European Commission


# VulnerABLE pilot project: Report of survey with people living in isolated and vulnerable situations

*Pilot Project related to the development of evidence based strategies to improve the health of people living in isolated and vulnerable situations (SANTE/2014/C4/034)*

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# Executive summary

## Introduction

As part of the 'VulnerABLE' pilot project to increase the knowledge and understanding of the health situation of vulnerable and isolated people in the EU, the current pan-European survey provides insights into the particular health needs and risk factors faced by:

- Families who are in a vulnerable situation (e.g. lone parents with young children);
- Having physical, mental and learning disabilities or poor mental health;
- In-work poor;
- Older people who are in a vulnerable/isolated situation;
- People with unstable housing situations (e.g., homeless people);
- Prisoners (or ex-prisoners in vulnerable situation);
- Persons living in rural/isolated areas in a vulnerable situation;
- Long-term unemployed / inactive (not in education, training or employment); and
- Victims of domestic violence.

As such, this survey contributes to identifying the most effective strategies for improving the health of vulnerable and isolated people, who are, due to circumstances, at a higher risk of experiencing poor health and/or facing barriers in accessing healthcare services.

The survey was conducted by GfK in 12 Member States: France, Germany, Greece, Italy, Lithuania, Netherlands, Poland, Romania, Slovakia, Spain, Sweden and the UK. To reach members of all target groups, the current survey used a mix of offline Paper-Assisted Personal Interviews (PAPI) and online Computer-Assisted Web Interviewing (CAWI). For the PAPI approach, local stakeholders (i.e., social workers, charity workers and other NGO's) that are in regular contact with vulnerable and isolated people were recruited. Under the guidance of GfK, these organisations collected 1.938 surveys between 20 July and 30 November 2016 from respondents of all nine target groups. The CAWI approach helped to collect additional 2.249 questionnaires via the local GfK panels between 22 November and 9 December 2016. While both approaches targeted all target groups, the PAPI approach was particularly successful in reaching people with physical, mental and learning disabilities, people with unstable housing and older people in vulnerable and isolated situations and the CAWI approach helped to reach in-work poor and long-term unemployed people.

## The health situation of people in vulnerable and isolated situations

Firstly, the survey investigated the health situation of people living in vulnerable or isolated situations and provides insights into the specific health issues this target group deals with. The findings of the survey suggest that a considerable proportion of vulnerable and isolated people deal with health issues: only 31% of respondents

evaluated their health as (very) good, while ***28% of the respondents evaluated their health as (very) bad***. Moreover, ***61% of respondents have long-standing illnesses, disabilities or infirmity***.

Most of those long-standing ***health problems*** were related to respondents' mobility (42%), stamina, breathing or fatigue (37%) and mental health (31%). Moreover, feelings of psychological stress were assessed. Many consumers reported feeling particularly tense (29%) feeling lonely (27%) and feeling depressed or downhearted (28%) at least most of the time, or did not wake up fresh and rested (60%) more than some of the time.

Focusing on ***barriers for the respondents' health***, the results show that while the health of vulnerable and isolated people was affected by various factors, the lack of money (62%) and feelings of stress (53%) were the most common factors. The role of financial means was further confirmed by the fact that respondents in difficult financial situations also report more health problems.

## Access to healthcare

Another aim of the survey was to assess problems that vulnerable or isolated people may have with accessing the healthcare services they need. While 37% of respondents found it easy to get access to the needed healthcare services, ***a considerable share of respondents (32%) perceived this as very or quite difficult***.

It is also important to note, that the access to healthcare was ***even more difficult for respondents with a bad health***: compared to respondents with a good health, 50% (vs. 19%) of respondents with a bad health found it difficult to access healthcare services.

To understand ***the reasons behind the problems with accessing healthcare***, the survey studied the factors that hindered respondents from accessing three healthcare facilities in the past year: medical practitioners, dental examination or treatment and medication. Also, respondents' ability to understand healthcare information provided by doctors, nurses or other healthcare professionals was investigated as a barrier to healthcare.

Respectively 65%, 52% and 45% of the respondents encountered at least one problem that stopped them from visiting a medical practitioner, from getting dental examination/treatment or from getting medication. Across all healthcare facilities, high costs were mentioned most often (respectively 25%, 30% and 26%). For medical practitioners, the inability to get an appointment (20%) and long waiting times (19%) were also reported quite often.

The results exploring respondents' ability to understand healthcare information show that a majority of respondents (51%) found understanding health information easy, while one fifth (21%) of the respondents experienced difficulties.

## Satisfaction with healthcare services

The survey results also provide insights into how satisfied people living in vulnerable and isolated situations are with the healthcare they receive. ***The average satisfaction with the health services was quite high***: 43% of respondents were either quite or very satisfied with the results of the health services they have used in the past 12 months, while only 22% were quite or very dissatisfied. However, the health situation of respondents also had an effect on the satisfaction with results. Concretely, ***respondents with a bad health were much more dissatisfied*** (40% is quite/very dissatisfied) than respondents with a good health (10%).

The satisfaction with health services was also somewhat dependent on the specific health issues of the respondents. As such, respondents were most dissatisfied with health services when their health problems concerned social or behavioural issues (37%) or the respondents' dexterity (34%), memory (34%), vision (33%), stamina, breathing or fatigue (32%)

Regarding the ***drivers of dissatisfaction with health services***, dissatisfied respondents reported long waiting times (mentioned by 52% of dissatisfied respondents), their disbelief that the medical treatment had an effect on their health (42%), the costs of the medical treatment (35%) and a bad attitude of the healthcare professional (35%) most regularly.

## Differences between different groups of vulnerable and isolated people

The survey results also portray certain differences for the included target groups.

First, the overall ***health situation*** was worse for people with physical, mental and learning disabilities (39% reported a bad health vs. the 28% average), older people in vulnerable and isolated circumstances (38%), victims of domestic violence (33%) and long-term unemployed (31%). These target groups (except for long-term unemployed) were also more likely to report ***long-term illnesses, disabilities and infirmity*** (respectively 84%, 73% & 67% vs. 61% average).

Problems with mobility, with stamina, breathing and fatigue and with mental health were the most common ***problem areas*** for all target groups. Looking at differences between the target groups shows that ***problems with mobility and stamina, breathing or fatigue*** were more often than average (respectively 42% & 37%) reported by vulnerable and isolated older people (respectively 56% & 48%) and physically or mentally disabled people (respectively 51% & 40%). ***Mental health problems*** were more often reported than average (31%) by physically or mentally disabled (44%), people with unstable housing (39%) and victims of domestic violence (45%).

Victims of domestic violence and people with unstable housing, but also members of vulnerable families were also most likely to portray other ***signs of psychological stress***. As such, members of these target groups felt more often particularly tense (respectively 41%, 39% & 38% felt so most or all of the time), lonely (39%, 40% & 32%) and depressed (44%, 39% & 35%). Also, people with disabilities also felt significantly more depressed or downhearted (32%) than the average respondent. In-

work poor respondents (17%) and persons living in rural or isolated areas (15%) were the least likely to wake up feeling fresh and rested.

The ***access to healthcare*** also differed across target groups. Members of vulnerable families (39% found it quite or very difficult), persons living in isolated or rural areas (42%) and vulnerable and isolated older people (43%) experienced more difficulties with accessing the healthcare services in the past year, compared to the average of all survey respondents (32%).

High costs were mentioned as the main ***reason for not visiting medical practitioners, getting dental examination/treatment or getting medication***. The unaffordability of all three healthcare facilities was reported most often by members of vulnerable families (respectively 41%, 45% & 39%) and persons living in isolated or rural areas (40%, 40% & 36%). Also, in-work poor (42%) had more problems with the costs of dental care and people with unstable housing (40%) had more problems with both the costs of dental care and medication. It is also quite striking that people with physical, mental and learning disabilities were significantly less affected by the cost-factor of all three healthcare facilities (21%, 27% & 21%).

Members of vulnerable families (28% found it quite or very difficult), people in unstable housing situations (27%) and older people in vulnerable and isolated situations (27%) also had more problems with ***understanding health information*** provided by doctors, nurses and other healthcare professionals.

The ***satisfaction with health services*** was particularly low for people without stable housing (29% is very or quite dissatisfied vs. 22% average). The role of the four most prominent ***reasons for dissatisfaction with the healthcare*** also differed across the target groups:

- ***Long waiting times*** were mentioned most often by dissatisfied people living in rural or isolated areas (65%), vulnerable older people (63%), the in-work poor (61%) and people with physical, mental and learning disabilities (57%).
- ***The perceived ineffectiveness of the medical treatment*** was most often mentioned by dissatisfied people with physical, mental and learning disabilities (53%) and long-term unemployed (49%).
- ***The costs of the medical treatment*** were most often mentioned by dissatisfied vulnerable older people (47%), the in-work poor (44%) and members of vulnerable families (43%).
- ***Dissatisfaction with the attitude of the healthcare professional*** was most often mentioned by people with physical, mental and learning disabilities (43%).

**<u>Differences between socio-demographic profiles</u>**

Socio-demographic breakdowns provided further insights into differences between different socio-demographic groups, with differences between respondents with different educational levels and financial situations as the most common factor.

Firstly, the ***health situation*** was the worst for respondents with only a basic education (37% have a bad or very bad health), respondents in a difficult financial situation (36%)

and vulnerable older respondents (55+ years; 37%). Similar results were found for long-standing illnesses, disabilities or infirmity (respectively 74%, 69%, 64%).

The ***type of health problem*** also differed across the socio-demographic profiles. As such, mobility issues were most common for older respondents (55%), while problems with stamina, breathing and fatigue were reported most often by older respondents (44%), women (41%) and respondents in a difficult financial situation (40%). Mental health issues were the most common among young respondents (18-34 years; 37%) and low-educated respondents (36%). Looking at ***signs of psychological stress***, respondents with only a basis education and with a difficult financial background were also more likely to feel particularly tense (respectively 33% & 35%), lonely (34% & 32% vs. 27%) and depressed (both 33% vs. 28%). Middle-aged respondents (35-54 years old) also felt more tense (32% vs. 24%) and depressed (30% vs. 25%) than older respondents. Women (19%) and middle-aged respondents (19%) were also less likely than average to wake up fresh and rested.

It is not surprising that the lack of money, as a ***potential barrier for a good health***, was most often reported by respondents in difficult financial situations (78%). However, also respondents with only a basis education (67%) and middle-aged respondents (64%) experienced the lack of money more often as a barrier to their health. Feelings of stress, another prominent reason for health problems, was also more common for respondents in a difficult financial situation (57%), while it respondents with only a basis education (44%) reported stress significantly less often than the average respondent. The results also show that respondents younger than 55 years (58%-60%) and women (57%) were also more affected by stress.

A difficult financial situation and a low (basic) education were also related to ***problems with accessing healthcare***. Respectively 39% of respondents with a difficult financial situation and 46% of low-educated respondents found it difficult to access healthcare. ***These difficulties with accessibility were generally caused by the high costs of the investigated health care facilities*** (i.e., medical practitioners, dental examination/treatment, and medication). It is noticeable that low-educated respondents and respondents in a difficult financial situation found it most difficult to pay for medical practitioners (37% & 33%), dental care (37% & 33%) and medication (35% & 39%). Women also experienced more difficulties with accessing healthcare (34%) and found it relatively more difficult to pay for dental care (32%) and for medication (28%).

Finally, the ***satisfaction with health services*** also differed across socio-demographic differences. Again, respondents in a difficult financial situation (28% is quite or very dissatisfied) and respondents with only a basis education (29%) were most dissatisfied with the results of the medical treatment they have received in the last 12 months. Also, the cost-aspect of medical treatments, as a ***driver for dissatisfaction***, was reported most often by respondents with a difficult financial background (39%). Low-educated respondents were most dissatisfied because of the long waiting times (48%).

**Differences between countries**

Finally, country breakdowns provided insights into differences between the surveyed countries. It is important to note, however, that country results are potentially driven by other factors than effective differences in the health situation or health access between

these countries. As such, the representativeness of the different target groups of vulnerable people in each country is most likely to have a large effect on these findings.

The ***health situation*** was most problematic for respondents in France (41% reported a bad health), the UK (34%) and in Sweden (36%). Also, in the UK (74%) and Sweden (61%), respondents reported more ***long-standing illnesses*** than average. The prevalence of long-standing health issues was also particularly high in Slovakia (72%), the Netherlands (71%) and Poland (71%). The ***areas affected by health problems*** also differed across the countries. *Mobility issues*, the most common health problems, were reported most often by respondents from France (55%), Slovakia (55%), Greece (54%) and Poland (50%). *Problems with stamina, fatigue and breathing* occurred more often in Lithuania (47%), Greece (46%) and Sweden (43%) and *mental health issues* were reported most often by German and Greek respondents (both 46%). Other ***signs of psychological stress*** were most apparent among respondents from the UK, who were most likely to feel particularly tense (35% felt this way) and depressed (38%), while they were the least likely to wake up feeling fresh and rested (only 13%).

***Access to health care*** also differed across the surveyed countries. In Italy, more than half of the respondents (55%) experienced difficulties accessing health care. In addition, about half of the respondents from Greece (46%) and from Poland (45%) experienced difficulties. The main ***reason why vulnerable people would not get health care*** were the *high costs*. Italian respondents particularly experienced problems with health care costs; almost half of the Italian respondent found it difficult to pay for medical treatment (41%), dental care (43%) and medication (44%). Lithuanian respondents also experienced more problems than average with paying for dental care (40%) and medications (35%). In contrast, only relatively few respondents from the UK had problems paying for these three health services (respectively 9%, 17% and 9%). The two other most prevalent reasons, *the inability to get an appointment* and *long waiting times* were reported particularly often by Polish respondents (respectively 38% and 31%). Finally, the findings report insights into vulnerable people's understanding of information provided by health professionals, as another potential reason for not getting the help one needs. While on average one fifth of respondents *understood the information provided by health care professionals*, this number was higher for Italian respondents (32%) and Romanian respondents (29%).

Finally, ***satisfaction with the health care*** was particularly low for Greek respondents (only 25% were satisfied) and Italian respondents (35%). Also, while respondents from France (57%), Slovakia (57%) and Lithuania (47%) were most satisfied with the health care they have received, this was still only about half of the respondents. The ***main reasons for dissatisfaction*** with the health services were long waiting lines, the perception that the health services had no positive effect on the respondents' health, the attitude of the health care provider and the costs of the health care. First, *long waiting lines* were reported most often by Polish (79%) and Greek (70%) respondents. A *negative perception of the effectiveness of the health treatments* was also mentioned particularly often in Poland (60%), but also in Germany (56%), France (55%) and Sweden (52%). A *bad attitude of health care professionals* was reported by half of the UK respondents and *high costs* were more often a reason for dissatisfaction for German (49%), Greek (47%) and Lithuanian (46%) respondents.

# 1 Introduction

This pan- European survey is part of 'VulnerABLE', a pilot project carried out for DG Health and Food Safety (DG SANTE), to increase knowledge and understanding of how best to improve the health of people who are living in vulnerable and isolated situations. The goal of this pilot project is to identify the most effective strategies for improving the health of vulnerable and isolated people[1], who are, due to circumstances, at a higher risk of experiencing poor health and/or of facing barriers in accessing healthcare services.

A core part of this pilot project is understanding the reasons why vulnerable and isolated people can be at a greater risk of poor health and to get a better insight into the types of barriers that they face in accessing healthcare services. This pan-European survey contributes to this, by providing primary data on particular health needs and risk factors faced by the target groups in 12 Member States: France, Germany, Greece, Italy, Lithuania, Netherlands, Poland, Romania, Slovakia, Spain, Sweden and the UK. The main topics covered in the subsequent chapters are summarised below.

**Chapter 2** discusses the methodology of the survey task and provides an overview of the sample characteristics.

**Chapter 3** focuses on the health situation of people in vulnerable and isolated situations. This chapter focuses not only on the overall health situation, but also provides insights into specific aspects, such as depression and loneliness. The findings also provide insights into the prevalence and types of long-standing illnesses and disabilities and into the factors that affect the people's health.

**Chapter 4** explores the target groups' access to the healthcare. This chapter provides insights into the overall ease of obtaining healthcare and factors that prevent vulnerable and isolated people from accessing medical, dental treatment and medication.

**Chapter 5** reports on the target groups' satisfaction with healthcare and the reasons of dissatisfaction with medical treatment.

Finally, **Chapter 6** provides the conclusions of this survey, with an overview and discussion of the key findings of this survey.

[1] families from disadvantaged backgrounds, those living in rural and isolated areas, those with physical, mental and/or learning disabilities, the long term unemployed and in-active, the in-work poor, older people, victims of domestic violence and intimate partner violence, people with unstable housing situations (homeless) and prisoners (See the methodology for more information about the selection of target groups)

# 2 Methodology

This section details the methodology implemented for the survey, from survey design to data collection.

## 2.1 Target population

The selection of the target population for the survey was centred on two aspects: the country selection and the selection of the target groups.

In relation to ***country selection***, the survey was conducted in 12 EU Member States, with three countries per region (i.e., North, South, East and West Europe). The table below details the EU Member States per region, according to the UN Division[2]. The 12 countries selected for the survey are highlighted in blue.

**Table 1 UN division of EU geographical regions**

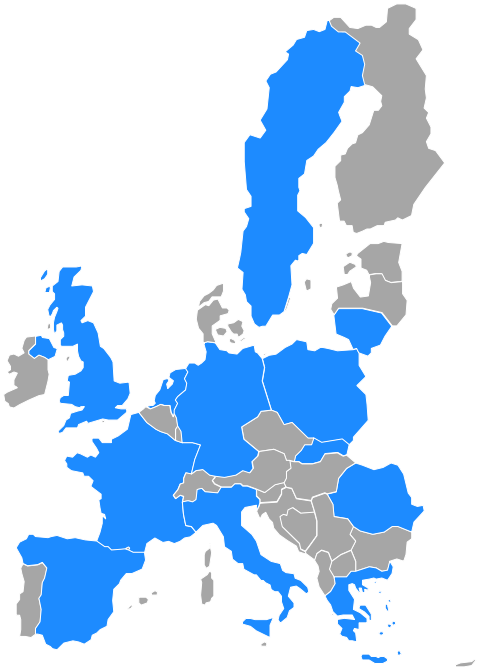
| North | South | East | West |
|---|---|---|---|
| Sweden | Italy | Croatia | Germany |
| Denmark | Spain | Czech Republic | France |
| Finland | Portugal | Hungary | Luxembourg |
| UK | Greece | Slovakia | Belgium |
| Ireland | Cyprus | Slovenia | Netherlands |
| Latvia | Malta | Poland | Austria |
| Lithuania | | Bulgaria | |
| Estonia | | Romania | |

These 12 selected countries provide an even spread in terms of the following:

- EU Membership: It includes a mix of EU15 and EU13 countries (EU15: France, Germany, Greece, Italy, Netherlands, Spain, Sweden, United Kingdom; EU13: Slovakia, Poland, Romania;
- GDP per capita: It includes a mix of high-income and lower-income countries;
- Geographical spread: There are three countries per EU region. The countries represent a strong regional spread, as shown in Figure 1 below;
- Languages, cultural and socio-demographic settings; and
- Health and social care economies.

