-	-	-
Other specialists	OECD	19	-	-	-
Midwives / nurses / caring personnel	OECD	17 / 18 / 14	-	-	-
Dentists / pharmacists / physiotherapists	OECD	18 / 21 / 23	-	-	-
Hospital employment	OECD	21	-	-	-
Medical graduates	OECD	23	-	-	-

Dentist / pharmacist / midwife / nursing graduates	OECD	22	-	-	-
Doctors, nurses and midwives, dentists, pharmacists, physiotherapists	Eurostat	20	-	-	NUTS

Table A3.6 Quality medicines and medical devices are readily available

Indicator (density per population)	Source	No of countries	Gender, age	SES	Sub-national
CT scanners total / in hospitals / in ambulatory settings	OECD	20 / 19 / 17	-	-	-
MRI units total / in hospitals / in ambulatory settings	OECD	19 / 20 / 17	-	-	-
PET scanners total / in hospitals / in ambulatory settings	OECD	20 / 20 / 16	-	-	-
Gamma cameras total / in hospitals / in ambulatory settings	OECD	20 / 19 / 16	-	-	-
Digital subtractions angiography units total / in hospitals / in ambulatory settings	OECD	18 / 18 / 15	-	-	-
Mammographs total / in hospitals / in ambulatory settings	OECD	18 / 15 / 12	-	-	-
Lithotriptors total / in hospitals / in ambulatory settings	OECD	15 / 16 / 12	-	-	-

Table A3.7 People can use services when they need them

Indicator	Source	No of countries	Gender, age	SES	Sub-national
Waiting time more than 4 weeks for an appointment with a specialist	OECD	5	Age standardised	-	-
Medical exam skipped due to travelling distance	Eurostat	33	Gender, age	I, LS, E	-
Medical exam skipped due to lack of time	Eurostat	34	Gender, age	I, LS, E	-
No unmet needs to declare for medical examinations	Eurostat	34	Gender, age	I, LS, E	-
Medical exam skipped due to not knowing any good doctor	Eurostat	32	Gender, age	I, LS, E	-
Medical exam skipped due to waiting time (waiting list)	Eurostat	34	Gender, age	I, LS, E	-
Medical exam skipped due to fear of doctors/treatment	Eurostat	34	Gender, age	I, LS, E	-
Medical exam skipped due to decision to wait to see if problem got better	Eurostat	34	Gender, age	I, LS, E	-
Medical exam skipped due to other reasons	Eurostat	34	Gender, age	I, LS, E	-
Dental exam skipped due to travelling distance	Eurostat	34	Gender, age	I, LS, E	-
Dental exam skipped due to lack of time	Eurostat	34	Gender, age	I, LS, E	-
No unmet needs to declare for dental examinations	Eurostat	34	Gender, age	I, LS, E	-
Dental exam skipped due to not knowing any good doctor	Eurostat	32	Gender, age	I, LS, E	-
Dental exam skipped due to waiting time	Eurostat	34	Gender, age	I, LS, E	-
Dental exam skipped due to fear of doctors/treatment	Eurostat	34	Gender. age	I, LS, E	-
Dental exam skipped due to decision to wait to see if problem got better	Eurostat	34	Gender, age	I, LS, E	-
Dental exam skipped due to other reasons	Eurostat	34	Gender, age	I, LS, E	-

Table A3.8 Services are acceptable to everyone

Indicator	Source	No of countries	Gender, age	SES	Sub-national
Patients reporting spending enough time with any / regular doctor during consultation	OECD	2 /7	Gender, age standardised	-	-
Patients reporting easy-to-understand explanations by any doctor / regular doctor	OECD	2 / 7	Gender, age standardised	-	-
Patients reporting having the opportunity to ask questions to any doctor / regular doctor	OECD	1 / 7	Gender, age standardised	-	-
Patients reporting being involved in decisions about care by any doctor / regular doctor	OECD	2 / 7	Gender, age standardised	-	-

LIST OF ABBREVIATIONS

ANCIEN project	Assessing Needs of Care in European Nations
BIG register	Registration of healthcare professionals (The Netherlands)
CESCR	Committee on Economic, Social and Cultural Rights
CT scan	Computerised Tomography scan
DNDi	Drugs for Neglected Diseases initiative
DOM	Départements d'Outre-Mer (overseas territories) (France)
DTP	Diphtheria, Tetanus and Pertussis
EASL	European Association for the Study of the Liver
EC	European Commission
ECHI	European Community Health Indicators
ECHO project	European Collaboration for Health Optimisation
EFPIA	European Federation of Pharmaceutical Industries and Associations
EHIS	European Health Interview Survey
EMA	European Medicines Agency
EP	European Parliament
ERN	European Reference Network
ERRC	European Roma Rights Centre
EU	European Union
EUnetHTA	European network for Health Technology Assessment
EU-SILC	European Union Survey on Income and Living Conditions
EXPH	Expert Panel on effective ways of investing in Health
GDP	Gross Domestic Product
GP	General Practitioner
HBS	Household Budget Survey
HCHS	Hospital and Community Health Services (UK)
HCV	Hepatitis C Virus
HEMS	Helicopter Emergency Medical Service (Spain)