[2] http://unstats.un.org/unsd/methods/m49/m49regin.htm

**Figure 1 Selected target countries**



For the ***selection of target respondents***, the survey focused on respondents in various isolated and vulnerable situations. There is no commonly agreed definition of vulnerability; however, certain groups might be more or less vulnerable depending on the circumstances. For this survey, vulnerability was approached as a dynamic phenomenon: the determinants of vulnerability are both individual (inborn or acquired) characteristics and external social, economic and environmental factors. Taking this into consideration, the following target groups were selected for this survey:

- Families who are in a vulnerable situation (e.g. lone parents with young children)
- Having physical, mental and learning disabilities or poor mental health
- In-work poor
- Older people who are in a vulnerable/isolated situation
- People with unstable housing situations (e.g., homeless people)
- Prisoners (or ex-prisoners in vulnerable situation)
- Persons living in rural/isolated areas in a vulnerable situation
- Long-term unemployed / inactive (not in education, training or employment)
- Victims of domestic violence

The scope of this study does not include people with a migrant, asylum seeker, refugee or Roma background. These groups were only included in the survey if they also belong to one of the categories mentioned above, but will not be targeted as such.

A minimum sample size of **300 respondents per Member State** was set (and collected) in each country. No quotas were set for the different target groups and no attempts were made to measure the representativeness of the sample with reference to

the population of isolated and vulnerable groups overall. The purpose of this approach is to have a rich-and varied understanding of the needs and experiences of vulnerable and isolated groups across a select number of EU countries.

## 2.2 Interviewing method

Vulnerable and isolated people can be a hard to survey due to both physical reasons and personal reasons. For example, they might be living in isolated communities (i.e., a physical reason) or are more likely to distrust external interviewers (i.e., a personal reason), which makes it hard to interview them personally. To deal with these restrictions, the current survey used a mix of offline Paper-Assisted Personal Interviews (i.e., pen and paper interviews; PAPI) and online Computer-Assisted Web Interviewing (CAWI). Both methods are discussed in more detail below.

### a) PAPI (offline survey)

Pen-and-paper surveys were used to reach populations that would be harder to reach online. However, given the potential challenges of identifying such target groups, and in order not to stigmatise persons facing vulnerability, surveys were collected with the assistance of local stakeholders, such as social workers, charity workers and other NGO's, that are in regular contact with vulnerable and isolated people. These local stakeholders were best-placed to act as survey-facilitators, because they are more likely to be trusted by vulnerable and isolated people. While local stakeholders were recruited for all the different target groups, this approach was especially valuable to reach vulnerable and isolated respondents that are unlikely to participate in online questionnaires, due to a lack of internet access (such as prisoners or homeless people) or physical limitations (such as people with disabilities). The recruitment of the local stakeholders was done through telephone and email by GfK, with the assistance of the Social Platform, EuroHealthNet and the European Public Health Alliance (EPHA).

The selection of respondents was done by the local stakeholders themselves. They selected respondents that they believed belonged to one or more of the defined target groups. All survey respondents were rewarded with an incentive for their participation.

### a) CAWI (online survey)

Surveys were also conducted using an online questionnaire via the local GfK consumer panels in each country. The advantages of online surveys do not only lie in the wide reach across different geographical areas, but also to the anonymity that is guaranteed to respondents. While the online survey was directed towards all target groups within this project, it was expected that this approach may be particularly relevant for target groups that are less likely involved with social or charity workers or would be more comfortable answering the questionnaire in private. These target groups may include families who are living in vulnerable situations (e.g., lone parents with young children), in-work poor, persons living in rural/isolated areas and long-term unemployed/inactive.

Respondents were selected via an invitation letter that clearly stated the scope of this

study and multiple screening questions in the questionnaire that connected the respondents to the respective target groups. Every target group was double checked with at least one control question that reaffirmed a respondents' status. The online survey respondents were also rewarded with an incentive for their participation.

## 2.3 Questionnaire

A short, clear and easy-to-understand questionnaire[3] was crucial in engaging vulnerable and isolated people with the survey. Therefore, the questionnaire consisted of simplified questions to measure the needs and challenges of vulnerable groups. Furthermore, the questionnaire utilised images to facilitate respondents to independently answer the questions. To inform respondents about their privacy rights, a privacy statement was also developed. The total length of the questionnaire using both methods was between 10 and 15 minutes.

In relation to languages, interviews using the PAPI method were conducted in the national languages of the 12 surveyed countries. Translations of the questionnaire were produced by professional translators with the respective national languages as mother tongue and a subsequent review of the translation was conducted by native speakers at GfK.

**Table 2 Overview of languages used for interviewing per country**

| Country | Official languages |
|---|---|
| France | French |
| Germany | German |
| Greece | Greek |
| Italy | Italian |
| Lithuania | Lithuanian |
| Netherlands | Dutch |
| Poland | Polish |
| Romania | Romanian |
| Slovakia | Slovak |
| Spain | Spanish |
| Sweden | Swedish |
| UK | English |

[3] The questionnaire can be found in Annex 1

## 2.4 Fieldwork

The pen-and-paper (PAPI) fieldwork started on 20 July 2016 and ran until 30 November 2016. Whilst the local stakeholders had a key role in facilitating the offline surveys, GfK was responsible for setting up the study, briefing the stakeholders, supporting stakeholders during the fieldwork phase and collating the completed questionnaires. This was done through local agencies in the 12 survey countries, coordinated by GfK Belgium.

The CAWI fieldwork started on 22 November 2016 and ran until 9 December 2016 without interruption. The online surveys were only conducted in countries where the offline (PAPI) surveys did not result in 300 completed surveys.

Table 3 provides an overview of the obtained sample size per method for each country:

**Table 3 Overview of languages used for interviewing per country**

| Country | PAPI (offline) | CAWI (online) | Total |
|---|---|---|---|
| France | 0 | 314 | 314 |
| Germany | 30 | 309 | 339 |
| Greece | 301 | 0 | 301 |
| Italy | 310 | 0 | 310 |
| Lithuania | 100 | 313 | 413 |
| Netherlands | 52 | 295 | 347 |
| Poland | 300 | 0 | 300 |
| Romania | 302 | 0 | 302 |
| Slovakia | 315 | 0 | 315 |
| Spain | 96 | 378 | 474 |
| Sweden | 31 | 335 | 366 |
| UK | 101 | 305 | 406 |
| **Total** | **1.938** | **2.249** | **4.187** |

## 2.5 Data cleaning, processing and validation

Once the PAPI questionnaires were completed, stakeholders returned the paper questionnaires to GfK Belgium via the national fieldwork agencies. The data from the different countries was then entered into a central scripting program, where it was cleaned, validated and finalised.

The collected online responses (CAWI) were recorded using a central located programming, meaning that all survey answers were directly recorded and stored in one central location. This approach excluded the need for later data merging of country

specific databases and allowed data quality checks during the fieldwork.

Following the fieldwork, data processing and preliminary analyses were conducted centrally at GfK Belgium. The main stage of the data cleaning process consisted of data quality controls, including consistency and missing answers checks. After the data cleaning stage, the raw data were processed for the analysis and reporting stage.

## 2.6 Sample characteristics

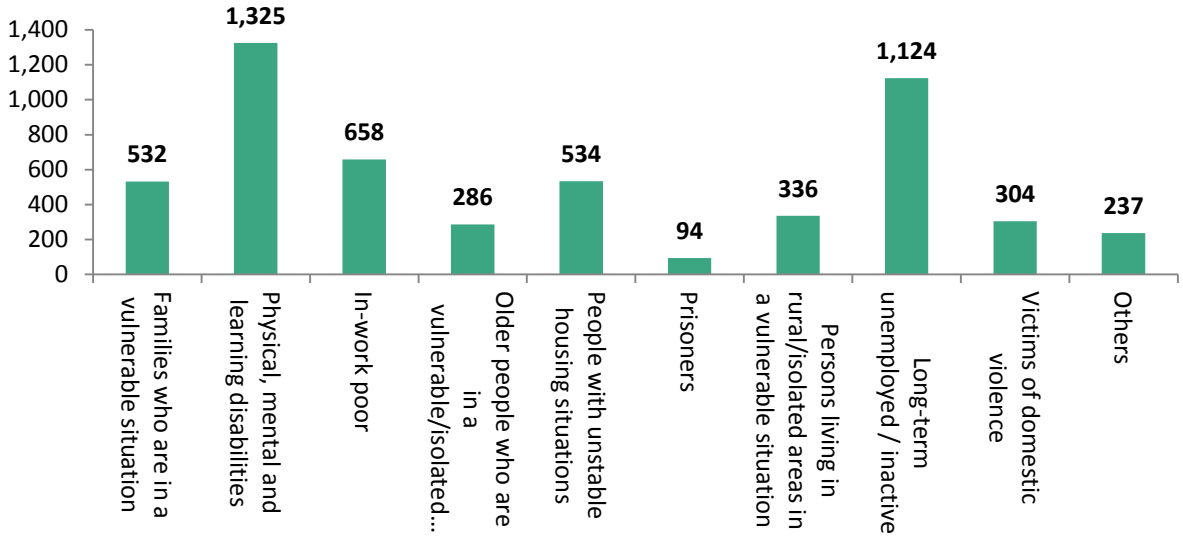
The survey was completed by 4.187 respondents. All target groups are included in the sample[4]. People with physical, mental and learning disabilities (n=1.325; 32%) and long-term unemployed and inactive persons (n=1.124; 27%) are represented most often. However, the size of other target groups is also large enough to draw conclusions. The smallest group of respondents are prisoners or ex-prisoners. Only 2% of all respondents belong to this group. The small number of respondents in this target group can be explained by the limited number of organisations working with prisoners in the current sample. While the CAWI approach also included ex-prisoners, this did not boost the size of this group.

A small number of respondents were specified as vulnerable or isolated but did not belong to one of the nine target groups. These included, among others, alcohol and drug addicts, sex workers or people with insufficient financial means. Given the small number of respondents in each of these categories, they were included as 'others'. Below is an overview of the respondents in each target group:

- People with physical, mental and learning disabilities (n=1.325; 32%)
- Long-term unemployed/inactive (n=1.124; 27%)
- In-work poor (n=68; 16%)
- Families who are in a vulnerable situation (n=532; 13%)
- People with unstable housing situations (n=534; 13%)
- Persons living in rural/isolated areas in a vulnerable situation (n=336; 8%)
- Older people who are in a vulnerable/isolated situation (n=286; 7%)
- Victims of domestic violence (n=304; 7%)
- Prisoners (n=94; 2%)
- Others (n=237; 6%)

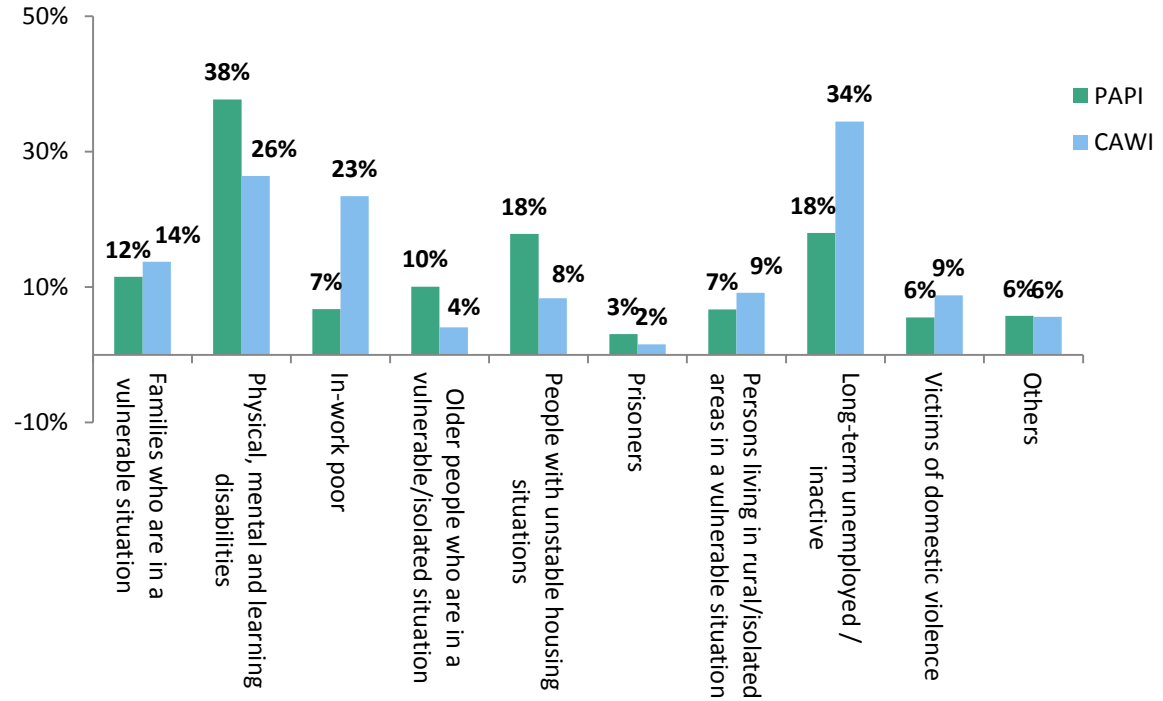
[4] Respondents can belong to more than one target group.

**Figure 2 Respondents per target group**




The results per data collection approach (PAPI vs. CAWI) show that all target groups were reached through both approaches. However, there are certain differences. People with physical, mental and learning disabilities (38% vs. 26%), older people in vulnerable and isolated situations (10% vs. 4%) and people living in unstable housing situations (18% vs. 8%) were surveyed more often using the PAPI approach. In-work poor (23% vs. 7%), long-term unemployed/inactive (34% vs. 18%) and victims of domestic violence (9% vs. 6%) were reached more often using the CAWI approach. It is important to note that the category 'prisoners' is divided into actual prisoners surveyed with the PAPI approach and ex-prisoners surveyed with the CAWI approach.

**Figure 3 Respondents per target group conditional on data collection approach**



The socio-demographic make-up of the sample regarding age, gender, number of children in the household, education, occupation, financial situation and accommodation is presented in Table 4. These categories were broken down into the following:

**Age:** 18-34 year olds (i.e., younger respondents), 35-54 year olds respondents (i.e., middle-aged respondents), and 55+ year olds (i.e., older respondents)

**Gender:** Male and Female

**Level of education:** Basic, Medium and High according to the following criteria:

- Basis: respondents that finished primary school or elementary school (left school under 15 years old).
- Medium: respondents that completed some high/secondary school or graduated from high/secondary school
- High: respondents that graduated from college, university or other third-level institute or post-graduate degree (Master, PhD) beyond the initial college degree.

**Financial situation**: Was included as a subjective measure and ranges from very difficult to very easy. To get a better idea about the concrete meaning of these labels, they are compared with the median of the respondents' total household income. The analysis reveals the following values:

- 'very difficult': Less than €79 weekly, less than €349 monthly and less than €4.199 yearly
- 'difficult': €80 to €209 weekly, €350 to €899 monthly and €4.200 to €10.799 yearly
- 'fair' & 'easy': €210 to €449 weekly, €900 to €1.949 monthly and €10.800 to €23.399 yearly
- 'very easy': €450 to €824 weekly, €1.950 to €3.599 monthly and €23.400 to €43.199 yearly.

The sample is quite evenly divided across different age groups and gender. While about 30% of respondents are aged between 18 and 34 years, 43% are aged between 35 and 54 years old and 27% are older than 55 years. About half of the respondents are male (48%) or female (52%). About half of all respondents in the sample (52%) have no children living in their household. Of those with children, most have either one or two children (respectively 22% and 17%), while only 8% of all respondents have 3 or more children living in their household (8%).

About half of all respondents are medium-educated (54%), while 27% are highly educated and 19% have only a basis education. Considering the respondents' occupation, the largest share of respondents is either employed (or an employer or self-employed; 30%) or long-term unemployed (> 12 months; 22%). A rather high proportion of respondents are also unable to work due to long-term illness or disability (16%) or retired (13%). The financial situation of the respondents is more often bad than good. More than half of the respondents evaluate their financial situation as either 'very difficult' (25%) or 'difficult' (37%), while 28% of the respondents evaluate their financial situation as fair. This is in strong contrast with the relatively few respondents that

describe their financial situations as 'easy' (8%) or 'very easy (3%). These findings illustrate the potential vulnerability of the target group.

Finally, respondent mostly live in accommodations rented from private landlords (25%) or own their accommodation, either with a mortgage (14%) or without (22%). A considerable proportion of respondents also live in social, voluntary or municipal housing (17%) or in other living situations (often including homelessness; 11%).

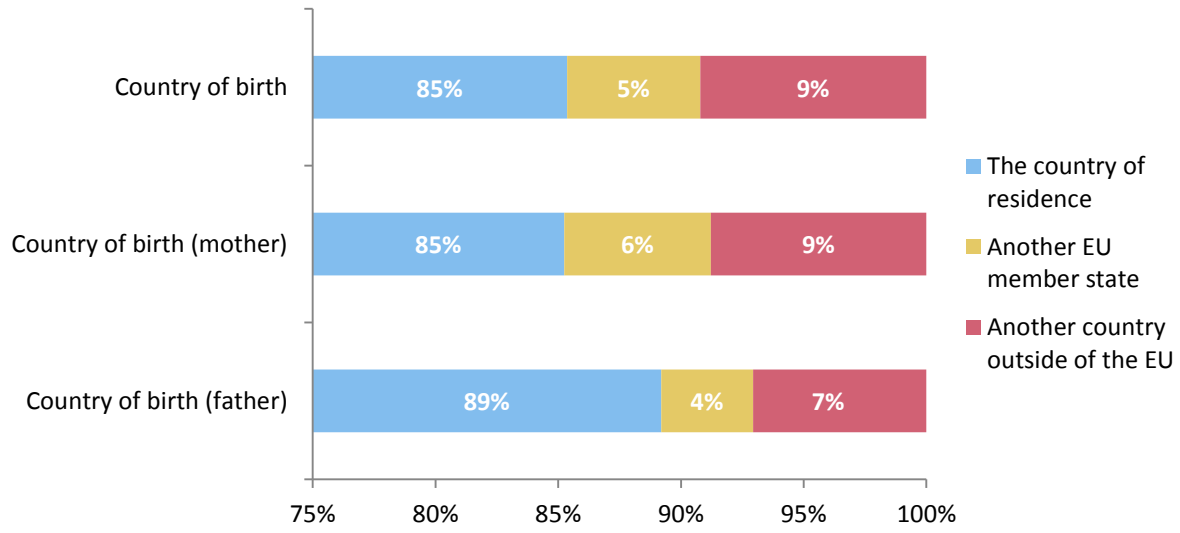
**Table 4 Sample characteristics**

| Variable | | Percentage |
|---|---|---|
| **Age** | 18 - 34 years | 30% |
| | 35 - 54 years | 43% |
| | 55+ years | 27% |
| **Gender** | Male | 48% |
| | Female | 52% |
| **Children in Household** | 0 | 53% |
| | 1 | 22% |
| | 2 | 17% |
| | 3 or more | 8% |
| **Education** | Basic | 19% |
| | Medium | 54% |
| | High | 27% |
| **Occupation** | Employee/employer/self-employed | 30% |
| | Child-care leave/other leave | 3% |
| | Family farm or business | 2% |
| | Unemployed < 12 months | 7% |
| | Unemployed > 12 months | 22% |
| | Not legally permitted to work | 3% |
| | Unable to work due to long-term illness or disability | 16% |
| | Retired | 13% |
| | Homemaker | 7% |
| | Full time care provider | 2% |

| | | |
|---|---|---|
| | In education | 5% |
| | Other | 6% |
| **Financial Situation** | Very difficult | 25% |
| | Difficult | 37% |
| | Fair | 28% |
| | Easy | 8% |
| | Very Easy | 3% |
| **Accommodation** | Own without mortgage | 22% |
| | Own with mortgage | 14% |
| | Tenant to private landlord | 25% |
| | Tenant in social/voluntary/municipal housing | 14% |
| | Tenant in rent free social/voluntary/municipal/public housing | 3% |
| | Accommodation is provided rent free | 9% |
| | Other | 11% |

Figure 4 presents the country of birth of the respondents, their mothers and their fathers. The vast majority of the respondents were born in their country of residence (85%), while 5% was born in another EU country and 9% was born in another country outside of the EU. The results are found for the respondents' parents.

**Figure 4 Country of birth of respondents, their mother and their father**



The results of the survey are presented in the next three chapters that focus on the health situation of vulnerable and isolated people, their access to healthcare and their satisfaction with healthcare. Next to the general results, analyses are done for the different target groups and for socio-demographic profiles. When presenting the results, green numbers imply that the value is significantly higher than the average across all groups (i.e., 'total'), while red numbers imply that the value is significantly lower than the average. For consistency, this colour code is kept constant, both when higher values indicate a positive result (e.g., a good health) or negative result (e.g., a bad health).

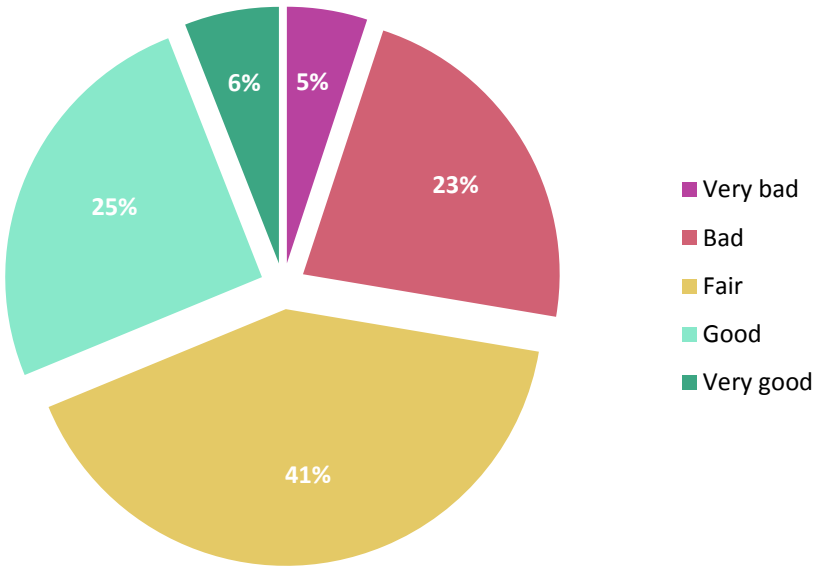
# 3 The health situation of people in vulnerable and isolated situations

This chapter looks into the health situation of people living in vulnerable and isolated situations and gives an assessment of both the respondents' health and about factors that affect their health.

## 3.1 Health situation

Almost half of all respondents evaluated their ***general health situation***[5] as fair (41%) and almost one third of respondents evaluated their health situation as good or very good (31%). However, a noticeable share of respondents indicated having bad (23%) or very bad (5%) health, showing that there is a certain need to obtain a detailed view on the health situation of vulnerable and isolated people.

**Figure 5 Health situation**




*Base: all respondents (n = 4.187)*

The results differ across the various surveyed target groups (see Figure 6), and some target groups reported a particularly bad versus good health. People with physical, mental and learning disabilities are more likely to report a (very) bad health (39% vs. 28%) and are less likely to report a (very) good health (22% vs. 31%) than the average respondent of this survey[6]. The same is found for older people living in a vulnerable or isolated situation (respectively 38% vs. 28% and 22% vs. 31%). Furthermore, long-term unemployed reported significantly more often that they have bad health (26% vs. 23%)

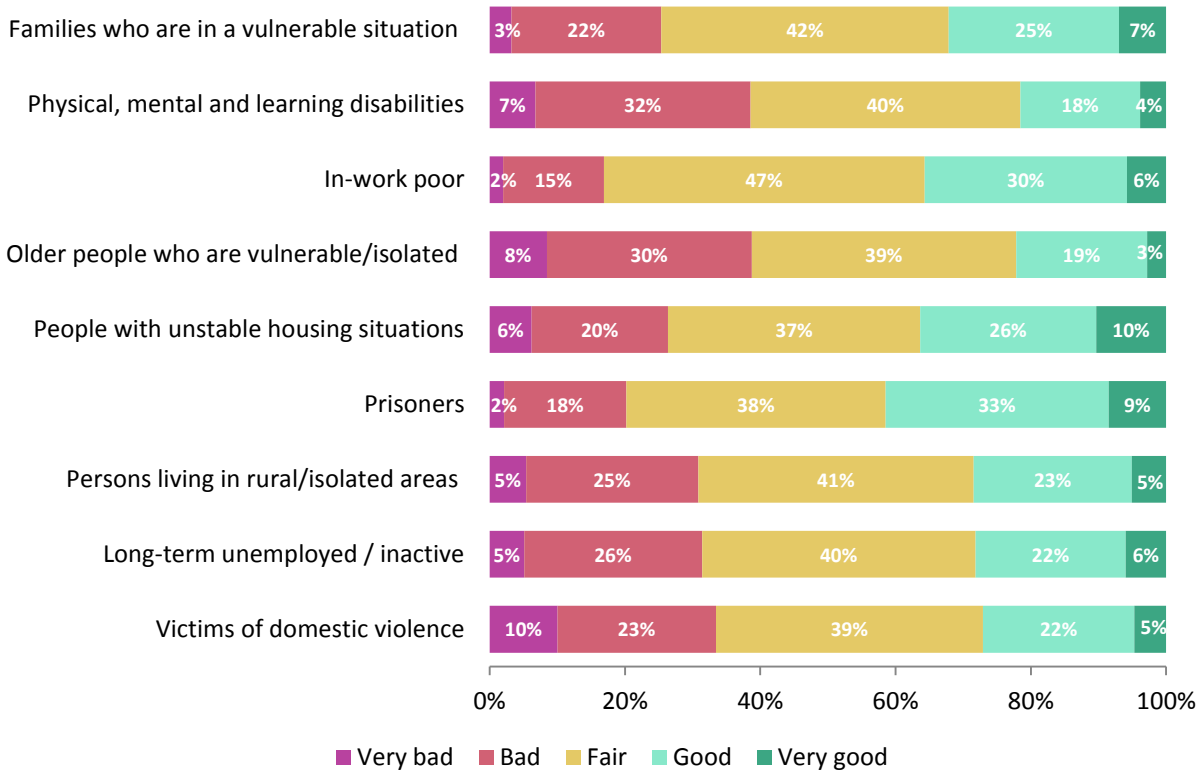
[5] Based on Question 1

[6] The average results as presented in Figure 5

and less often that they have a good health (22% vs. 25%) and victims of domestic violence are more likely to report a very bad health (10% vs. 5%).

In contrast, the in-work poor respondents and people with unstable housing reported a better health. Concretely, in-work poor were significantly less likely to report a (very) bad health (17% vs. 28%), while they are more likely to report a fair health (47% vs. 41%) and good health (30% vs. 25%) than the average respondent. People with unstable housing were more likely to report a very good health compared to the average (10% vs. 6%).

**Figure 6 Health situation of target groups**




*Base: all respondents (n = 4.187)*

The survey analysed responses by socio-demographic profiles, in order to understand the health situation between gender, age, education and financial situation. It showed that the health situation differed for some socio-demographic profiles, as is indicated in Table 5 below. The results show that younger respondents (18-34 year olds) have a better self-reported health than older respondents. As such, 47% of respondents between 18 and 34 years old reported a good or very good health. In contrast, this is the case for only 27% of 35 to 54 year olds and for 20% of 55+ year olds.

Education also appears to be related to the respondents' health situation. Respondents with only a basic education reported significantly more often a (very) bad health (37%) than the average (28%). In contrast, respondents with a high education reported more often a (very) good health (38%) than the average (31%).

Similarly, respondents in difficult financial situations were more likely to report a (very) bad health than respondents in easy financial situations (36% vs. 15%), while respondents in an easy financial situations were more likely to report a (very) good health than the average (43% vs. 24%).

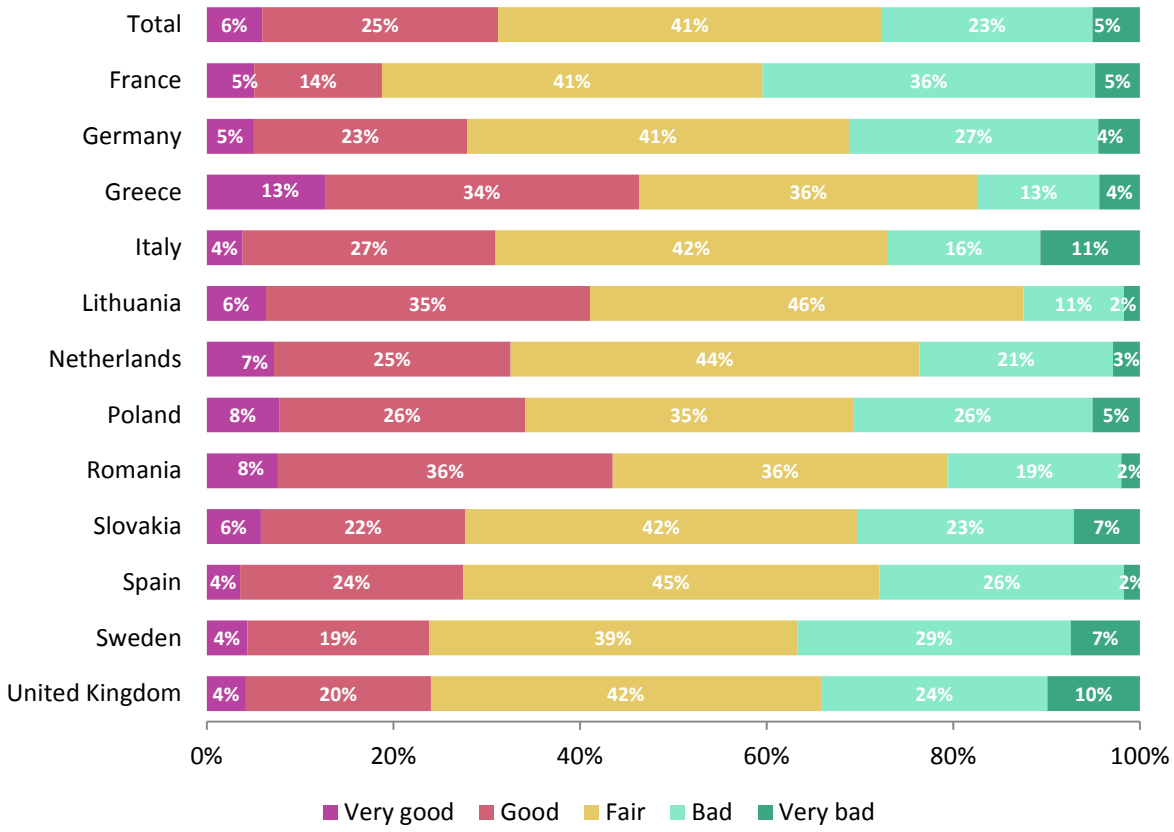
**Table 5 Health situation of socio-demographic profiles**

| | Very bad | Bad | Fair | Good | Very good |
|---|---|---|---|---|---|
| **Total** | **5%** | **23%** | **41%** | **25%** | **6%** |
| Male | 5% | 23% | 40% | 26% | 7% |
| Female | 5% | 22% | 42% | 25% | 5% |
| 18-34 | 3% | 14% | 37% | 35% | 12% |
| 35-54 | 6% | 24% | 43% | 23% | 4% |
| 55+ | 7% | 30% | 43% | 18% | 2% |
| Basis education | 8% | 29% | 36% | 21% | 6% |
| Medium education | 4% | 23% | 43% | 25% | 5% |
| High education | 4% | 18% | 41% | 28% | 9% |
| (Very) difficult financial situation | 7% | 29% | 41% | 20% | 4% |
| (Very) easy financial situation | 2% | 13% | 42% | 34% | 9% |

*Base: all respondents (n = 4.187)*

The health situation was also investigated at country-level, as is illustrated in Figure 7. The findings illustrate that compared to the average results (28% had a 'bad' or 'very bad' health), the health situation was particularly poor among the respondents in Sweden (36%), in France (41%) and in the UK (34%). In contrast, Greek respondents (47% had a good or very good health), Lithuanian respondents (41%) and Romanian respondents (44%) had a better health than average.

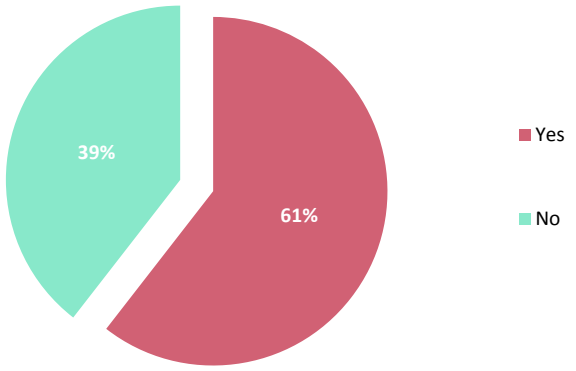
**Figure 7 Health situation per country**




The survey also explored to which degree vulnerable and isolated people had any long-standing illnesses, disabilities or infirmity[7]. The results show that more than half of all respondents confirmed that they deal with long-term health issues (61%; see Figure 8). This is somewhat consistent with the findings above, which show that only 31% of all respondents have a good or very good self-reported health.

[7] 'Long-standing' includes any illness that troubled the respondents in the past 6 months and is likely to affect them in the next 6 months.

**Figure 8 Respondents with long-standing illnesses, disabilities or infirmity**



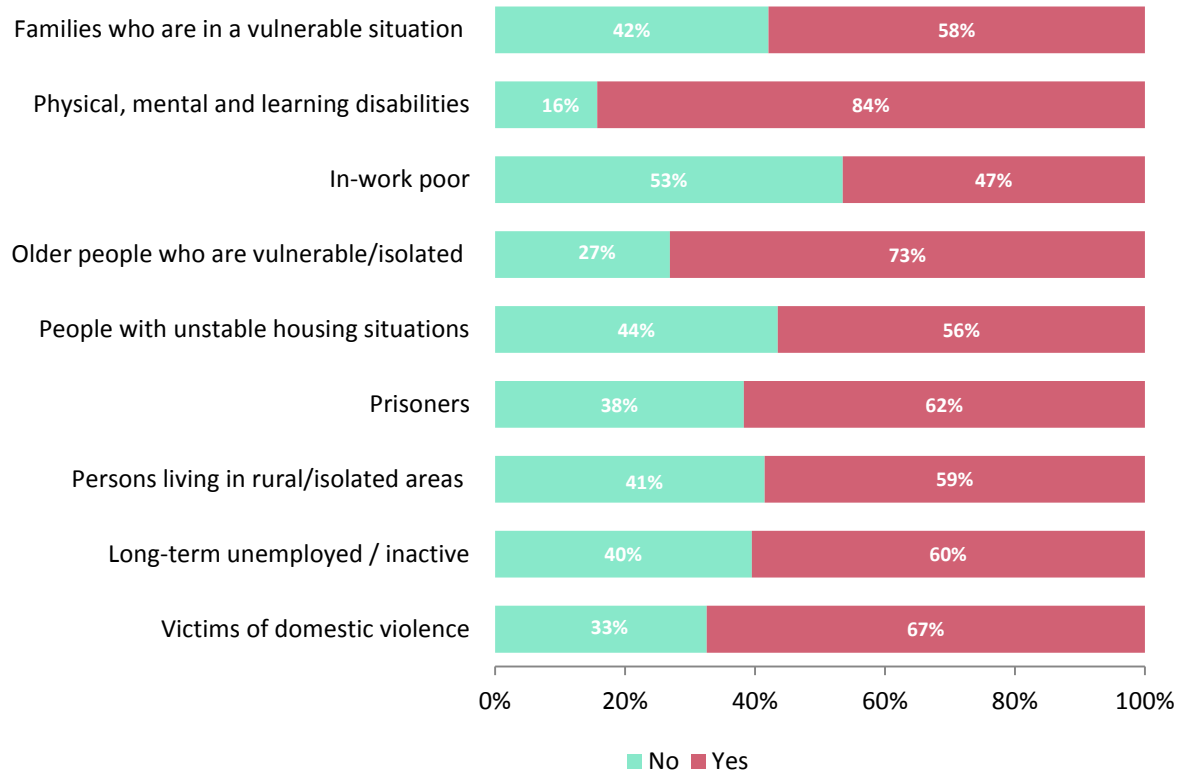

*Base: all respondents (n = 4.187)*

Comparing the results across the different target groups shows that some of the groups were more or less likely to report long-standing illnesses (see Figure 9). Concretely, respondents with physical, mental and learning disabilities reported much more often than the average that they have a long-standing illnesses or disabilities (84% vs. 61%). Hence, while members of this target group have by definition some kind of disabilities, not every respondent perceived their disability as long-standing[8].

Older people living in vulnerable and isolated circumstances (73%) and victims of domestic violence (67%) were also more likely to report long-standing illnesses, disabilities or infirmity than the average. In contrast, in-work poor (47%) and people with unstable housing situations (56%) reported fewer long-standing illnesses. Nevertheless, at least about half of the respondents in these three target groups reported to have long-term health issues.

[8] For the PAPI surveys the target group was indicated by the interviewer and not by the respondent itself, which may partly explain the difference in target group membership and reported disabilities.[9] Eurostat (2016c), '*People having a long-standing illness or health problem, by sex, age and degree of urbanisation.*' Brussels: European Commission. Available from: http://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_19.

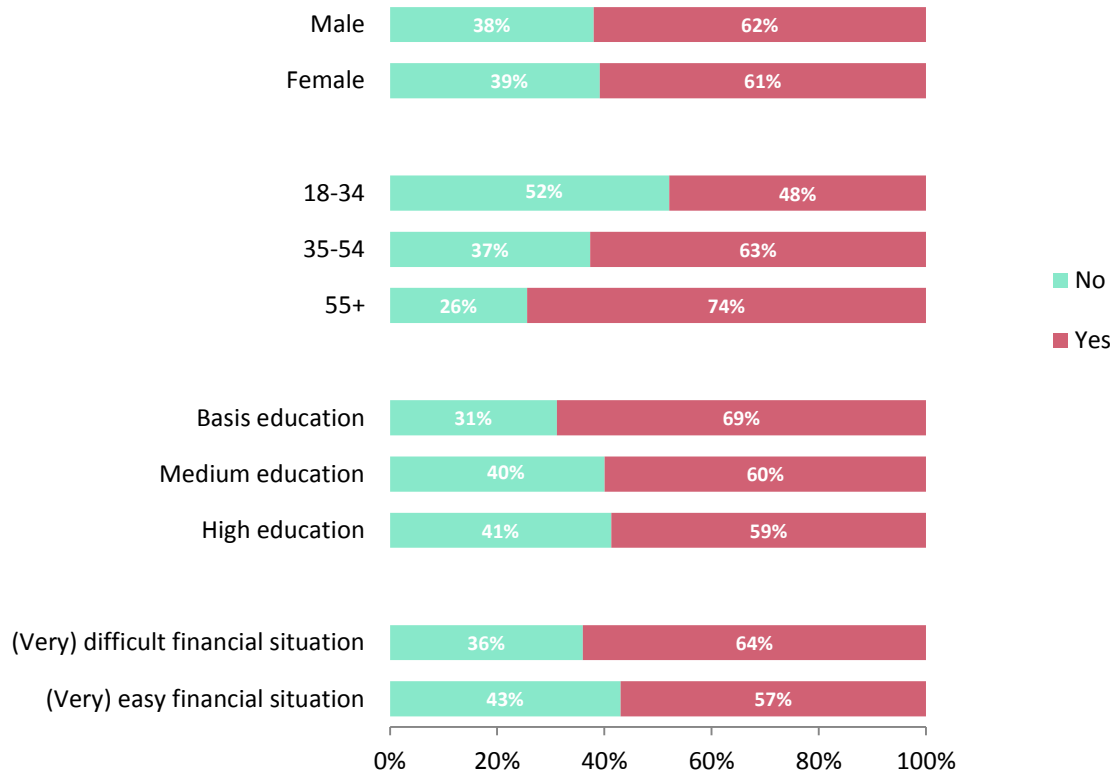
**Figure 9 Respondents with long-standing illnesses, disabilities or infirmity for target groups**




*Base: all respondents (n = 4.187)*

When considering the socio-demographic breakdown, the occurrence of long-standing illnesses, disabilities or infirmity was less common for 18 to 34 year old respondents (48%) and more common for respondent aged 55 years or older (74%) as compared to the average (61%). Education and the respondents' financial situation were also found to be related to the frequency that long-standing illnesses or infirmity were reported. Concretely, respondents with a basic education (69%) and respondents living in a difficult financial situation (64%) were more likely to report long-standing illnesses, while highly educated respondents (59%) and respondents with an easy financial situation (57%) were less likely to report long-standing illnesses.