HiT	European Observatory on Health Systems and Policies reports on Health Systems in Transition
HLS-EU	European Health Literacy Survey
HTA	Health Technology Assessment
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IMF	International Monetary Fund
KNMG	Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst - Royal Dutch Society for the Advancement of Medicine (The Netherlands)
MINECO	Ministry of Economy and Competitiveness (Spain)
MRI	Magnetic Resonance Imaging
MS	Member States
NGO	Non-Governmental Organisation
NHS	National Health Service (England)
OECD	Organisation for Economic Co-operation and Development
OJEU	Official Journal of the European Union
OOP	Out-Of-Pocket payment
PET scan	Positron Emission Tomography
PHAMEU Project	Primary Health Care Activity Monitor for Europe
PICUM	Platform for International Cooperation on Undocumented Migrants
QUALICOPC project	Quality and Costs of Primary Care in Europe
R&D	Research & Development
SHA	Strategic Health Authority (England)
SHARE	Survey of Health, Ageing and Retirement in Europe
SSB	Social Statistical Database (The Netherlands)
UK	United Kingdom
UNESCO	United Nations Educational, Scientific and Cultural Organisation
VHI	Voluntary Health Insurance

WHA	World Health Assembly
WHO	World Health Organisation

[This page intentionally left blank]

REFERENCES

Alonso, J., Codony, M., Kovess, V., Matthias, C., Angermeyer, M. C. et al. (2007) Population level of unmet need for mental healthcare in Europe. British Journal of Psychiatry, 190, 299-306.

Arora V, Karanikolos M, Clair A, Reeves A, Stuckler D, McKee M. Data Resource Profile: The European Union Statistics on Income and Living Conditions (EU-SILC). International journal of epidemiology. 2015; doi:10.1093/ije/dyv069.

Autorità Garante della Concorrenza e del Mercato. Pharmaceuticals and antitrust: the Italian Competition Authority fines Roche and Novartis over Eur 180 million for cartelizing the sales of two major ophthalmic drugs, Avastin and Lucentis. Rome: Autorità Garante della Concorrenza e del Mercato; 2014.

Babinska, I., Geckova, A. M., Jarcuska, P., Pella, D., Marekova, M., Stefkova, G., et al. (2014). Does the Population Living in Roma Settlements Differ in Physical Activity, Smoking and Alcohol Consumption from the Majority Population in Slovakia? Central European Journal of Public Health, 22, S22-S27.

Bahtsevani, C., G. Uden and A. Willman (2004). "Outcomes of evidence-based clinical practice guidelines: a systematic review." Int J Technol Assess Health Care 20(4): 427-433.

Bandura, A. (1977)

Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet. 2012 Jul 7;380(9836):37-43.

Barry MM, Clarke AM, Jenkins R, Patel V. (2013a) The effectiveness of mental health promotion interventions for young people in low and middle income countries: A systematic review. BMC Public Health, 13, 835.

Barry, M.M., D'Eath, M,, Sixsmith, J. (2013b). Interventions for improving population health literacy: insights from a rapid review of the evidence. Journal of Health Communication: International Perspectives, 18 :1507-1522.

Bauer GR. Soc Sci Med. 2014 Jun;110:10-7. Incorporating intersectionality theory into population health research methodology: challenges and the potential to advance health equity.

Bensing J: Doctor-patient communication and the quality of care. Soc Sci Med 1991, 32:1301-1310.

Berkman, N., Sheridan, S., Donahue, K., Halpern, D., Crotty, K. (2011) Low health literacy and health outcomes: an updated systematic review. Ann Intern Med, 155(2), 97-107.

Bernheim SM, Ross JS, Krumholz HM, Bradley EH: Influence of patients’socioeconomic status on clinical management decisions: a qualitative study. Ann Fam Med 2008, 6(1):53-59.

Björnberg A (2015), Euro Health Consumer Index 2014 Report, Stockholm: Health Consumer Powerhouse.

Bloemen S, Hammerstein D (2012). Time for the EU to lead on innovation. EU policy opportunities in biomedical innovation and the promotion of public knowledge goods. Health Action International, Trans Atlantic Consumer Dialogue. Netherlands, April 2012.

Bostock, S., Steptoe, A. (2012) Association between low functional health literacy and mortality in older adults: longitudinal cohort study. Br Med J, 344, e1602.

Bradshaw J A taxonomy of social need in McLachlan G (ed.) Problems and progress in medical care. Seventh series NPHT/Open University Press. 1972.

Britz and McKee 2015 Charging migrants for health care could compromise public health and increase costs for the NHS. J Public Health. doi:10.1093/pubmed/fdv043

Brown, S., Kim, M., Mitchell, C. and Inskip, H. (2010). Twenty-five year mortality of a community cohort with schizophrenia. British Journal of Psychiatry, 196: 116-121. doi:10.1192/bjp.bp.109.067512

Buchan J, Sochalski J. The migration of nurses: trends and policies. Bull World Health Organ. 2004 Aug;82(8):587-94.

Buck D and A Dixon (2013) Dixon and Buck (2013) Improving the allocation of health resources in England: How to decide who gets what, London: The King’s Fund

Bussing R, Zima BT, Gary FA, Wilson Garvan C. Barriers to Detection, Help-Seeking, and Service Use for Children with ADHD Symptoms. JBHS&R 2003;30 (2):176-189.

Campion, J., Bhui, K., Bhugra, D. (2012). European Psychiatric Association (EPA) guidance on prevention of mental disorder. European Psychiatry 27: 68-80.

Canavan, R., Barry, M. M., Matanov, A., Barros, H., Gabor, E., Greacen, T., 2012

Carr, S., Lhussier, M., Forster, N., Goodall, D., Geddes, L., Pennington, M., Bancroft, A., Adams, J. and Michie S. (2014). Outreach programmes for health improvement of Traveller Communities: a synthesis of evidence. Public Health Research Vol 2 (3), doi:10.3310/phr02030

CESCR (2000) General Comment Nº 14. The right to the highest attainable standard of health. E /C.12/2000/4

CESCR (2001). Human rights and intellectual property. Statement by the Committee on Economic, Social and Cultural Rights. 29 Nov 2001. E/C 12/2001/15

CESCR 2005

Chamberlain and O'Neill Understanding social class differences in health: a qualitative analysis of smokers’ health beliefs Psychology and Health, 1998, Vol. 13, pp. 1105-1119.

Chan, M. Opening remarks on creating synergies between intellectual property rights and public health, delivered at a joint technical symposium by WHO, WIPO and WTO on Access to Medicines: lessons from procurement practices. Geneva. Switzerland, 16, July, 2010. http://www.who.int/dg/speeches/2010/access_medicines_20100716/en/

Chauvin, P., Parizot, I., Simonnot, N. (2009). Access to Healthcare for cities. BMC Health Services Research, 12: 222.

Chauvin P, Simonnot N, Vanbiervliet F, Vicart M, Vuillermoz C. (2015). Paris: Doctors of the World – Médecins du Monde International Network, May 2015. Accessible at: https://mdmeuroblog.wordpress.com/resources/publications/new-report-2015/

Cohen D. Attacks on publicly funded trials: what happens when industry does not want to know the answer. BMJ. 2015;350:h1701.

Cohen D. Why have UK doctors been deterred from prescribing Avastin? BMJ. 2015;350:h1654.
Council Conclusions 2010 May 10

Council 2014

Council of Europe Resolution 1509 (2006) on Human Rights of Irregular Migrants – Article 13.2.

EU (2010) Council of the European Union. Council conclusions on the EU role in Global Health, 10 may 2010.

Council of Europe (2014). European Social Charter. European Committee of Social Rights. Conclusions XX-2 (2013) (SPAIN). January 2014.

Cromwell DA. Waiting time information services: an evaluation of how well clearance time statistics can forecast a patient's wait. Soc Sci Med. 2004 Nov;59(9):1937-48.

Cross, T., Bazron, B., Dennis, K. and Isaacs, M. (1989) Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Volume 1, Washington, DC: Georgetown University.

Cuadra, C.B. (2011) Right of access to health care for undocumented migrants in EU: a comparative study of national policies. European Journal of Public Health, 22(20, 267-271.

Dahlgren, G. and Whitehead, M. (1991) Policies and strategies to promote social equity in health, Stockholm: Institute of Futures Studies.

Dale J, Lang H, Roberts JA, Green J, Glucksman E. Cost effectiveness of treating primary care patients in accident and emergency: a comparison between general practitioners, senior house officers, and registrars. Bmj. 1996 May 25;312(7042):1340-4.

Dani KA, Stobo DB, Capell HA, Madhok R. Audit of literacy of medical patients in north Glasgow. Scottish medical journal. 2007 May;52(2):21-4.

Dauvrin, M., Lorant, V., Sandhu, S. et al. (2012). Health care for irregular migrants: pragmatism across Europe: a qualitative study. BMC Research Notes 5: 99.

De Boer 2015

De Hert, Correll, C.U., Bobes, J., Cetkovich-Baskmas, M., Cohen, D., Asai, I., et al., (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World Psychiatry, 10 (1): 52-77.

De Maeseneer JM, Mieke L van Driel, Larry A Green, Chris van Weel. Translating research into practice 2: the need for research in primary care. The Lancet 2003;362:1314-1319.

De Maeseneer J, Boeckxstaens P. James MacKenzie Lecture 2011 : multimorbidity, goal-oriented care, and equity. Br J Gen Pract. 2012; (62) (600) : e522-4. http://www.ncbi.nlm.nih.gov/pubmed/22782000

De Maeseneer J, Roberts RG, Demarzo M, et al. Tackling NCDs: a different approach is needed. Lancet 2012;379(9829):1860-1.