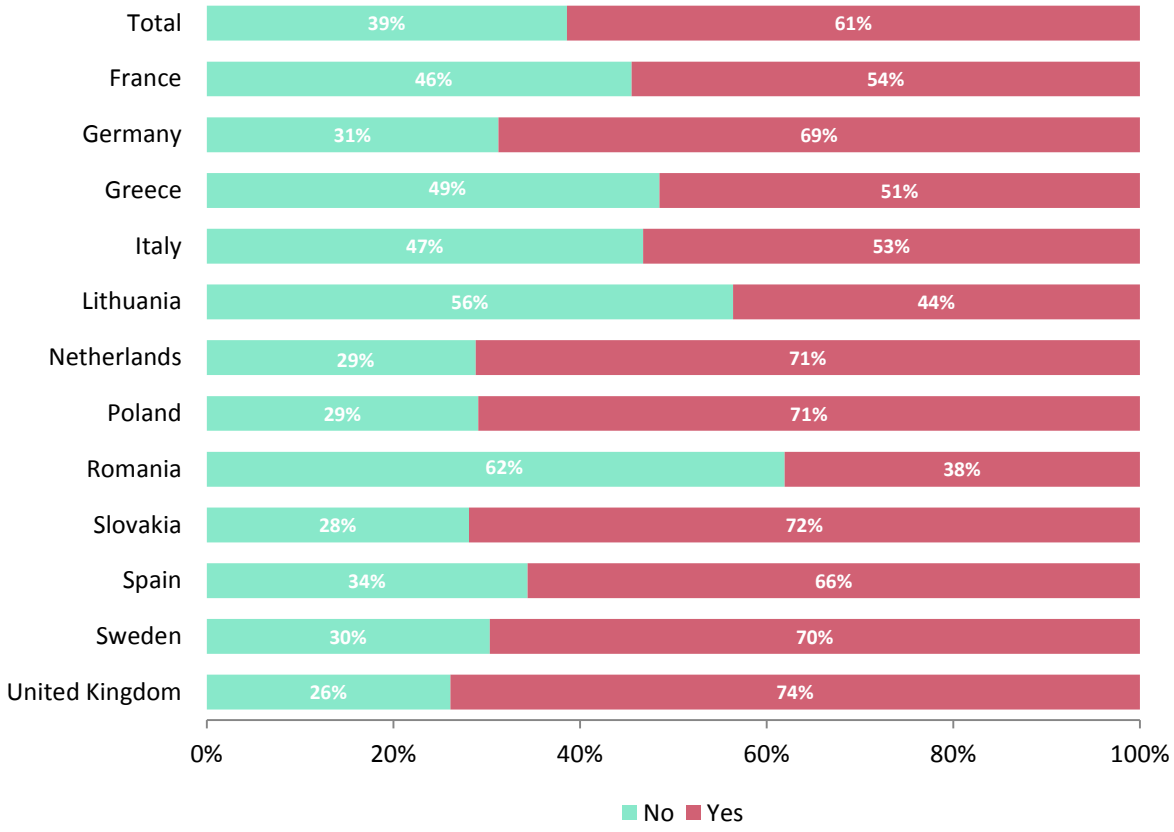
**Figure 10 Respondents with long-standing illnesses, disabilities or infirmity for socio-demographic profiles**




*Base: all respondents (n = 4.187)*

At country-level, the analyses reveal interesting differences (Figure 11). Respondents in the UK (74%), Slovakia (72%), the Netherlands, Poland (71%), Sweden (70%), Germany (69%) and Spain (66%) were significantly more likely to deal with long-standing illnesses, disabilities or infirmity. In contrast respondents from Romania (38%), Lithuania (44%), Greece (51%), Italy (53%) and France (54%) reported fewer instances of long-standing health issues.

**Figure 11 Respondents with long-standing illnesses, disabilities or infirmity per country**



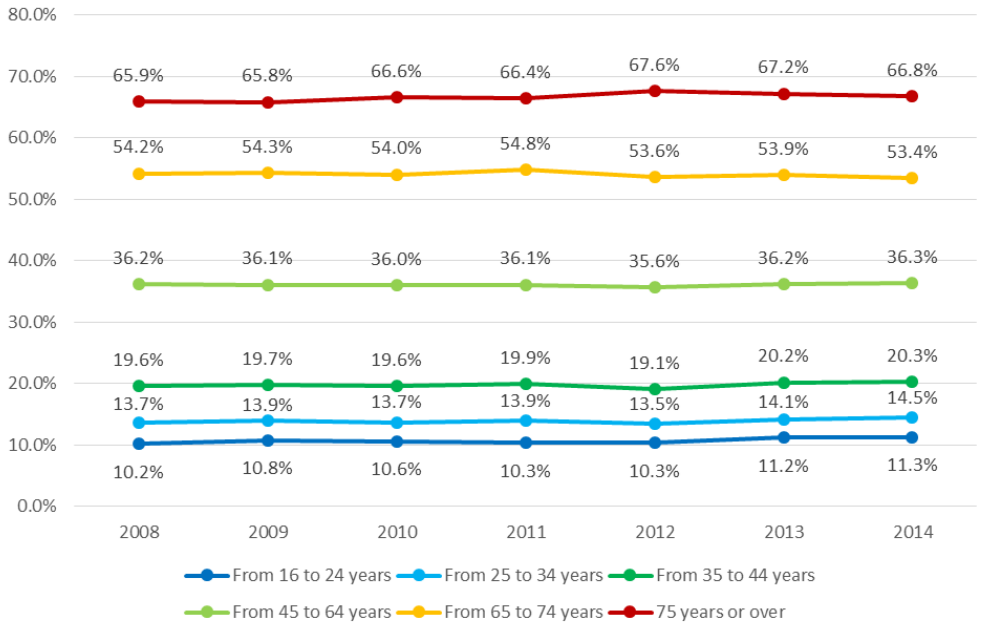

**Differences in the prevalence of health conditions: Comparisons with the general population**

Similar to the current findings, the prevalence of long-standing illness or health problems for the general EU population also differs both by age and by financial income. However, comparing the current findings with Eurostat data[9] shows that poor long-standing health conditions are much more common among people living in vulnerable circumstances. For example, in 2014, between 36% and 67% of EU-27 residents aged at least 45 years old, reported long-standing illness or health problems. In contrast, the current findings show that respondents aged 55 years or older had a 74% chance of having long-term health issues. This gap is even bigger for younger people. On EU-27 level, between 11% and 15% of people aged 16 to 34 years reported long-standing health issues. The current study indicates that 48% of the vulnerable respondents in this age bracket (18-34 years

[9] Eurostat (2016c), *'People having a long-standing illness or health problem, by sex, age and degree of urbanisation.'* Brussels: European Commission. Available from: http://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_19.

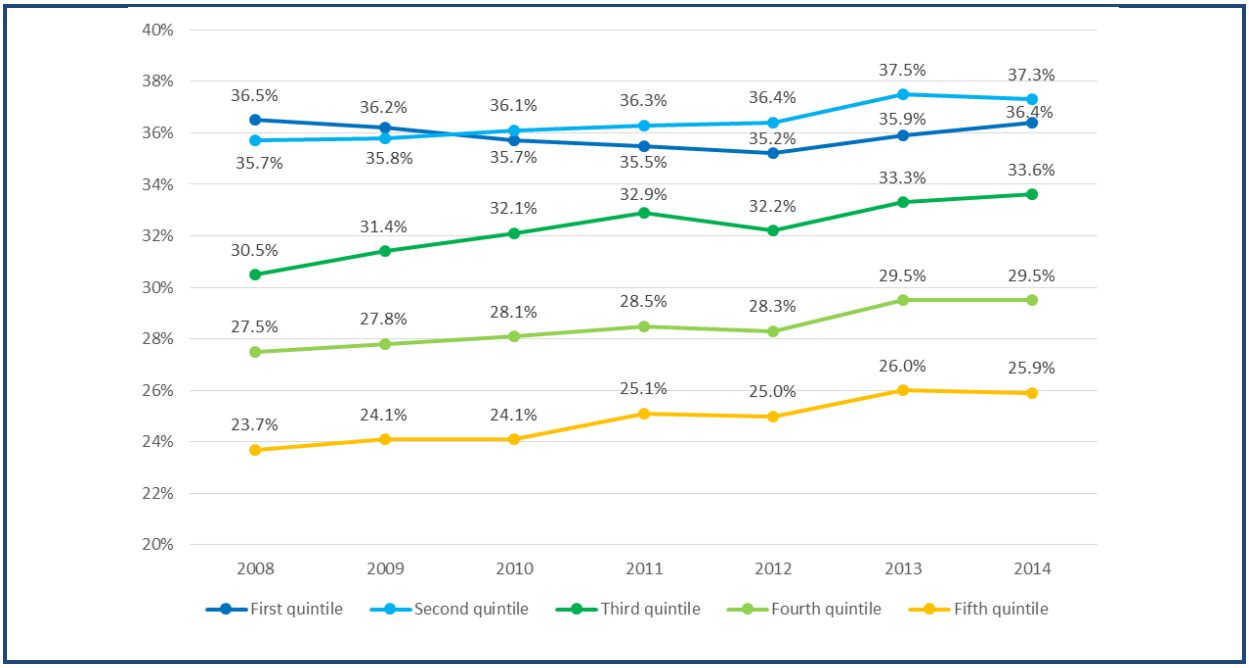
old) reported long-standing health problems.

**Figure 12 Proportion of people with long-standing illness or health problem, by age**




Similar conclusions can be drawn from comparing the findings of the current survey with the findings for EU-27 residents with different levels of wealth. The Eurostat data shows that EU-27 residents with the highest incomes (fifth quintile; 26%) have a significantly lower rate of long-standing illness or health problems than those with the lowest incomes (first and second quintiles; 36-37%). However, the findings for EU-27 residents with low incomes still look positive compared to the current findings, where 57% of the respondents in a good financial situation and 64% of respondents in a bad financial situation reported long-standing illness or health problems.

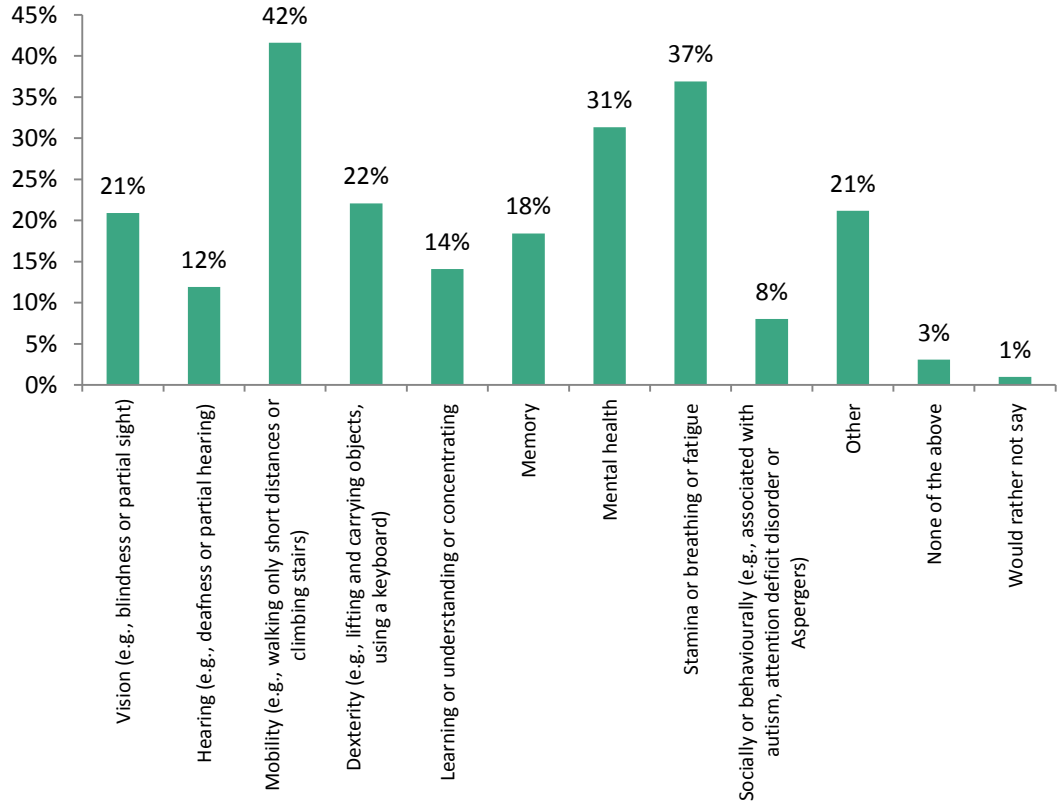
**Figure 13 Proportion of people with long-standing illness or health problem, by income quintile**




All respondents that reported long-standing illnesses, disabilities or infirmity (i.e., answered 'yes' to Question 2), were asked which areas were affected by these health issues[10]. The results, detailed in Figure 14 below, show that most long-term problem areas were related to *mobility* (e.g., walking only short distances or climbing stairs; 42%), *stamina, breathing or fatigue* (37%) or *mental health* (31%). Other problems reported linked to dexterity (22%) and *vision* (21%), and issues with *memory* (18%) were experienced by about one fifth of all respondents.

[10] Based on Question 3

**Figure 14 Specific areas affected by long-standing illnesses, disabilities or infirmity**




*Base: respondents that reported long-standing illnesses, disabilities or infirmity (Q2; n = 2.569)*

Focusing on the most prevalent problem areas, differences are observed for the different target groups (see Table 6 below). ***Mobility*** issues were more often reported by older people living in vulnerable or isolated situations than by the average respondent (56% vs. 42%). This was also the case for people with physical, mental or learning disabilities (51%). In contrast, prisoners (26%), in-work poor (31%) and people living in unstable housing situations (36%) reported fewer instances of mobility problems.

For issues with ***stamina, breathing or fatigue*** most target groups did not differ greatly. Only older people living in vulnerable or isolated circumstances (48%) and people with physical, mental or learning disabilities (40%) reported more problems than the average (37%).

The occurrence of ***mental health*** problems differed greatly across target groups. Victims of domestic violence (45%), people with physical, mental and learning disabilities (44%) and people living in unstable housing conditions (39%) were more likely than the average (31%) to report issues with mental health. In contrast, older people living in vulnerable or isolated circumstances (21%), in-work poor (23%), persons living in rural and isolated areas (25%) and members of vulnerable families (26%) were less likely to experience mental health issues.

**Table 6 Specific areas affected by long-standing illnesses, disabilities or infirmity for target groups**

| | Vision | Hearing | Mobility | Dexterity | Learning, understanding or concentrating | Memory | Mental health | Stamina, breathing or fatigue | Socially or behaviourally | Other | None of the above | Would rather not say |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **21%** | **12%** | **42%** | **22%** | **14%** | **18%** | **31%** | **37%** | **8%** | **21%** | **3%** | **1%** |
| Families who are in a vulnerable situation | 25% | 13% | 43% | 27% | 15% | 16% | 26% | 35% | 10% | 18% | 3% | 1% |
| Physical, mental and learning disabilities | 22% | 12% | 51% | 28% | 20% | 23% | 44% | 40% | 12% | 18% | 1% | 1% |
| In-work poor | 25% | 12% | 31% | 17% | 10% | 18% | 23% | 37% | 8% | 18% | 6% | 0% |
| Older people who are vulnerable/isolated | 29% | 23% | 56% | 34% | 13% | 23% | 21% | 48% | 5% | 27% | 3% | 1% |
| People with unstable housing situations | 24% | 15% | 36% | 20% | 20% | 24% | 39% | 35% | 12% | 23% | 2% | 1% |
| Prisoners | 36% | 16% | 26% | 14% | 17% | 16% | 24% | 40% | 12% | 28% | 5% | 0% |
| Persons living in rural/isolated areas | 21% | 15% | 46% | 22% | 10% | 13% | 25% | 42% | 7% | 30% | 3% | 1% |
| Long-term unemployed / inactive | 16% | 9% | 39% | 21% | 14% | 16% | 34% | 40% | 9% | 24% | 5% | 2% |
| Victims of domestic violence | 19% | 17% | 39% | 21% | 16% | 20% | 45% | 37% | 16% | 14% | 2% | 1% |

*Base: respondents that reported long-standing illnesses, disabilities or infirmity (Q2; n = 2.569)*

The socio-demographic analyses also reveal differences, as shown in Table 7. Confirming what has been found for the different target groups, the respondents' age had an effect on the prevalence of ***mobility*** problems. Older respondents (55+ years) were more likely to experience problems with mobility (55%) than middle-aged (35-54 years; 39%) or younger respondents (18-34 years, 28%).

Problems with ***stamina, breathing or fatigue*** were also reported more often by 55+ years old respondents (44%) and less often by 18 to 34 years olds (28%). Problems in this area were also more likely experienced by women (41%) than by men (32%). The financial background of respondents was also related to the occurrence of this health problem. More problems with stamina, breathing or fatigue were reported by respondents in a difficult financial situation (24%) than by respondents in a good financial situation (17%).

Problems with ***mental health*** were also affected by age. However, younger respondents (18-34 years; 37%) experienced more mental health issues than older respondents (55+ years; 24%). Moreover, people reporting mental health issues were more likely to have only a basic education (36%).

Table 8 shows the results at country-level, revealing that ***mobility problems*** were reported particularly often in France, Slovakia (both 55%), Greece (54%) and Poland (50%), while respondents in Lithuania (30%) and Spain (31%) reported the fewest mobility issues. Respondents in Greece (46%) also reported more problems with ***stamina, breathing or fatigue*** (46%). The same was found for Lithuanian (47%) and Swedish respondents (43%). In contrast, respondents from Italy reported this health issue the least often (18%).

***Mental health*** issues were reported more often in Germany, Greece (both 46%) and the United Kingdom (44%) than in the other countries. Respondents from Romania (10%), France (11%) and Italy (15%) had the least long-term mental health problems.