Decade of Roma Inclusion (2005). Decade Declaration. Retrieved 27 April, 2015, Available from: http://www.romadecade.org/article/decade-declaration/9240

Declaration on the TRIPS Agreement and Public Health (Doha Declaration) adopted on 14 November 2001 at the Fourth Ministerial Conference of the WTO.

DNDi 2014

Dolea C, Stormont L, Braichet JM. Evaluated strategies to increase attraction and retention of health workers in remote and rural areas. Bull World Health Organ. 2010 May;88(5):379-85.

Drieskens S., Charafeddine R., Demarest S., Gisle L., Tafforeau J. & Van der Heyden J. (2015) Health Interview Survey, Belgium, 1997 - 2001 - 2004 - 2008 - 2013: Health Interview Survey Interactive Analysis. Brussels: WIV-ISP.

du Monde European Observatory on Access To Healthcare.

Dubois C-A, Nolte E, McKee M. Human resources for health in Europe: McGraw-Hill International; 2005.

Duvell, F. (2010). Foreword in: Lund Thomsen T., Bak Joorgensen, M., Meret, S. et al. (Eds) Irregular Migration in a Scandinavian Perspective. Maastricht: Shaker Publishing, 3-8.

EASL (2014) European Association for the Study of the Liver. Clinical Practice Guidelines: Management of hepatitis C virus infection. Journal of Hepatology 2014; 60: 392-420

EFPIA (2014), The pharmaceutical industry in figures: key data 2014

Elgin C, Öztunali O. Shadow Economies around the World: Model Based Estimates. Bogazici University, Working Papers 5, 2012

ERRC - European Roma Rights Center. Ambulance not on the way : the disgrace of health care for Roma in Europe. Budapest, Hungary: European Roma Rights Centre; 2006.

ERRC - European Roma Rights Centre (2006), 'Ambulance not on the way – the disgrace of healthcare for Roma in Europe', Retrieved 23 April, 2015, Available from: http://www.errc.org/cms/upload/media/01/E6/m000001E6.pdf

Ettelt, S., E. Nolte, S. Thomson and N. Mays (2007). The systematic use of cost-effectiveness criteria to inform reviews of publicly funded benefits packages. A report commissioned by the Department of Health. London, London School of Hygiene and Tropical Medicine.

Eurofound (2012). Living conditions of the Roma: Substandard housing and health. Retrieved 23 April, 2015, Available from: http://www.eurofound.europa.eu/pubdocs/2012/02/en/1/EF1202EN.pdf

Eurofound (2014), Access to healthcare in times of crisis, Publications Office of the European Union, Luxembourg.

European Commission (2004). Left out: Roma and access to health care in Eastern and Southeastern Europe, Retrieved 23 April, 2015, Available from: http://www.opensocietyfoundations.org/sites/default/files/leftout_20070423.pdf

European Commission (2009). Communication from the Commission. Executive Summary of the Pharmaceutical Sector Inquiry Report

EC 2012

European Commission (2014). Report on the implementation of the EU framework for National Roma Integration Strategies. Retrieved 27 April, 2015, Available from: http://ec.europa.eu/justice/discrimination/files/roma_implement_strategies2014_en.pdf

EC 2014

European Commission (2014). Roma Health Report: Health status of the Roma population. Retrieved 24 April, 2015, Available from: http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf

EP 2012

EU 2007

European Union. Consolidated Versions of the Treaty on European Union and the Treaty on the Functioning of the European Union (2008/C 115/01): Office for Official Publications of the European Communities; 2008.

European Union. Charter of Fundamental Rights of the European Union. Brussels: European Union; 2010.

Eurostat (2014). Living Conditions in Europe. Retrieved 8 June, 2015. Available from: http://ec.europa.eu/eurostat/documents/3217494/6303711/KS-DZ-14-001-EN-N.pdf/d867b24b-da98-427d-bca2-d8bc212ff7a8

Eurostat (2015)
http://ec.europa.eu/eurostat 2015.

falling back? HNP Discussion Paper, Washington DC: The World Bank.

female immigrants. 5th European Congress on Tropical Medicine and International Health, Amsterdam. Tropical Medicine and International Health, 12: 18–19.

Fesus, G., Ostlin, P., McKee, M., & Adany, R. (2012). Policies to improve the health and well-being of Roma people: The European experience. Health Policy, 105(1), 25-32.

Figueras J, McKee M. Health Systems, Health, Wealth And Societal Well-Being: Assessing The Case For Investing In Health Systems: Assessing the case for investing in health systems: McGraw-Hill International; 2011.

Fortier, J.P. and Bishop, D. (2003) Setting the Agenda for Research on Cultural Competence in Health Care. Edited by C. Brach. Rockville, MD: U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality.

Fox ER, Sweet BV, Jensen V, editors. Drug shortages: a complex health care crisis. Mayo Clinic Proceedings; 2014: Elsevier.

FRA - European Union Agency for Fundamental Rights (2012). The situation of Roma in 11 EU Member States: Survey results at a glance. Retrieved 23 April, 2015, Available from: Roma-at-a-glance_EN.pdf

Friedli, L. (2009). Mental Health, Resilience and Inequalities. Copenhagan: WHO Regional Office for Europe.

Gaal P, McKee M. Informal payment for health care and the theory of 'INXIT'. Int J Health Plann Manage. 2004 Apr-Jun;19(2):163-78.

Gaal P, Belli PC, McKee M, Szocska M. Informal payments for health care: definitions, distinctions, and dilemmas. J Health Polit Policy Law. 2006 Apr;31(2):251-93.

Garcia-Perez MA, Amaya C, Otero A. Physicians' migration in Europe: an overview of the current situation. BMC health services research. 2007;7:201.

Garner AA et al (2015) The head injury retrieval trial: a single-centre randomised controlled trial of physician prehospital management of severe blunt head injury compared with management by paramedics only. Emerg Med J 2015 Mar 20.

Garner AA, Mann KP, Fearnside M, Poynter E, Gebski V. The Head Injury Retrieval Trial (HIRT): a single-centre randomised controlled trial of physician prehospital management of severe blunt head injury compared with management by paramedics only. Emergency medicine journal : EMJ. 2015 Mar 20.

Giannakopoulos GF et al (2013). Helicopter Emergency Medical Services save lives: outcome in a cohort of 1,073 polytraumatized patients. Eur J Emerg Med 2013 Apr; 20(2): 79-85

Goddard M, Smith P: Equity of access to health care services: theory and evidence from the UK. Soc Sci Med 2001, 53(9):1149-1162.

Grimshaw JM, Thomas RE, MacLennan G, et al. Effectiveness and efficiency of guideline dissemination and implementation strategies. Health Technol Assess. 2004 FEB;8(6):III-IV, 1-72.

Grimshaw J, Eccles M, Tetroe J. Implementing clinical guidelines: current evidence and future implications. J Contin Educ Health Prof.2004 Fall;24 Suppl 1:S31-7.

groups in Europe: a qualitative study of expert views in 14 countries. BMC

Gulliford M and M Morgan 2003 Access to health care, Routlege.

Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multi-disciplinary review. BMJ 2003;327(7425):1219-21.

Hajioff, S., & McKee, M. (2000). The health of the Roma people: a review of the published literature. Journal of Epidemiology and Community Health, 54(11), 864-869.

Hasselberg M, Beer N, Blom L, Wallis LA, Laflamme L. Image-based medical expert teleconsultation in acute care of injuries. A systematic review of effects on information accuracy, diagnostic validity, clinical outcome, and user satisfaction. PloS one. 2014;9(6):e98539.

Healy J, McKee M. Accessing health care: responding to diversity. Oxford: Oxford University Press; 2004.

Hill A et al (2014). Minimum costs for providing Hepatitis C Direct Acting Antivirus for use in large-scale treatment access programs in developing countries. Clinical Infectious Diseases Advance Access publication February 13, 2014.

Hill et al 2014

HLS-EU Consortium (2012). Comparative report of health literacy in eight EU member states. The European health literacy survey HLS-EU. Accessible online publication: http://www.health-literacy.eu

Holcnerova, P. et al. (2012) Service provision and barriers to care for homeless people with mental health problems across 14 European capital

Honer, D. (2004). The enigma of the Gypsy patient.

Hunter DJ, McKee CM, Black NA, Sanderson CF. Health care sought and received by men with urinary symptoms, and their views on prostatectomy. Br J Gen Pract. 1995 Jan;45(390):27-30.

Illich I Medical Nemesis. London: Calder & Boyars. 1974.

IOM - Institute of Medicine (2013). Integrating Health Literacy with Health Care Performance Measurement.

IOM - Institute of Medicine. (2004). Health literacy: A prescription to end confusion. Washington DC: the National Academies.

Jarauta MJP, Arive MAG, Merino BM (2010). Spain: Health Promotion among Navarre Ethnic Minorities programme.In: Poverty and social exclusion in the European Region: Health systems respond. Copenhagen, WHO Regional Office for Europe.

Jarcuska, P., Bobakova, D., Uhrin, J., Bobak, L., Babinska, I., Kolarcik, P., et al. (2013). Are barriers in accessing health services in the Roma population associated with worse health status among Roma? International Journal of Public Health, 58(3), 427-434.

Jensen JD, King AJ, Guntzviller LM, Davis LA: Patient-provider communication and low-income adults: age, race, literacy, and optimism predict communication satisfaction. Patient Educ Couns 2010, 79:30-35.

Kickbusch, I., Pelikan, J.M., Apfel, F. and Tsouros, A. (Eds,) (2013). Health Literacy: The Solid Facts. Copenhagen: World Health Organization Regional Office for Europe.