**Table 7 Specific areas affected by long-standing illnesses, disabilities or infirmity for socio-demographic profiles**

| | Vision | Hearing | Mobility | Dexterity | Learning, understanding or concentrating | Memory | Mental health | Stamina, breathing or fatigue | Socially or behaviourally | Other | None of the above | Would rather not say |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **21%** | **12%** | **42%** | **22%** | **14%** | **18%** | **31%** | **37%** | **8%** | **21%** | **3%** | **1%** |
| Male | 24% | 14% | 41% | 21% | 13% | 17% | 32% | 32% | 8% | 20% | 2% | 1% |
| Female | 18% | 10% | 43% | 24% | 15% | 19% | 31% | 41% | 8% | 22% | 4% | 1% |
| 18-34 | 20% | 7% | 28% | 15% | 18% | 17% | 37% | 28% | 15% | 20% | 4% | 1% |
| 35-54 | 19% | 9% | 39% | 23% | 14% | 17% | 33% | 37% | 7% | 22% | 3% | 1% |
| 55+ | 24% | 20% | 55% | 26% | 12% | 22% | 24% | 44% | 5% | 21% | 3% | 1% |
| Basis education | 25% | 16% | 42% | 21% | 18% | 22% | 36% | 34% | 7% | 24% | 2% | 1% |
| Medium education | 18% | 10% | 43% | 22% | 13% | 17% | 30% | 37% | 9% | 21% | 3% | 1% |
| High education | 24% | 13% | 39% | 22% | 12% | 18% | 29% | 38% | 8% | 20% | 4% | 1% |
| (Very) difficult financial situation | 21% | 11% | 43% | 23% | 14% | 19% | 31% | 40% | 7% | 24% | 3% | 1% |
| (Very) easy financial situation | 20% | 13% | 40% | 21% | 14% | 18% | 32% | 31% | 10% | 17% | 4% | 1% |

*Base: respondents that reported long-standing illnesses, disabilities or infirmity (Q2; n = 2.569)*

**Table 8 Specific areas affected by long-standing illnesses, disabilities or infirmity per country**

| | Vision | Hearing | Mobility | Dexterity | Learning, understanding or concentrating | Memory | Mental health | Stamina, breathing or fatigue | Socially or behaviourally | Other | None of the above | Would rather not say |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **21%** | **12%** | **42%** | **22%** | **14%** | **18%** | **31%** | **37%** | **8%** | **21%** | **3%** | **1%** |
| France | 11% | 9% | 55% | 23% | 10% | 20% | 11% | 43% | 5% | 26% | 5% | 0% |
| Germany | 24% | 9% | 41% | 22% | 12% | 12% | 46% | 37% | 7% | 20% | 3% | 0% |
| Greece | 22% | 8% | 54% | 35% | 19% | 15% | 46% | 46% | 8% | 20% | 1% | 2% |
| Italy | 21% | 16% | 37% | 18% | 10% | 9% | 15% | 18% | 2% | 32% | 0% | 1% |
| Lithuania | 39% | 17% | 30% | 22% | 12% | 24% | 26% | 47% | 6% | 13% | 4% | 1% |
| Netherlands | 15% | 9% | 38% | 21% | 16% | 16% | 30% | 33% | 13% | 20% | 2% | 0% |
| Poland | 38% | 18% | 50% | 31% | 18% | 27% | 29% | 42% | 4% | 26% | 2% | 2% |
| Romania | 23% | 17% | 35% | 11% | 11% | 16% | 10% | 39% | 1% | 22% | 2% | 6% |
| Slovakia | 27% | 11% | 55% | 35% | 7% | 20% | 25% | 36% | 3% | 29% | 1% | 0% |
| Spain | 16% | 11% | 31% | 16% | 11% | 15% | 36% | 32% | 9% | 16% | 4% | 0% |
| Sweden | 17% | 8% | 38% | 16% | 20% | 26% | 36% | 43% | 22% | 20% | 7% | 1% |
| United Kingdom | 10% | 14% | 42% | 18% | 19% | 18% | 44% | 33% | 8% | 17% | 4% | 1% |

*Base: respondents that reported long-standing illnesses, disabilities or infirmity (Q2; n = 2.569)*

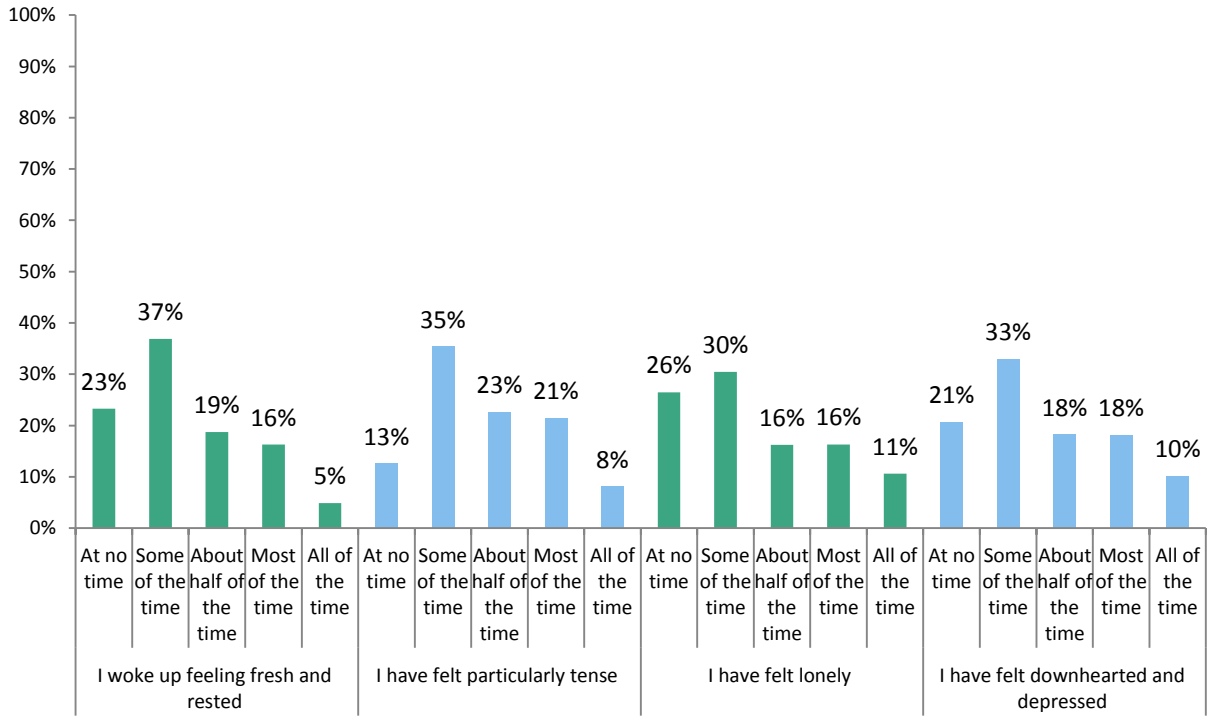
Problems with mental health are among the top three reasons for long-term illnesses or disabilities. The survey looked closer at the role of different ***types of psychological stress*** by asking all respondents about their experience with four particular aspects of psychological problems[11]:

- Waking up fresh and rested (healthy)
- Feeling particularly tense (unhealthy)
- Feeling lonely (unhealthy)
- Feeling downhearted and depressed (unhealthy)

***Waking up fresh and rested***, an indication of feeling healthy, was experienced by only 21% of all respondents most or all of the time. In contrast, 23% of the respondents never woke up fresh and rested and 37% did so only some of the time.

The results also show that the negative aspects occurred relatively often. While 48% of respondents felt never or only some of the time ***particularly tense***, 56% felt never or only sometimes ***lonely*** and 54% felt never or only sometimes ***downhearted and depressed***, a significant proportion of respondents still experienced these issues most or all of the time. Concretely, 29% of respondents felt particularly tense, 27% felt lonely and 28% felt downhearted and depressed most or all of the time.

**Figure 15 Aspects related to feeling healthy/unhealthy**




*Base: all respondents (n = 4.187)*

[11] Based on Question 12

There are certain differences regarding these four aspects between the different target groups. As illustrated in Table 9 below, members of vulnerable families, people with unstable housing situations and victims of domestic violence were more likely to feel particularly tense (respectively 38%, 39% & 41%), lonely (respectively 32%, 40% & 39% vs. 27%) and downhearted or depressed (respectively 35%, 39% & 44%). Also, respondents with physical, mental and learning disabilities (32%) felt significantly more often downhearted and depressed. Waking up fresh and rested was reported to happen less frequently for in-work poor respondents (17%) and for persons living in rural/isolated areas (15%). In contrast, feelings of depression were much less common for prisoners (16%) and loneliness occurs less frequently for the in-work poor (23%).

**Table 9 Aspect of feeling healthy/unhealthy ('most of the time' & 'all of the time') for target groups**

| | I woke up feeling fresh and rested | I have felt particularly tense | I have felt lonely | I have felt downhearted and depressed |
|---|---|---|---|---|
| **Total** | **21%** | **30%** | **27%** | **28%** |
| Families who are in a vulnerable situation | 19% | 38% | 32% | 35% |
| Physical, mental and learning disabilities | 21% | 30% | 27% | 32% |
| In-work poor | 17% | 30% | 23% | 26% |
| Older people who are vulnerable/isolated | 19% | 26% | 31% | 24% |
| People with unstable housing situations | 18% | 39% | 40% | 39% |
| Prisoners | 29% | 25% | 26% | 16% |
| Persons living in rural/isolated areas | 15% | 33% | 29% | 30% |
| Long-term unemployed / inactive | 21% | 29% | 27% | 31% |
| Victims of domestic violence | 17% | 41% | 39% | 44% |

*Base: all respondents (n = 4.187)*

Socio-demographic analyses also reveal a number of differences (see Table 10 below). As such, men were more likely to wake up feeling fresh and rested most or all of the time (24% vs. 21%), while they were less likely to feel particularly tense (27% vs; 30%). For

women, the opposite was true: they were less likely to wake up fresh and rested (19%) and more likely to feel particularly tense (31%).

Young respondents (18 -34 years old) were more likely to wake up fresh and rested (24% vs. 21%), while 35 to 54 year olds were less likely to experience this (19%). The latter group was, in contrast, more likely to feel particularly tense (32% vs. 30%) and to be downhearted and depressed (30% vs. 28%). In contrast, older respondents (55+ years) were less likely to feel particularly tense (24%) or downhearted and depressed (25%).

It is quite noticeable that respondents with a low education background (i.e., having only a basic education) were more likely than the average respondent to experience all three negative aspects at least most of the time. They were more tense (33%), felt more lonely (34%) and felt more downhearted and depressed (33%). In contrast, highly educated respondents were less likely to feel lonely (24%) or downhearted and depressed (26%), and respondents with a medium education-level were less likely to feel particular tense (28%) than the average.

The financial situation of respondents also had an impact on how likely the respondents experienced the listed aspects most or all of the time. Concretely, respondents in difficult financial situations were less likely than respondents in an easy financial situation to wake up fresh and rested at least most of the time (16% vs. 30%), but more likely to feel particularly tense (35% vs. 21%), lonely (32% vs. 18%) and downhearted/depressed (33% vs. 20%).

**Table 10 Aspect of feeling healthy/unhealthy ('most of the time' & 'all of the time') for socio-demographic profiles**

| | I woke up feeling fresh and rested | I have felt particularly tense | I have felt lonely | I have felt downhearted and depressed |
|---|---|---|---|---|
| **Total** | **21%** | **30%** | **27%** | **28%** |
| Male | 24% | 27% | 27% | 29% |
| Female | 19% | 31% | 26% | 28% |
| 18-34 | 24% | 31% | 27% | 28% |
| 35-54 | 19% | 32% | 27% | 30% |
| 55+ | 21% | 24% | 25% | 25% |
| Basis education | 21% | 33% | 34% | 33% |
| Medium education | 21% | 28% | 26% | 28% |
| High education | 22% | 29% | 24% | 26% |

| | | | | |
|---|---|---|---|---|
| (Very) difficult financial situation | 16% | 35% | 32% | 33% |
| (Very) easy financial situation | 30% | 21% | 18% | 20% |

*Base: all respondents (n = 4.187)*

The country results (Table 11) show that respondents from Slovakia experience consistently fewer aspects of psychological stress. As such, they report fewer instances of feeling particularly tense (21%), lonely (15%) and depressed (19%) than the overall average. Somewhat similarly, Romanian respondents also were less likely to feel lonely (21%) and depressed (15%) and more likely to wake up fresh and rested (31%) than the average, while Polish respondents felt less depressed (21%) than the average.

In contrast, respondents in the United Kingdom (13%), France and Germany (both 17%) were less likely to wake up fresh and rested. For the UK, this is combined with more tense feelings and depression (respectively 35% and 38%), while in France, respondents felt significantly more lonely. In Spain, depression was experienced somewhat more often than the average (32%).

A particularly interesting country in terms of the results for signs of psychological stress is Greece. Greek respondents reported both that they were more likely to wake up fresh and rested than average (28%), but also reported more instances of feeling particularly tense (39%) and depressed (34%).

**Table 11 Aspect of feeling healthy/unhealthy ('most of the time' & 'all of the time') per country**

| | I woke up feeling fresh and rested | I have felt particularly tense | I have felt lonely | I have felt downhearted and depressed |
|---|---|---|---|---|
| **Total** | **21%** | **30%** | **27%** | **28%** |
| France | **17%** | 31% | **36%** | 27% |
| Germany | **17%** | 32% | 30% | 31% |
| Greece | **28%** | **39%** | 31% | **34%** |
| Italy | 21% | 28% | 29% | 25% |
| Lithuania | 21% | 28% | 26% | 28% |
| Netherlands | 21% | 31% | 27% | 29% |
| Poland | 24% | 26% | 25% | **21%** |
| Romania | **31%** | 25% | **21%** | **15%** |
| Slovakia | 24% | **21%** | **15%** | **19%** |

| | | | | |
|---|---|---|---|---|
| Spain | 23% | 30% | 26% | **32%** |
| Sweden | 18% | 26% | 26% | 32% |
| United Kingdom | **13%** | **35%** | 29% | **38%** |

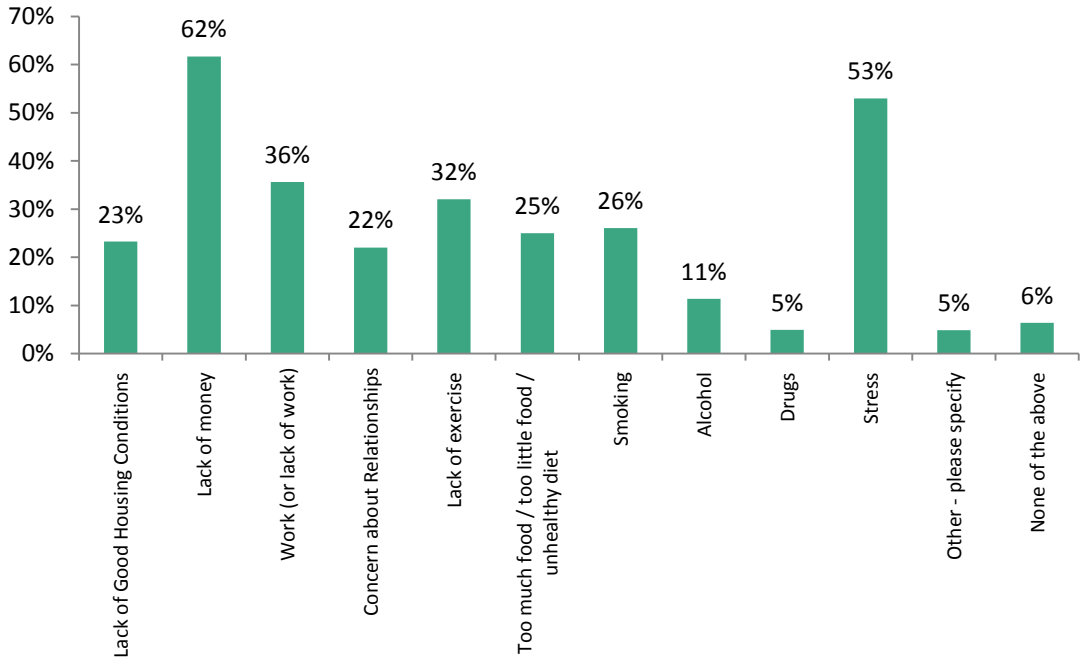
*Base: all respondents (n = 4.187)*

## 3.2 Factors that affect people's health

People's health can be affected by different factors[12]. Identifying factors that affect the health of vulnerable and isolated people can help develop evidence-based strategies and policies to improve their health. This sub-section provides an analysis of things that may create barriers to the health of vulnerable and isolated people.

The findings illustrated in Figure 16 show that more than half of respondents reported that the lack of money (62%) and feelings of stress (53%) create barriers to their health. Regarding the use of harmful substances, smoking (26%) was reported most often, much more so than alcohol (11%) and drugs (4%). Other relevant factors also included work-related factors (i.e., work or the lack of work; 36%), the lack of exercise (32%), food-related factors (i.e., too much, too little food, or too much unhealthy food; 25%), concerns about relationships (22%) and the lack of good housing conditions (23%).

**Figure 16 Factors that affect people's health**




*Base: all respondents (n = 4.187)*

[12] Based on Question 11

While the ***lack of money*** was the most commonly reported factor affecting respondents' health, this was not the case for all respondents. As such, the findings reveal interesting differences between the included target groups (Table 12).

The findings for the different target groups illustrate that the lack of money played a greater role for the in-work poor (72%), people living in an unstable housing situation (71%), members of vulnerable families (68%) and long-term unemployed or inactive people (66%). In contrast, the lack of money had a lower impact on the health of the surveyed prisoners (41%) and people with physical, mental or learning disabilities (57%). For prisoners, the lack of money was 'only' the third most mentioned factor, after smoking (55%) and stress (54%).

***'Feelings of stress'*** was the second most prevalent factor for most respondents and this is the case across all target groups. However, victims of domestic violence (62%), members of vulnerable families (59%) and people with an unstable housing situation (58%) were relatively more likely to report feelings of stress as being detrimental for their health. In contrast, the health of vulnerable and/or isolated older people was less affected by feelings of stress (40%).

**Table 12 Factors that affect people's health for target groups**

| | Lack of Good Housing Conditions | Lack of money | Work (or lack of work) | Concern about Relationships | Lack of exercise | Food/Diet - related | Smoking | Alcohol | Drugs | Stress | Other | None of the above |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **23%** | **62%** | **36%** | **22%** | **32%** | **25%** | **26%** | **11%** | **5%** | **53%** | **5%** | **6%** |
| Families who are in a vulnerable situation | 28% | 68% | 39% | 27% | 33% | 26% | 31% | 12% | 5% | 59% | 7% | 3% |
| Physical, mental and learning disabilities | 20% | 57% | 31% | 24% | 37% | 25% | 25% | 10% | 4% | 55% | 8% | 7% |
| In-work poor | 23% | 72% | 37% | 23% | 34% | 31% | 27% | 14% | 4% | 56% | 1% | 4% |
| Older people who are vulnerable/isolated | 23% | 63% | 17% | 17% | 29% | 19% | 22% | 7% | 1% | 40% | 10% | 6% |
| People with unstable housing situations | 53% | 71% | 45% | 27% | 27% | 29% | 35% | 18% | 9% | 58% | 2% | 5% |
| Prisoners | 34% | 41% | 24% | 20% | 38% | 26% | 55% | 28% | 16% | 54% | 2% | 4% |
| Persons living in rural/isolated areas | 29% | 67% | 39% | 27% | 33% | 29% | 29% | 14% | 6% | 51% | 14% | 5% |
| Long-term unemployed / inactive | 23% | 66% | 49% | 24% | 36% | 29% | 25% | 12% | 5% | 54% | 7% | 6% |
| Victims of domestic violence | 30% | 66% | 34% | 37% | 37% | 31% | 34% | 18% | 12% | 62% | 4% | 6% |

*Base: all respondents (n = 4.187)*

The impact of these two factors (lack of money and stress) also differed among the socio-demographic profiles (Table 13) and between countries (Table 14).