Kühlbrandt C1, Footman K2, Rechel B2, McKee M2. Eur J Public Health. 2014 Oct;24(5):707-12. An examination of Roma health insurance status in Central and Eastern Europe.

Kutzin, J. (2010). Conceptual framework for analysing health financing systems and the effects of reforms, in J Kutzin et al (eds.) Implementing health financing reform: lessons from countries in transition. Copenhagen: WHO Regional Office for Europe (European Observatory on Health Systems and Policies).

Lamata F, Oñorbe M (2014). Crisis (esta crisis) y Salud (nuestra salud). Bubok Publishing, Madrid 2014.

Legido-Quigley H, D Panteli, J Car, M McKee and R Busse, eds (2013), Clinical guidelines for chronic conditions in the European Union, Copenhagen: WHO/European Observatory on Health Systems and Policies.

Light and Warburton 2011

Light DW, Kantarjian H. Market spiral pricing of cancer drugs. Cancer 2013 Nov; 119 (22): 3900-3902. doi: 10.1002/cncr.28321 http://onlinelibrary.wiley.com/doi/10.1002/cncr.28321/abstract;jsessionid=C56893E6A8DE26DC7C1A17D7CCF89000.f04t01

Mackenbach JP, Stirbu I, Roskam A-JR, Schaap MM, Menvielle G, Leinsalu M, et al. Socioeconomic inequalities in health in 22 European countries. New England Journal of Medicine. 2008;358(23):2468-81.

Mailankody and Prasal 2015

Maresso A, Mladovsky P, Thomson S, Sagan A, Karanikolos M, Richardson E, Cylus J, Evetovits T, Jowett M, Figueras J and Kluge H, eds (2015). Economic crisis, health systems and health in Europe: country experience, Copenhagen: WHO/European Observatory on Health Systems and Policies.

Martinez-Gonzalez NA, Rosemann T, Tandjung R, Djalali S. The effect of physician-nurse substitution in primary care in chronic diseases: a systematic review. Swiss medical weekly. 2015;145:w14031.

Maxwell, R (1992). Dimensions of quality revisited: from thought to action. Quality in Health Care, (1):171–177

MedTech 2014

MINECO (2013). Programa Nacional de Reformas. Reino de España. 2013. Ministerio de Economía y Competitividad. Gobierno de España.

Ministry of Health of Spain 2015

Mistry H, Garnvwa H, Oppong R. Critical appraisal of published systematic reviews assessing the cost-effectiveness of telemedicine studies. Telemedicine journal and e-health : the official journal of the American Telemedicine Association. 2014 Jul;20(7):609-18.

Mladovsky, P. (2007). Migration and Mental Health in the EU. Research Note for the European Commission from the Health and Living Conditions Network of the European Observatory on the Social Situation and Demography. London School of Economics and Political Science, UK.

Moynihan R, Cassels A (2005) Selling sickness. How the world's biggest pharmaceutical companies are turning us all into patients. New York: Nation Books. 254 p.

Moynihan R, Henry D (2006) The Fight against Disease Mongering: Generating Knowledge for Action. PLoS Med 3(4): e191. doi:10.1371/journal.pmed.0030191

Murphy P. (1999) Primary Health Care for Travellers Project: Implementation Report 1996–1999. Dublin: Pavee Point.

Nolte E, McKee M. Caring For People With Chronic Conditions: A Health System Perspective: A Health System Perspective: McGraw-Hill International; 2008.

Nolte E, McKee M. Variations in amenable mortality—trends in 16 high-income nations. Health Policy. 2011;103(1):47-52.

Nordheim LV, Haavind MT, Iversen MM. Effect of telemedicine follow-up care of leg and foot ulcers: a systematic review. BMC health services research. 2014;14:565.

Nutbeam 2000
O'Malley AS, Forrest CB. The Mismatch Between Urban Women's Preferences for and Experiences with Primary Care. Women Health Iss 2002;12(4):191-203.

OECD 2004 Private health insurance, Paris: OECD.

OECD 2013

OECD 2013 waiting times

OECD 2014 drug patent

OECD budget survey 2014

OECD (2014). Health at a Glance: Europe 2014. OECD 3 Dec 2014

OECD health data 2015 http://www.oecd.org/health/

OJEU 2006 Common values

Omachi, Theodore A.; Sarkar, Urmimala; Yelin, Edward H.; et al. JOURNAL OF GENERAL INTERNAL MEDICINE Volume: 28 Issue: 1 Pages: 74-81 Published: JAN 2013

Open Society Institute. (2005) Mediating Romani Health: Policy and Program Opportunities. New York, NY: Open Society Institute Network Public Health Program.

Parker RM, Ratzan SC. Health literacy: a second decade of distinction for Americans. J Health Commun 2010;15:20-33

Patel V, Flisher AJ, Hetrick S, McGorry P. Mental health of young people: a global public-health challenge. The Lancet. 2007;369(9569):1302-13.

Peiró and Alan Maynard 2015 Variations in health care delivery within the European Union http://eurpub.oxfordjournals.org/content/25/suppl_1/1

Pickard L, Jimenez-Martin S, Vegas R, Prieto CV. The supply of informal care in Europe. Brussels: European Network of Economic Policy Research Units (ENEPRI); 2011.

PICUM – Platform for International Cooperation on Undocumented Migrants (2010). Undocumented Migrants' Health Needs and Strategies to Access Health Care in 17 EU Countries. Summary report in the framework of the project Healthcare in NowHereland. Brussels.

PICUM - Platform for International Cooperation on Undocumented Migrants (2014). Access to healthcare for people facing multiple health vulnerabilities. Obstacles in access to care for children and pregnant women in Europe.

PICUM – Platform for International Cooperation on Undocumented Migrants (2015) Protecting undocumented children-Promising policies and practices from governments.

Poduval S1, Howard N1, Jones L1, Murwill P1, McKee M1, Legido-Quigley H2.Int J Health Serv. 2015;45(2):320-33. Experiences among undocumented migrants accessing primary care in the United Kingdom: a qualitative study.

Pope CJ, Roberts JA, Black NA. Dissecting a waiting list. Health services management research : an official journal of the Association of University Programs in Health Administration / HSMC, AUPHA. 1991 Jul;4(2):112-9.

Priebe, S., Matanov, A., Schor, R., Strasmayr, C., Barros, H., Barry, M.M., Diaz-Olalla, J.M. et al. (2012) Good practice in mental health care for socially marginalized Public Health, 12: 248.

QUALICOPC 2015

Rechel, B., Mladovsky, P., Devillé, W. Rijks, B., Petrova-Benedict, R. and McKee, M. (2011) Migration and Health in the European Union. World Health Organization on behalf of the European Observatory on health Systems and policies. Berkshire: Open University Press.

Reeves A, Basu S, McKee M, Meissner C, Stuckler D. Does investment in the health sector promote or inhibit economic growth? Global Health. 2013;9:43.

Reeves A, McKee M, Stuckler D. The attack on Universal Health Coverage in Europe: recession, austerity, and unmet needs. Eur J Publ Health. 2015:doi: 10.1093/eurpub/ckv040.

Rudd, R.E. (2004). Adult education and public health partner to adress health literacy needs. Adult Learning, 15(1), 7-9.

Sagan A and S Thomson 2015 Voluntary health insurance in Europe: role, regulation and implications for policy

Saltman R, Bankauskaite V, Vrangbaek K. Decentralization in health care: strategies and outcomes: McGraw-Hill International; 2006.

Siciliani L, Moran V, Borowitz M. Measuring and comparing health care waiting times in OECD countries. OECD Health working paper 67. Paris: OECD Publishing, 2013

Sorensen K, Van den Broucke S, Fullam J, et al. Health literacy and public health: a systematic review and integration of definitions and models. BMC Public Health 2012;12:80.

Sorensen, K. 2012: Health literacy and public health: A systematic review and integration of definitions and models, BMC Public Health, 12(80).

Sørensen, K., Broucke, S. V. D., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z., & Brand, H. (2012). Health literacy and public health: a systematic review and integration of definitions and models. BMC Public Health, 12(80), 1-13. doi: doi: 10.1186/1471-2458-12-80.

Sorenson, C., M. Drummond and P. Kanavos (2008). Ensuring value for money in health care. The role of health technology assessment in the European Union. Copenhagen, World Health Organization, on behalf of the European Observatory on Health Systems and Policies.

Starkiene L, Smigelskas K, Padaiga Z, Reamy J. The future prospects of Lithuanian family physicians: a 10-year forecasting study. BMC family practice. 2005 Oct 4;6:41.

Stevens and Gillam 1998 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1113121/

Strassmayr, C.C., Matanov, A.A., Priebe, S.S., Barros, H., Canavan, R., Diaz-Olalla, J.M. et al. (2012. Mental health care for irregular migrants in Europe: Barriers and how they are overcome. BMC Public Health, 12: 367.

Stuckler D, Basu S (2013). The body economic: why austerity kills. New York, NY. Basic Books.

Sutherland A: Gypsies and health care, In Cross-cultural Medicine [Special Issue]. West J Med 1992 Sep; 157:276-280)
Swartz, K. (2010). Cost-sharing: effects on spending and outcomes. Princeton, Robert Wood Johnson Foundation. 2011.

Taylor CB et al. (2010) A systematic review of the costs and benefits of helicopter emergency medical services. Injury 2010 Jan; 41(1): 10-20

Tefferi et al 2014

Thomas et al 2000

Thompson CR, McKee M. An analysis of hospital capital planning and financing in three European countries: Using the principal-agent approach to identify the potential for economic problems. Health Policy. 2011 Feb;99(2):158-66.

Thomson S and E Mossialos 2009 Private health insurance in the European Union, Brussels: European Commission.

Thomson S, Figueras J, Evetovits T, Jowett M, Mladovsky P, Maresso A, Cylus J, Karanikolos M, Kluge H (2014). Policy Summary. Economic crisis, health Systems and health in Europe: impact and implications for policy. World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2014.