Looking at the socio-demographic breakdown (Table 13), it is not very surprising that the ***lack of money*** especially affected the health of respondents in a difficult financial situation (78%), compared to respondents in an easy financial situation (35%). For the latter, feelings of stress (46%) had a greater impact than the lack of money. In addition, the lack of money was also more prevalent for respondents with only a basic education (67% vs. 62% average) and by middle-aged respondents (35-54 years; 64% vs. 62%). In contrast, younger respondents (18-34 years; 57%) reported money issues less often than average.

At the country-level, the findings show that the lack of money was reported particularly often as a factor affecting respondents' health in Greece (73%), France (72%), Lithuania (71%) and Germany (68%). In contrast, respondents in Slovakia, Romania (both 50%) and Poland (55%) reported this factor relatively less often. However, still at least half of the respondents in all countries mention the lack of money as a factor affecting their health, which makes this one of the two main factors in all countries.

The second most important factor was ***stress***. The socio-demographic analysis shows that stress was a greater driver for health problems for women than for men (57% vs. 48%). Also, consistent with the findings for vulnerable and isolated people, respondents older than 55 years were less likely to experience feelings of stress (38%) than younger and middle-aged respondents (18-34 years: 60%; 35-54 years: 58%). Education and financial background was found to also play a role in factors that affect people's health. For the health of respondents with only a basis education, stress played a smaller role, than for the health of respondents with a high education (57%). In contrast, people living in a difficult financial situation were more likely to report feelings of stress as a health-impacting factor (57%) than people living in an easy financial situation (46%). Nevertheless, as reported earlier, stress was the most-reported factor for financially secure respondents.

Country-level analyses show that stress is a particularly prevalent factor in Greece (72%), the UK (65%), Romania (59%) and Lithuania (58%). In contrast, in Slovakia (28%) only about half the number of respondents (as compared to the average) report stress as a reason for their health problems. Respondents in the Netherlands (44%) and in Sweden (45%) were also less likely to report stress as a factor affecting their health.

**Table 13 Factors that affect people's health for socio-demographic profiles**

| | Lack of Good Housing Conditions | Lack of money | Work (or lack of work) | Concern about Relationships | Lack of exercise | Food/Diet - related | Smoking | Alcohol | Drugs | Stress | Other | None of the above |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **23%** | **62%** | **36%** | **22%** | **32%** | **25%** | **26%** | **11%** | **5%** | **53%** | **5%** | **6%** |
| Male | 25% | 61% | 37% | 22% | 32% | 24% | 31% | 16% | 6% | 48% | 4% | 6% |
| Female | 21% | 63% | 34% | 22% | 32% | 26% | 21% | 7% | 4% | 57% | 6% | 6% |
| 18-34 | 27% | 57% | 39% | 26% | 33% | 28% | 25% | 13% | 7% | 60% | 3% | 6% |
| 35-54 | 24% | 64% | 40% | 24% | 33% | 27% | 30% | 12% | 5% | 58% | 4% | 5% |
| 55+ | 18% | 63% | 25% | 15% | 29% | 18% | 22% | 9% | 1% | 38% | 7% | 8% |
| Basis education | 31% | 67% | 32% | 20% | 24% | 22% | 30% | 14% | 7% | 44% | 7% | 5% |
| Medium education | 21% | 61% | 36% | 22% | 32% | 25% | 27% | 11% | 5% | 54% | 4% | 7% |
| High education | 21% | 59% | 37% | 23% | 37% | 27% | 22% | 10% | 4% | 57% | 5% | 8% |
| (Very) difficult financial situation | 29% | 78% | 41% | 23% | 31% | 27% | 29% | 12% | 5% | 57% | 5% | 3% |
| (Very) easy financial situation | 15% | 35% | 27% | 20% | 33% | 23% | 21% | 10% | 5% | 46% | 5% | 13% |

*Base: all respondents (n = 4.187)*

**Table 14 Factors that affect people's health per country**

| | Lack of Good Housing Conditions | Lack of money | Work (or lack of work) | Concern about Relationships | Lack of exercise | Too much food / too little food / unhealthy diet | Smoking | Alcohol | Drugs | Stress | Other - please specify | None of the above |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **23%** | **62%** | **36%** | **22%** | **32%** | **25%** | **26%** | **11%** | **5%** | **53%** | **5%** | **6%** |
| France | 20% | 72% | 41% | 20% | 32% | 33% | 20% | 7% | 2% | 49% | 4% | 6% |
| Germany | 24% | 68% | 34% | 31% | 39% | 29% | 37% | 19% | 10% | 51% | 2% | 6% |
| Greece | 31% | 73% | 52% | 26% | 36% | 32% | 33% | 8% | 3% | 72% | 10% | 3% |
| Italy | 34% | 57% | 53% | 26% | 31% | 19% | 25% | 10% | 4% | 54% | 3% | 3% |
| Lithuania | 28% | 71% | 35% | 20% | 30% | 32% | 25% | 15% | 2% | 58% | 1% | 5% |
| Netherlands | 18% | 60% | 32% | 29% | 29% | 24% | 25% | 10% | 7% | 44% | 5% | 9% |
| Poland | 24% | 55% | 25% | 16% | 29% | 19% | 33% | 12% | 5% | 56% | 2% | 5% |
| Romania | 16% | 50% | 19% | 4% | 23% | 19% | 23% | 8% | 4% | 59% | 1% | 4% |
| Slovakia | 17% | 50% | 23% | 8% | 14% | 10% | 15% | 4% | 1% | 28% | 10% | 15% |
| Spain | 20% | 59% | 42% | 23% | 37% | 18% | 31% | 13% | 7% | 53% | 3% | 6% |
| Sweden | 22% | 62% | 37% | 32% | 40% | 30% | 20% | 11% | 3% | 45% | 9% | 8% |
| United Kingdom | 25% | 61% | 31% | 25% | 38% | 33% | 26% | 15% | 9% | 65% | 8% | 7% |

*Base: all respondents (n = 4.187)*

## 3.3 Summary

This chapter looked at the health situation of vulnerable and isolated people. This includes both looking at the current health and potential health-related problem areas, as well as looking at factors that are likely to impact the health of vulnerable and isolated people.

The findings of this survey suggest that vulnerable and isolated people ***experience considerable health problems.*** Concretely, only about one third of the respondents (31%) reported a good or very good health, while a large share of respondents reported a fair health (41%) or even a bad or very bad health (28%). Moreover, 61% of all respondents also dealt with long-standing illnesses, disabilities or infirmity. Hence, the current results not only show that a considerable proportion of people from the target group dealt with at least some health issues, but that the majority of respondents experienced health problems over a longer period of time.

Focusing on respondents with long-standing health issues, the survey also provides insights into the specific ***areas affected by health problems***. Almost half of the respondents experienced problems with their mobility (42%), while a sizeable proportion also experienced stamina, breathing or fatigue issues (37%) or mental health problems (31%). Additionally, problems with dexterity (22%), vision (21%) and memory (18%) were, however, also found to be quite common.

The severity of health problems among this target group was further investigated by looking at ***signs of psychological stress***. Up to half of all the survey respondents felt particularly tense (52%), lonely (43%) and depressed (46%) at least half of the time, while 60% of the respondents did wake up fresh and rested only sometimes or never. As such, the results suggest that people living in vulnerable and/or isolated situations may not only have a significant amount of physical health problems, but are also quite likely to deal with psychological issues.

To better understand the health situation of the target group, the current survey also provided first insights into ***factors that create barriers for a good health*** of the respondents (i.e., factors that affect respondents' health). The findings show that more than half of all respondents reported the lack of money (62%) and feelings of stress (53%) as a barrier to their health.

The findings also provide interesting insights for the different ***target groups*** of vulnerable and isolated people. First, the ***health situation*** is more severe for some target groups than for others. The target groups of *people with physical, mental and learning disabilities* (39%), *vulnerable and/or isolated older people* (38%), *victims of domestic violence* (33%) and *long-term unemployed* (31%) were more likely to report a (very) bad health than the average respondent (28%). Similarly, *disabled people* (84%), *vulnerable elderly* (73%) and *victims of domestic violence* (67%) also reported more instances of long-standing health issues.

As reported above, problems with *mobility*, *stamina, breathing and fatigue*, and *mental health* issues were the three most common ***long-term health issues***, The magnitude of these problems differed, however, across the different target groups. Problems with mobility and with stamina, breathing or fatigue were most common for the *vulnerable*

*and isolated elderly* (respectively 56% & 48% experienced these problems) and *people with disabilities* (respectively 51% & 40%). Mental health issues were reported most often by *victims of domestic violence* (45%), followed by *people with disabilities* (44%) and *people living in unstable housing situations* (39%).

The results for the ***feelings of psychological stress*** were also reported more often by the target groups that experienced more mental health problems. *Victims of domestic violence* and *people living in unstable housing situations*, but also *members of vulnerable families* are more likely to feel particularly tense (respectively 41%, 39% & 38%), lonely (respectively 39%, 40% & 32%) and depressed (respectively 44%, 39% & 35%). People with disabilities (32%) also more often depressed than average. *Persons living in rural and isolated areas* (15%) and the *in-work poor* (17%) were the least likely to wake up feeling fresh and rested.

The target groups also differed in the degree that the lack of money and stress formed ***barriers to their health***. In particular, the lack of money was reported most often by the *in-work poor* (72%), *people living in an unstable housing situation* (71%), *members of vulnerable families* (68%) and *long-term unemployed* (66%). Stress, in contrast, is most often mentioned by *victims of domestic violence* (62%), followed by *members of vulnerable families* (59%) and *people living in unstable housing situations* (58%). The findings for stress are consistent with the findings for the psychological stress factors, reported in the previous paragraph.

***Socio-demographic breakdowns*** revealed that the results also differed between socio-demographic profiles. First, ***health issues*** were more prevalent for older respondents (55+ years), respondents with only a basis education and respondents in a difficult financial situation. In particular, 55+ year olds (37%), low-educated respondents (37%) and respondents in a difficult financial situation (36%) were more likely to report a (very) bad health than the average (28%). The same is also the case for long-standing illnesses, disabilities and infirmity (respectively 74%, 69% & 64%).

The occurrence of problems with mobility, stamina, breathing or fatigue issues and mental health problems for respondents ***with long-term health issues*** also differed across the socio-demographic profiles. Mobility issues were most common for older respondents (55%), who report this problem more often than middle-aged and younger respondents (18-34 years: 28%; 35-54 years: 39%). Stamina, breathing or fatigue problems were more common for women (41%), for older respondents (44%) and for respondents with a difficult financial background (40%). In contrast, mental health problems were most common for young respondents (18-34 years: 37%) and for respondents with only a basis education (36%).

It is noticeable that the education of the respondents and their financial situation was also related to ***feelings of psychological stress***. Concretely, respondents with only a basic education and respondents in a difficult financial situation were most likely to feel particularly tense (respectively 33% & 35%), lonely (respectively 34% & 32%) and depressed (respectively 33% & 33%). In addition, middle-aged respondents (35-54 years old) felt more than average particularly tense (32% and depressed (30%), while they were less likely to wake up fresh and rested (19%), Women also felt more tense (31%) and were less likely to wake up rested (19%).

Finally, socio-demographic analyses looked at differences for the two most common ***barriers for a good health.*** The lack of money was most often mentioned by respondents in a difficult financial situation (78%), followed by respondents with only a basic education (67%) and 35-54 year olds (64%). Stress was also mentioned more often by respondents in a bad financial situation (57%). In addition, women (57%) and respondents under 55 years (18-34 years: 60%, 35-54 years: 58%) also saw stress more often as a barrier to their health. Moreover, compared to the lack of money, a reversed relationship between feelings of stress and the level of education was observed. Highly-educated respondents were more likely to report stress as a barrier to their health than low-educated respondents (57% vs. 44%).

***Country-level breakdowns*** reveal a number of interesting differences between the results of the 12 surveyed countries. It is important to note however, that country-level findings may be caused by a different sample composition in each country. Certain target groups are represented more often in some countries than in others.

Respondents in the UK (respectively 34% and 74%) and Sweden (respectively 36% and 70%) were more likely to report both a bad ***health situation and long-term health issues*** than the average respondent (respectively 28% and 61%). In addition, French respondents (41%) also reported a relatively worse health situation than the average and respondents from Slovakia (72%), the Netherlands (71%), Poland (71%), Germany (69%) and Spain (66%) also dealt more often with long-standing health issues.

The ***specific health problems*** that the respondents of this survey experienced also differed across the countries. Focusing on the three biggest health issues, *mobility issues* were more common in France (55%), Slovakia (55%), Greece (54%) and Poland (50%), *problems with stamina, fatigue and breathing* occurred more often in Lithuania (47%), Greece (46%) and Sweden (43%) and *mental health issues* were reported most often by German and Greek respondents (both 46%). It is noticeable that all three main health problems occurred consistently often in Greece. When looking closer at aspects of ***psychological stress***, it became apparent that respondents from the UK were most likely to feel particularly tense (35% felt this way) and depressed (38%), while they were the least likely to wake up feeling fresh and rested (only 13%).

Finally, two main factors were identified that affect the respondents' health: the lack of money and stress. Greek (respectively 73% and 72%) and Lithuanian respondents (respectively 71% and 58%) were among the respondents that reported both factors relatively often. In addition, respondents from France (72%)and Germany (68%) were more often affected by the lack of money, while respondents from the UK (65%) and Romania (59%) experienced problems with stress most often.

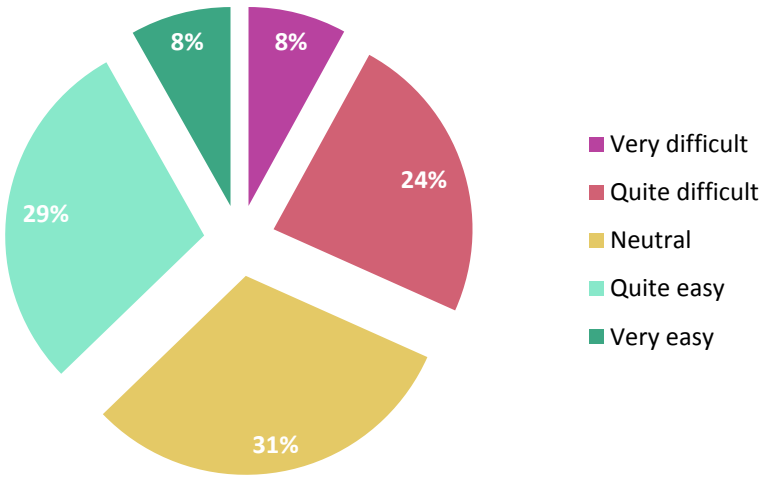
# 4 Access to healthcare

After assessing the current health situation of vulnerable and isolated people, the current survey also studies their access to healthcare. This chapter consists of two parts: a first part looks at the general ease with which people can access healthcare and a second part takes a closer look at the factors that may pose problems to the healthcare access.

## 4.1 Ease of accessing healthcare

The results, illustrated in Figure 15, show that a considerable proportion of the respondents had experienced problems with accessing the healthcare they need[13]. About one third of respondents experienced at least some problems with accessing healthcare (respectively 24% and 8% found accessing healthcare 'quite' and 'very' difficult). This was more or less equal to the proportion of respondents that found accessing healthcare quite or very easy (37%). Lastly, 31% of the respondents had a neutral attitude.

**Figure 17 Ease of accessing healthcare**



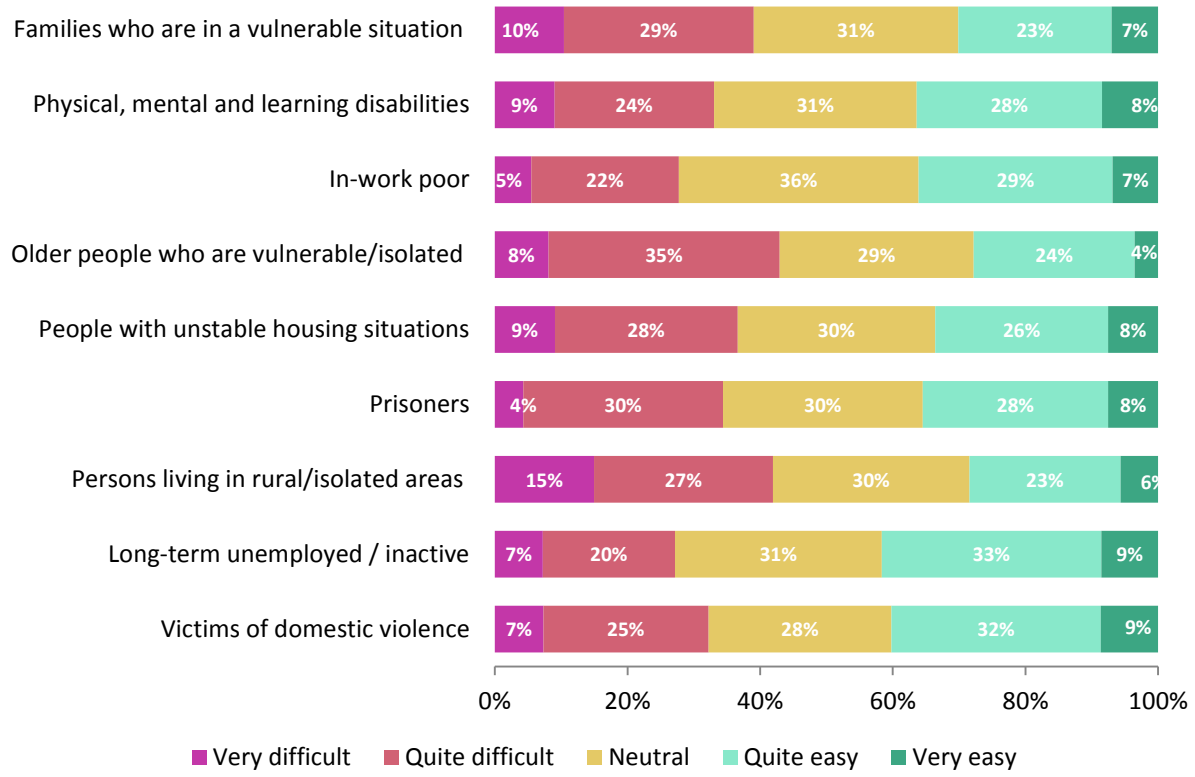

*Base: all respondents (n = 4.187)*

The ease with which respondents could obtain healthcare differed slightly across the surveyed target groups (Figure 18). For example, members of vulnerable families found it slightly more difficult to access healthcare: 39% (vs. 32% average) found it very or quite difficult, while 23% (vs. 29% average) found it quite easy. The same is true for people living in rural or isolated areas (15% vs. 8% found it 'very difficult'; 23% vs. 29% found it 'quite easy') and older respondents in vulnerable and/or isolated situations (35% vs. 24% found it 'quite difficult' and 4% vs. 8% found it 'very easy'.

[13] Based on Question 4

In contrast, long-term unemployed or inactive respondents found accessing healthcare slightly easier: fewer respondents in this group had difficulties accessing healthcare (20% instead of 24% found it 'quite difficult') and more of these respondents found accessing healthcare ('quite') easy (33% vs. 29%). Similarly, fewer in-work poor respondents found accessing healthcare ('very') difficult (5% vs. 8%) and more of them felt neutral about this (36% vs. 31%).