Thomson S, Figueras J, Evetovits T, Jowett M, Mladovsky P, Maresso A, Cylus J, Karanikolos M and Kluge H (2015). Economic crisis, health systems and health in Europe: impact and implications for policy, Maidenhead: Open University Press.

Tudor Hart, J. (1971). The inverse care law. Lancet, 1(7696):405-412.

Undocumented Migrants in 11 European Countries. Paris: Médecins Sans Frontieres

United National Economic and Social Council (2010) Health literacy and the millennium development goals: United Nations Economic and Social Council (ECOSOC) regional meeting background paper. Journal of Heath Communication 15, (suppl 2):211-23

Van Den Muijsenbergh M. (2007). Maternity care and undocumented
van Ryn M, Burke J: The effect of patient race and socio-economic status on physicians' perceptions of patients. Soc Sci Med 2000, 50(6):813-828.

Velasco Garrido, M., F. Børlum Kristensen, C. Palmhøj Nielsen and R. Busse (2008). Health Technology Assessment and Health Policy-Making in Europe. Current status, challenges and potential. Copenhagen, World Health Organization, on behalf of the European Observatory on Health Systems and Policies.

Velényi E and M Smitz (2014), Cyclical patterns in government health expenditures between 1995 and 2010: are countries graduating from the procyclical trap or

Verlinde et al. (2012). The social gradient in doctor-patient communication. International Journal for Equity in Health 2012, 11:12

Wahlbeck, K. and Huber, M. (2009) Access to health care for people with mental disorders in Europe. Policy Brief, April 2009. European Centre for Social Welfare Policy and Research. Accessible at: http://www.euro.centre.org/data/1240307367_27951.pdf

Wahlbeck, K. (2010) Moving towards integrated addiction treatment systems. Nordic Studies on Alcohol and Drugs, 27:699-702.

WHA (2015) World Health Assembly addresses antimicrobial resistance, immunization gaps and malnutrition. New release. 25 May 2015. http://www.who.int/mediacentre/news/releases/2015/wha-25-may-2015/en/

WHO (2010), World health report 2010: Health systems financing - the path to universal coverage, Geneva: World Health Organization.

WHO (2008). Emergency Medical Service Systems in the European Union. WHO Regional Office for Europe.

World Health Organization. The Tallinn Charter: Health systems for health and wealth. Tallinn: World Health Organization; 2008.

WHO How health systems can address health inequities linked to migration and ethnicity. Copenhagen, WHO Regional Office for Europe, 2010.

WHO (2012) Research and Development to Meet Health Needs in Developing Countries: Strengthening Global Financing and Coordination. Report of the Consultative Expert Working Group on Research and Development: Financing and Coordination. World Health Organization, 2012.

WHO 2012a

WHO 2012b

WHO 2013

World Health Organization (2013). Mental Health Action Plan. Geneva: World Health Organization.

World Health Organization (2014). Global health estimates 2014 summary tables: YLD by cause, age and sex by WHO region, 2000-2012. Geneva: World Health Organization.

WHO 2014 global atlas med devices

WHO 2015 new meds report

WHO health expenditure data 2015 http://www.who.int/gho/database/en/

WHO (2015) Access to new medicines in Europe: technical review of policy initiatives and opportunities for collaboration and research. WHO, Regional Office for Europe, March 2015. http://www.euro.who.int/en/health-topics/Health-systems/medicines/publications2/2015/access-to-new-medicines-in-europe-technical-review-of-policy-initiatives-and-opportunities-for-collaboration-and-research

WHO XXXX

WHO, WTO, WIPO (2013). Promoting Access to Medical Technologies and Innovations. Intersections between health, intellectual property and trade. World Health Organization, World Trade Organization, World Intellectual Property Organization.

Wilcock GK. The prevalence of osteoarthrosis of the hip requiring total hip replacement in the elderly. International journal of epidemiology. 1979 Sep;8(3):247-50.

Willems 2005

Wismar M, McKee M, Ernst K, Srivastava D, Busse R. Health targets in Europe: learning from experience. Brussels: European Observatory on Health Systems and Policies; 2008.

Wittchen, H. U., Jacobi, F., Rehm, J., Gustavsson, A., Svensson, M., Jonsson, B., Steinhausen, H. C. (2011). The size and burden of mental disorders and other disorders of the brain in Europe 2010. Eur Neuropsychopharmacology, 21:665–79.

Woodward, A., Howard, N. and Wolffers, I. (2014) Access to health care for undocumented migrants living in the EU: a scoping review. Health Policy and Planning, 29(7): 818-830.

WTO (2001) Agreement on Trade-Related aspects of Intellectual Property rights.

Xu K, Saksena P, Jowett M, Carrin G., Kutzin J, & Evans D. (2010). Exploring the thresholds of health expenditure for protection against financial risk. World Health Report 2010 Background Paper 19. Geneva: World Health Organization.