**Figure 18 Ease of accessing healthcare for target groups**




*Base: all respondents (n = 4.187)*

The ease of accessing healthcare was shown to be at least partly related to the socio-demographic characteristics of the respondents. The socio-demographic breakdown in Table 15 shows that men found it slightly easier to access healthcare than women. Concretely, men were more likely to find it very easy (9% vs. 7%), while they were less likely to find it very difficult (7% vs. 9) to access healthcare than women.

Respondents' education and financial background were also related to the ease with which they can access healthcare. In particular, respondents with a basic education found it more difficult to access healthcare (46% found it very or quite difficult) than average (32%), while the opposite was true for respondents with a medium education (28% vs. 32%) and with a high education (27% vs. 32%). In contrast, medium-educated respondents found it more often quite easy than average (31% vs. 29%), while highly-educated respondents found it more often very easy (10% vs. 8%).

Similarly, respondents in a difficult financial situation found it more difficult (very or quite difficult: 39% vs. 19%) and less easy (quite or very easy: 29% vs. 52%) than respondents in an easy financial situation.

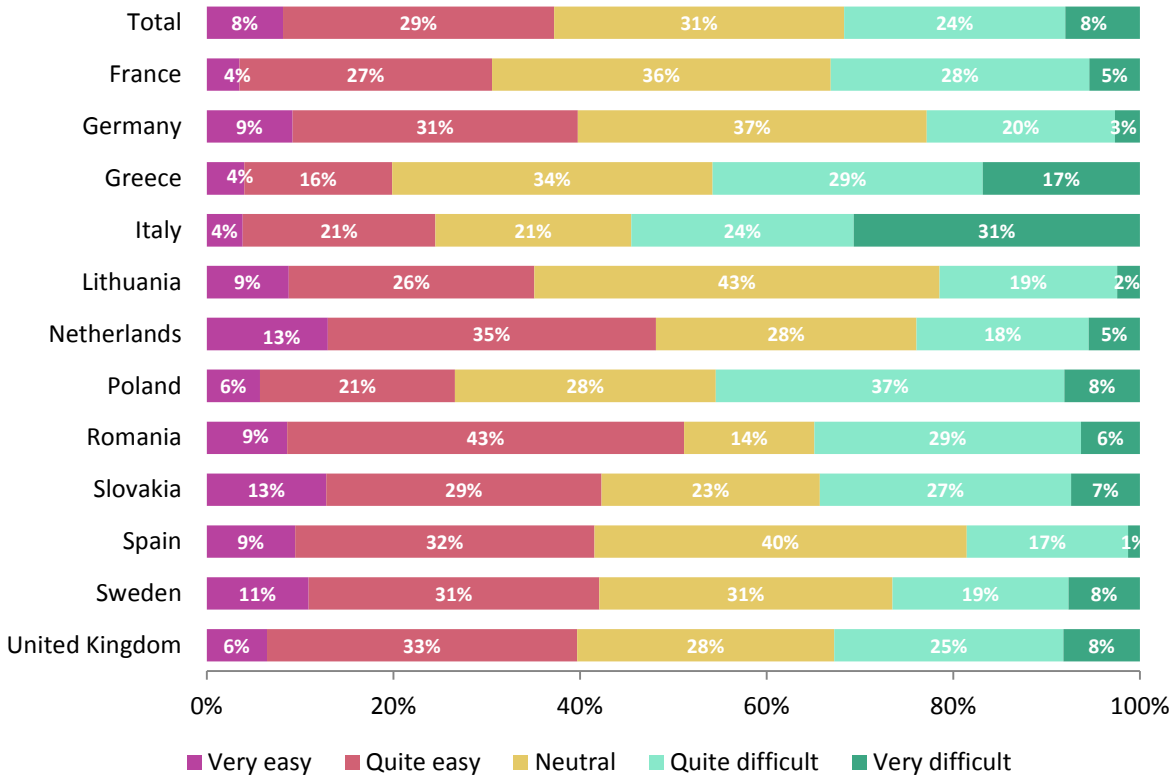
**Table 15 Ease of accessing healthcare for socio-demographic profiles**

| | Very difficult | Quite difficult | Neutral | Quite easy | Very easy |
|---|---|---|---|---|---|
| **Total** | **8%** | **24%** | **31%** | **29%** | **8%** |
| Male | 7% | 22% | 31% | 30% | 9% |
| Female | 9% | 25% | 31% | 28% | 7% |
| 18-34 | 8% | 22% | 32% | 28% | 10% |
| 35-54 | 8% | 23% | 33% | 29% | 7% |
| 55+ | 8% | 27% | 28% | 30% | 8% |
| Basis education | 14% | 32% | 23% | 22% | 9% |
| Medium education | 6% | 22% | 33% | 31% | 7% |
| High education | 6% | 21% | 33% | 31% | 10% |
| (Very) difficult financial situation | 11% | 28% | 32% | 24% | 5% |
| (Very) easy financial situation | 3% | 16% | 29% | 38% | 13% |

*Base: all respondents (n = 4.187)*

The ease of accessing healthcare also differed across countries (Figure 19). As such, respondents found accessing healthcare significantly more difficult in Italy (55% found it 'quite difficult' and 'very difficult'), Greece (46%), Poland (45%) and Romania (35%) than the average (32%). In contrast, respondents from Romania (52%), the Netherlands (48%), Slovakia (42%) and Sweden (42%) found accessing healthcare easier (i.e., 'quite easy' and 'very easy') than average (37%).

**Figure 19 Ease of accessing healthcare per country**




*Base: all respondents (n = 4.187)*

The ease of accessing healthcare is ***related to the respondents' general health situation***[14], as is confirmed by the results illustrated in Table 16. Respondents with a bad or very bad health were significantly more likely to find it more ('very' or 'quite') difficult (40%) to get healthcare than respondents with a (very) good health (19%). In contrast, respondents with a (very) good health found it ('quite' or 'very) easier to access healthcare (56%) than respondents with a (very) bad health (22%).

**Table 16 The effect of the general health situation on the ease of accessing health care**

| | | Ease of accessing health care | | | | |
|---|---|---|---|---|---|---|
| | | **Very difficult** | **Quite difficult** | **Neutral** | **Quite easy** | **Very easy** |
| **Total** | | **8%** | **24%** | **31%** | **29%** | **8%** |
| General health | (Very) bad | 15% | 35% | 28% | 17% | 5% |
| | Fair | 6% | 24% | 37% | 29% | 5% |

[14] See Question 1

| | | | | | | |
|---|---|---|---|---|---|---|
| situation | (Very) good | 5% | 14% | 26% | 40% | 16% |

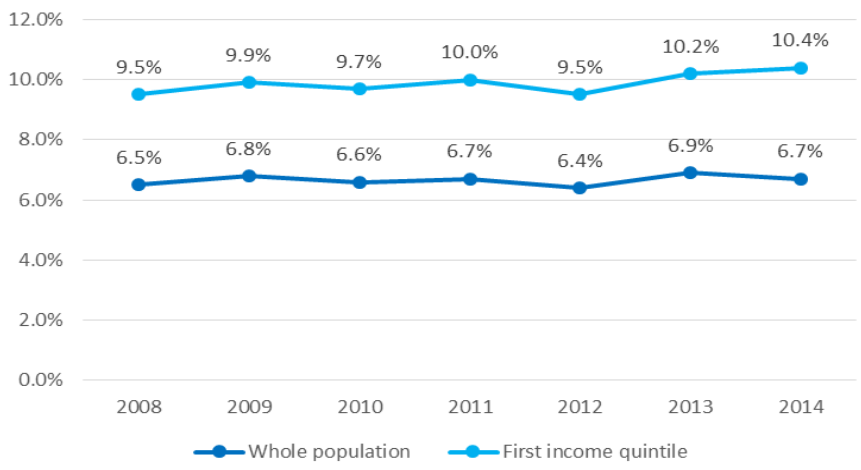
*Base: all respondents (n = 4.187)*

### Differences in the access to health care: Comparisons with the general population

The ease of accessing health care by vulnerable people can be compared to the situation of Europeans in general. The results of the EU Statistics on Income and Living Conditions survey (EU-SILC[15]) show that in 2014, **6,7% of Europeans reported having unmet healthcare needs**. This is somewhat similar to the 8% of vulnerable people that found it 'very difficult' to access healthcare and, hence are very likely to have unmet healthcare needs. However, an additional 24% of vulnerable people in the current study found accessing health care 'quite difficult', hinting towards at least some health needs that were unmet.

In the EU as a whole[16], people with low incomes are more likely to report having unmet healthcare needs than the population as a whole, as shown in Figure 20. In particular, they are the most likely to report having unmet needs due to the cost of healthcare. The same was found for the employment status, which is likely to be related to the income quintile. Both of these findings are consistent with the current findings for vulnerable people, where 11% of the respondents in difficult financial situations found it 'very difficult' to access health care (however, an additional 28% found it 'quite difficult').

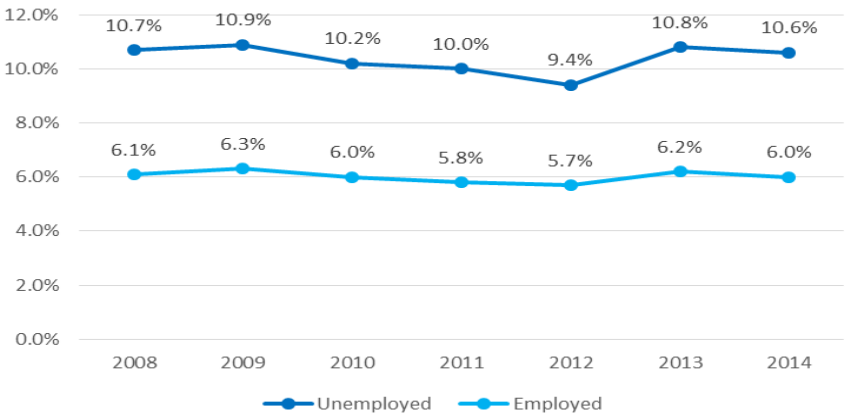
**Figure 20 Self-reported unmet needs for medical examination, focus on the first income quintile**




[15] EU Statistics on Income and Living Conditions survey (EU-SILC): http://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions

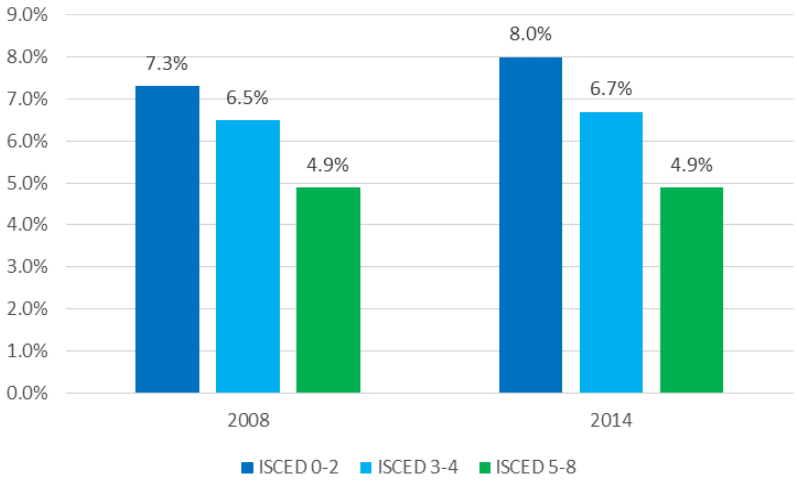
[16] *All data are for EU-27 (excluding Croatia);* Eurostat (2016e), '*Self-reported unmet needs for medical examination by sex, age, detailed reason and income quintile.*' Brussels: European Commission. Available from: http://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_08

**Figure 21 Self-reported unmet medical examination needs, by employment status income quintile**




The level of educational attainment also correlates with access to healthcare. As shown in Figure 22[17], people with a higher level of education were consistently less likely to have an unmet healthcare need than people with a lower level of education. In 2014, 8% of individuals educated up to a junior high school level had an unmet need, compared to 5% of individuals with a tertiary education. The findings of the current survey of vulnerable people is somewhat consistent, at least for respondents with a medium education (6% vs. 7%) and a higher education (6% vs. 5%). However, vulnerable respondents with only a basic education were more likely to have (severe) difficulties meeting their medical needs (14% vs. 8%), as compared to the EU-27 data.

**Figure 22 Self-reported unmet medical examination needs, by educational attainment**




[17] *All data are for EU-27 (excluding Croatia). ISCED levels 0-2 equate to a junior high school education or lower; ISCED 3-4 to a senior high school education; and ISCED 5-8 to tertiary education (undergraduate or postgraduate);* Eurostat (2016f), *'Self-reported unmet needs for medical examination by sex, age, detailed reason and labour status.'* Brussels: European Commission. Available from: http://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_13.

## 4.2 Factors that affect access to healthcare

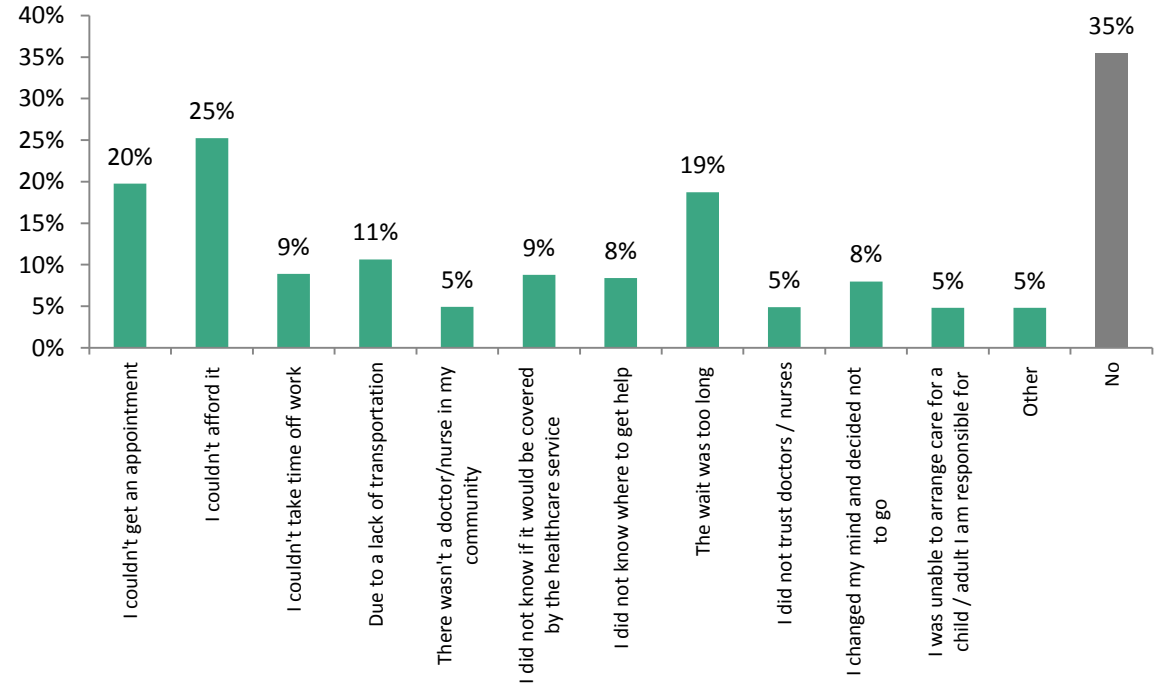
This second part of the survey explored the factors that affected access to healthcare. The findings illustrate the factors may stop people from accessing three healthcare facilities:

- medical practitioners;
- dental examinations or treatments; and
- medication.

Moreover, respondents' ability to understand health information is also studied as a potential barrier to healthcare for vulnerable and isolated people.

First, factors that hinder vulnerable and isolated people from ***visiting medical practitioners*** are discussed. Two thirds of all respondents of this survey experienced some problem(s) that stopped them from visiting a medical practitioner during the past 12 months when it was necessary[18,19]. As illustrated in Figure 23 below, the three most prominent reasons why vulnerable and isolated people did not get the medical attention they needed, were that they could not afford it (25%), that they couldn't get an appointment (20%) and that the wait was too long (19%). This is further detailed below.

**Figure 23 Problems when trying to get medical treatment**




*Base: all respondents (n = 4.187)*

[18] Based on Question 5

[19] 34% of respondents answered 'No' to this question. This may include both respondents that have encountered no problem when trying to get medical attention and respondents that had no reason to get medical attention in the past 12 months.

The occurrence of these three reasons differs across the target groups (Table 17). The ***affordability of medical attention*** was reported as the main reason for not getting medical treatment. While this factor was the most prevalent problem for all target groups, the extent of this problem varied across the target groups. Compared with the average, this problem was reported more often by members of vulnerable families (41%), respondents living in rural and/or isolated areas (40%), respondents with unstable housing situations (33%), vulnerable/isolated older respondents (33%) and in-work poor (32%). In contrast, respondents with physical, mental and learning disabilities reported this problem significantly less often (21%).

The second most reported problem was the ***inability to get an appointment***. The analysis of the target groups shows that members of vulnerable families (30%), older respondents living in vulnerable or isolated circumstances (26%), respondents living in isolated rural areas (26%) and respondents with physical, mental and learning disabilities encounter more problems with getting an appointment than the average respondent (20%). In contrast, long-term unemployed or inactive respondents report this problem slightly less often (18% vs. 20%).

Finally, almost one fifth of the respondents reported ***long waiting times*** as a problem in accessing medical treatment. Similar to the inability to get an appointment, long-term unemployed or inactive respondents had the least problems with long waiting times (16% vs. 19%), as compared with the average findings. In contrast, members of vulnerable families, in-work poor, older respondents who are vulnerable or isolated and respondents living in rural or isolated areas (all 24% vs. 19%) were somewhat more likely to be stopped by long waiting lines from getting the medical attention they needed.

**Table 17 Problems when trying to get medical treatment for target groups**

| | Couldn't get an appointment | Couldn't afford it | Couldn't take time off work | Due to a lack of transportation | There wasn't a doctor/nurse in my community | Uncertain about healthcare service coverage | Did not know where to get help | The wait was too long | Did not trust doctors / nurses | Changed mind and decided not to go | Unable to arrange care for a child / adult | Other | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **20%** | **25%** | **9%** | **11%** | **5%** | **9%** | **8%** | **19%** | **5%** | **8%** | **5%** | **5%** | **35%** |
| Families who are in a vulnerable situation | 30% | 41% | 16% | 19% | 13% | 20% | 14% | 24% | 7% | 9% | 17% | 4% | 19% |
| Physical, mental and learning disabilities | 22% | 21% | 8% | 14% | 7% | 10% | 9% | 19% | 7% | 10% | 4% | 7% | 36% |
| In-work poor | 20% | 32% | 21% | 10% | 6% | 10% | 8% | 24% | 5% | 9% | 6% | 1% | 30% |
| Older people who are vulnerable/isolated | 26% | 33% | 4% | 14% | 7% | 12% | 12% | 24% | 3% | 6% | 2% | 3% | 33% |
| People with unstable housing situations | 19% | 33% | 9% | 11% | 5% | 12% | 9% | 21% | 6% | 11% | 5% | 6% | 31% |
| Prisoners | 28% | 22% | 7% | 10% | 7% | 7% | 6% | 18% | 15% | 9% | 4% | 6% | 32% |
| Persons living in rural/isolated areas | 26% | 40% | 12% | 29% | 18% | 17% | 14% | 24% | 9% | 11% | 12% | 5% | 23% |
| Long-term unemployed / inactive | 18% | 23% | 2% | 11% | 5% | 11% | 9% | 16% | 6% | 9% | 5% | 5% | 44% |
| Victims of domestic violence | 24% | 26% | 15% | 18% | 8% | 10% | 11% | 21% | 9% | 13% | 9% | 6% | 27% |

*Base: all respondents (n = 4.187)*

The analyses also provide insights into differences across the socio-demographic profiles (Table 18) and the countries (Table 19).

The role of the ***affordability of medical attention*** was related to the financial background of the respondents, as indicated by the socio-demographic results. Respondents in a difficult financial situation found medical help less affordable than respondents in an easy financial situation (33% vs. 13%). The latter group report to an almost equal amount problems with the financial aspect of medical services (13%) and with long waiting times (15%).

Respondents from Italy (41%) and Greece (39%) were also more likely than average to not visit a medical practitioner because they could not afford it. In contrast, less than one tenth of the UK respondents (9%) could not afford visiting a medical practitioner. In Spain (15%) and Sweden (17%) this reason was also reported less often.

Socio-demographic results also show that the second most reported problem – the ***inability to get an appointment*** – was especially applicable for younger respondents (18-34 years; 22% vs. 20%), while it was less often mentioned by 35 to 54 year old respondents (18% vs. 20%). The results also show that highly educated respondents were more likely to not be able to get an appointment than the average (23% vs. 20%).

Difficulties with getting an appointment was also reported more often by Greek respondents (25%) than the average. However, this reason was reported even more often in Poland (38%), the United Kingdom (30%) and Germany (29%). In Italy, Slovakia (both 9%), Lithuania and Romania (both 14%) fewer respondents couldn't get an appointment.

Finally, ***long waiting times*** also stopped respondents from visiting a medical practitioner when needed relatively often. This problem was encountered more often by respondents with a high education (21%) than by respondents with a basis education (16%) and more often by people in a difficult financial situation (21%) than by people in an easy financial situation (15%). Moreover, this issue was also reported relatively more often by Polish (31%), Lithuanian (25%), German (24%) and Spanish (22%) respondents. In contrast, relatively few respondents in the Netherlands (7%), Slovakia (11%) and Romania (12%) experienced long waits that stopped them from getting healthcare.

**Table 18 Problems when trying to get medical treatment for socio-demographic profiles**

| | Couldn't get an appointment | Couldn't afford it | Couldn't take time off work | Due to a lack of transportation | There wasn't a doctor/nurse in my community | Uncertain about healthcare service coverage | Did not know where to get help | The wait was too long | Did not trust doctors / nurses | Changed mind and decided not to go | Unable to arrange care for a child / adult | Other | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **20%** | **25%** | **9%** | **11%** | **5%** | **9%** | **8%** | **19%** | **5%** | **8%** | **5%** | **5%** | **35%** |
| Male | 19% | 24% | 9% | 10% | 5% | 9% | 8% | 18% | 6% | 8% | 3% | 5% | 38% |
| Female | 21% | 26% | 9% | 11% | 5% | 9% | 9% | 19% | 4% | 8% | 6% | 5% | 33% |
| 18-34 | 22% | 27% | 13% | 11% | 6% | 11% | 11% | 19% | 7% | 9% | 7% | 5% | 31% |
| 35-54 | 18% | 25% | 10% | 10% | 4% | 9% | 8% | 20% | 5% | 8% | 5% | 5% | 36% |
| 55+ | 20% | 24% | 3% | 10% | 4% | 6% | 7% | 17% | 3% | 6% | 2% | 5% | 40% |
| Basis education | 18% | 37% | 6% | 16% | 6% | 9% | 11% | 16% | 5% | 7% | 5% | 6% | 31% |
| Medium education | 19% | 23% | 8% | 9% | 4% | 9% | 7% | 18% | 5% | 8% | 5% | 4% | 38% |
| High education | 23% | 22% | 13% | 9% | 5% | 8% | 8% | 21% | 6% | 9% | 5% | 4% | 35% |
| (Very) difficult financial situation | 19% | 33% | 9% | 12% | 5% | 11% | 10% | 21% | 4% | 8% | 6% | 5% | 30% |
| (Very) easy financial situation | 21% | 13% | 9% | 8% | 4% | 6% | 6% | 15% | 6% | 7% | 3% | 5% | 44% |

*Base: all respondents (n = 4.187)*

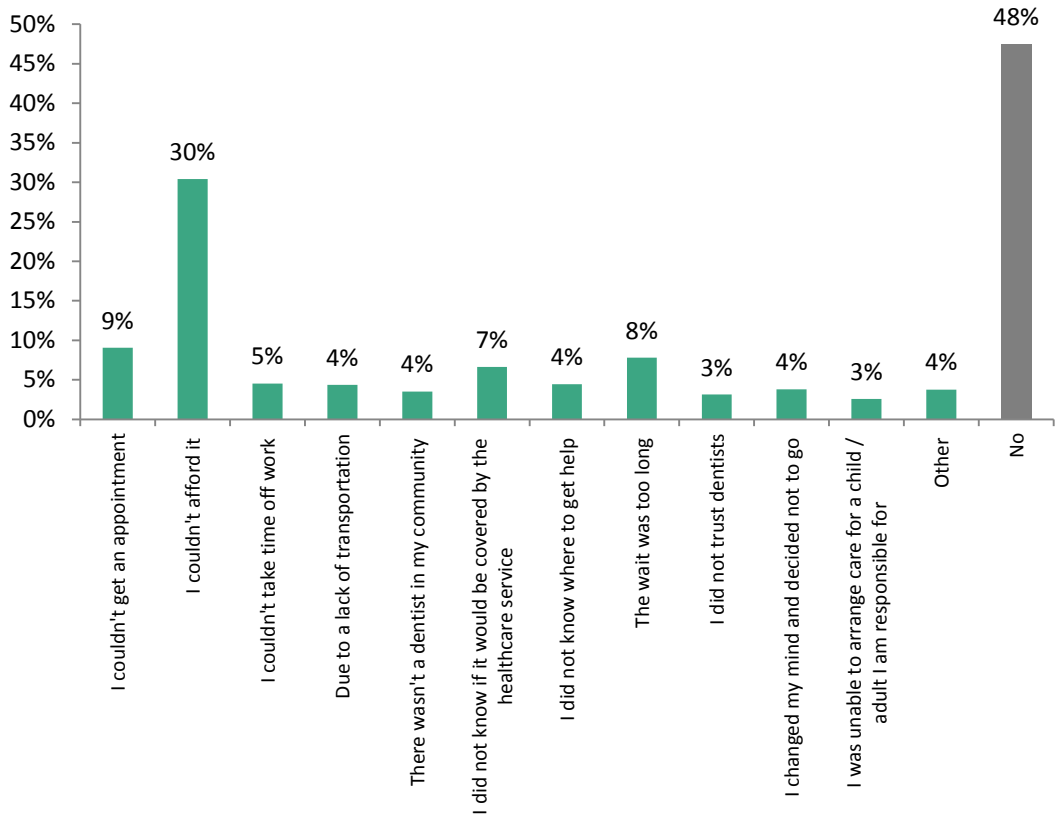
**Table 19 Problems when trying to get medical treatment per country**

| | I couldn't get an appointment | I couldn't afford it | I couldn't take time off work | Due to a lack of transportation | There wasn't a doctor/nurse in my community | I did not know if it would be covered by the healthcare service | I did not know where to get help | The wait was too long | I did not trust doctors / nurses | I changed my mind and decided not to go | I was unable to arrange care for a child / adult I am responsible for | Other | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **20%** | **25%** | **9%** | **11%** | **5%** | **9%** | **8%** | **19%** | **5%** | **8%** | **5%** | **5%** | **35%** |
| France | 17% | 28% | 8% | **14%** | 7% | **14%** | 8% | 18% | 3% | 10% | 3% | 4% | 36% |
| Germany | **29%** | 28% | 10% | **15%** | **9%** | **14%** | **12%** | **24%** | **9%** | 8% | 5% | **2%** | 32% |
| Greece | **25%** | **39%** | 6% | **16%** | **15%** | **24%** | **12%** | 23% | 7% | 6% | **11%** | **7%** | 35% |
| Italy | **9%** | **41%** | **4%** | 11% | **0%** | **4%** | **20%** | 21% | 4% | **5%** | **2%** | 5% | **27%** |
| Lithuania | **14%** | **29%** | **13%** | **6%** | 3% | **5%** | **4%** | **25%** | 4% | **12%** | 5% | 3% | **31%** |
| Netherlands | **13%** | 22% | **5%** | 12% | 4% | **14%** | 8% | **7%** | 3% | 7% | 3% | 3% | **47%** |
| Poland | **38%** | 28% | **5%** | **6%** | 5% | 11% | 9% | **31%** | 4% | **4%** | **2%** | 3% | 32% |
| Romania | **14%** | 28% | 8% | 10% | 4% | **4%** | **5%** | **12%** | 4% | 6% | 4% | 3% | 36% |
| Slovakia | **9%** | 29% | **13%** | 9% | 5% | 6% | **3%** | **11%** | **2%** | **5%** | 6% | **8%** | **30%** |
| Spain | 18% | **15%** | **19%** | 11% | 4% | 7% | 7% | **22%** | 5% | 10% | **9%** | 5% | 34% |
| Sweden | 20% | **17%** | **4%** | **6%** | **2%** | **4%** | 8% | 16% | **8%** | 11% | **3%** | 6% | **45%** |
| United Kingdom | **30%** | **9%** | 7% | 13% | 3% | **3%** | 8% | 15% | 5% | 8% | 3% | **9%** | 39% |

*Base: all respondents (n = 4.187)*

Other medical service, that vulnerable and isolated people may have problems with accessing, are ***dental examinations or treatments***[20] (Figure 24). About half of all interviewed respondents (52%), reported that they have experienced issues that stopped them from getting dental treatment. The majority of those that needed dental examination/treatment but didn't get it reported the unaffordability as the reason (30%).

**Figure 24 Problems when trying to get dental treatment or examination**




*Base: all respondents (n = 4.187)*

The unaffordability of dental care was the main factor that stopped respondents from getting the necessary medical attention across all target groups (see Table 20 for an overview). However, this issue was most often reported by members of vulnerable families (45%), in work poor (42%), respondents with unstable housing situations (40%) and respondents living in rural and/or isolated areas (40%). Respondents with physical, mental and learning disabilities were less likely to report this problem (27%).

[20] Based on Question 6

**Table 20 Problems when trying to get dental treatment or examination for target groups**

| | I couldn't get an appointment | I couldn't afford it | I couldn't take time off work | Due to a lack of transportation | There wasn't a dentist in my community | I did not know if it would be covered by the healthcare service | I did not know where to get help | The wait was too long | I did not trust dentists | I changed my mind and decided not to go | I was unable to arrange care for a child / adult I am responsible for | Other | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **9%** | **30%** | **5%** | **4%** | **4%** | **7%** | **4%** | **8%** | **3%** | **4%** | **3%** | **4%** | **48%** |
| Families who are in a vulnerable situation | 18% | 45% | 11% | 12% | 10% | 15% | 8% | 12% | 5% | 6% | 9% | 4% | 28% |
| Physical, mental and learning disabilities | 9% | 27% | 4% | 6% | 4% | 7% | 5% | 6% | 4% | 5% | 3% | 6% | 49% |
| In-work poor | 11% | 42% | 10% | 5% | 5% | 7% | 5% | 13% | 3% | 6% | 4% | 1% | 37% |
| Older people who are vulnerable/isolated | 6% | 29% | 1% | 4% | 3% | 6% | 4% | 3% | 1% | 2% | 1% | 4% | 58% |
| People with unstable housing situations | 14% | 40% | 5% | 5% | 3% | 11% | 7% | 12% | 4% | 4% | 3% | 4% | 37% |
| Prisoners | 14% | 28% | 6% | 4% | 17% | 7% | 6% | 15% | 14% | 5% | 4% | 11% | 43% |
| Persons living in rural/isolated areas | 18% | 40% | 5% | 13% | 11% | 11% | 7% | 13% | 4% | 3% | 8% | 4% | 39% |
| Long-term unemployed / inactive | 7% | 29% | 1% | 4% | 4% | 7% | 4% | 6% | 4% | 3% | 2% | 3% | 55% |
| Victims of domestic violence | 13% | 34% | 9% | 10% | 5% | 8% | 7% | 9% | 5% | 7% | 6% | 6% | 42% |

*Base: all respondents (n = 4.187)*

The socio-demographic findings in Table 21 also reveal certain differences. Women were somewhat more likely to not get dental care because of its costs than men (32% vs. 29%). In addition, 35 to 54 year olds reported the unaffordability of dental care more often (33%), while 55+ year olds mentioned this problem less often (27%). Education and financial background was also seen to affect the affordability of dental care for respondents. In particular, respondents with a basic education (35%) and in a difficult financial situation (39%) were somewhat more likely to be stopped from getting dental care due to the costs of this service, compared to the average results (30%). In contrast, people with a medium education (29%) and especially respondents with a good financial background (17%) were less likely to mention this problem.

The country-level results indicate that respondents in some countries were significantly less able to pay for dental care than respondents in other countries. Especially in Italy (43%), Lithuania (40%) and Spain (35%), the proportion of respondents that could not afford dental care is noticeable higher. In contrast, compared to the average only about half of the UK respondents could not afford dental care (17%). In Romania this number was "only" 24%.

**Table 21 Problems when trying to get dental treatment or examination for socio-demographic profiles**

| | I couldn't get an appointment | I couldn't afford it | I couldn't take time off work | Due to a lack of transportation | There wasn't a dentist in my community | I did not know if it would be covered by the healthcare service | I did not know where to get help | The wait was too long | I did not trust dentists | I changed my mind and decided not to go | I was unable to arrange care for a child / adult I am responsible for | Other | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **9%** | **30%** | **5%** | **4%** | **4%** | **7%** | **4%** | **8%** | **3%** | **4%** | **3%** | **4%** | **48%** |
| Male | 10% | 29% | 5% | 4% | 4% | 7% | 5% | 9% | 4% | 4% | 2% | 4% | 48% |
| Female | 9% | 32% | 4% | 4% | 3% | 6% | 4% | 7% | 2% | 4% | 3% | 4% | 47% |
| 18-34 | 12% | 30% | 7% | 6% | 5% | 7% | 5% | 10% | 4% | 5% | 3% | 3% | 43% |
| 35-54 | 9% | 33% | 5% | 4% | 4% | 7% | 5% | 8% | 3% | 4% | 3% | 4% | 45% |
| 55+ | 6% | 27% | 1% | 3% | 2% | 6% | 3% | 6% | 2% | 2% | 1% | 4% | 56% |
| Basis education | 8% | 35% | 3% | 7% | 5% | 7% | 5% | 7% | 3% | 3% | 2% | 5% | 44% |
| Medium education | 8% | 29% | 4% | 4% | 2% | 7% | 4% | 7% | 3% | 4% | 2% | 4% | 50% |
| High education | 11% | 30% | 6% | 4% | 4% | 6% | 4% | 10% | 4% | 4% | 3% | 3% | 47% |
| (Very) difficult financial situation | 9% | 39% | 4% | 5% | 4% | 8% | 5% | 8% | 3% | 3% | 3% | 4% | 41% |
| (Very) easy financial situation | 9% | 17% | 6% | 4% | 3% | 4% | 3% | 7% | 4% | 4% | 2% | 4% | 58% |

*Base: all respondents (n = 4.187)*

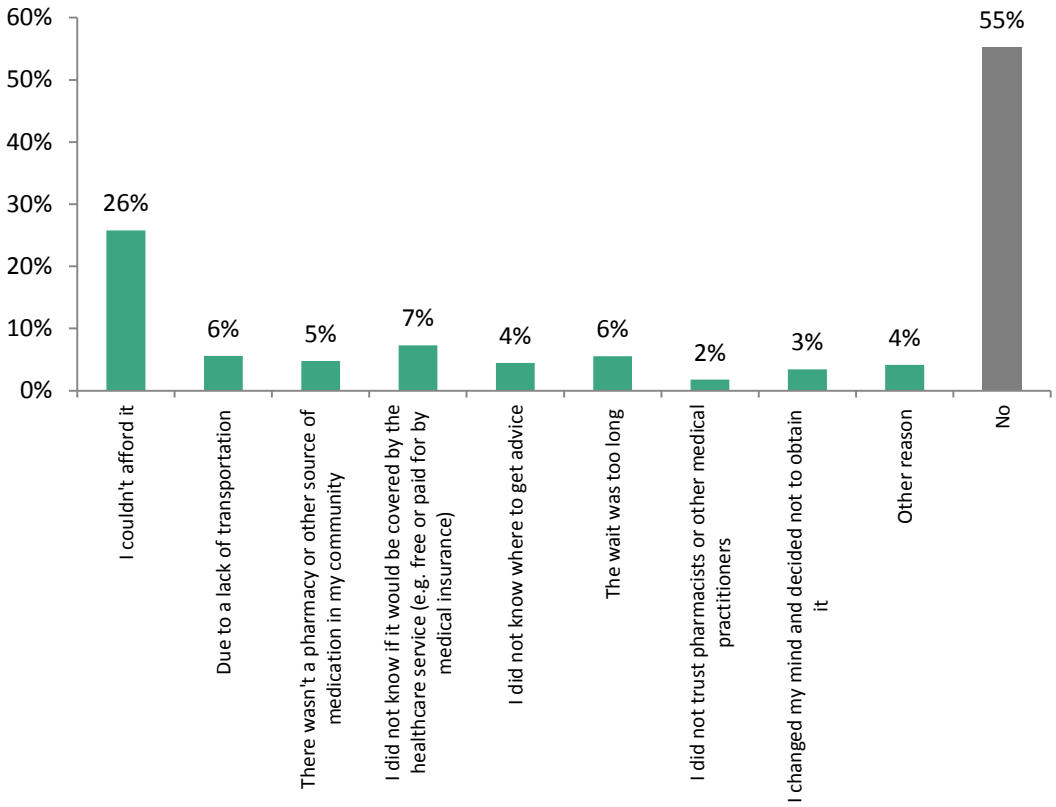
**Table 22 Problems when trying to get dental treatment or examination for socio-demographic profiles**

| | I couldn't get an appointment | I couldn't afford it | I couldn't take time off work | Due to a lack of transportation | There wasn't a dentist in my community | I did not know if it would be covered by the healthcare service | I did not know where to get help | The wait was too long | I did not trust dentists | I changed my mind and decided not to go | I was unable to arrange care for a child / adult I am responsible for | Other | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **9%** | **30%** | **5%** | **4%** | **4%** | **7%** | **4%** | **8%** | **3%** | **4%** | **3%** | **4%** | **48%** |
| France | 11% | 28% | 3% | 3% | 2% | 12% | 4% | 4% | 3% | 3% | 1% | 1% | 53% |
| Germany | 11% | 26% | 8% | 7% | 4% | 6% | 5% | 9% | 4% | 5% | 4% | 1% | 55% |
| Greece | 15% | 35% | 2% | 10% | 10% | 17% | 8% | 8% | 6% | 5% | 6% | 7% | 46% |
| Italy | 5% | 43% | 2% | 5% | 1% | 2% | 15% | 10% | 1% | 2% | 1% | 3% | 35% |
| Lithuania | 7% | 40% | 5% | 2% | 2% | 6% | 3% | 11% | 2% | 6% | 1% | 1% | 42% |
| Netherlands | 8% | 27% | 5% | 4% | 3% | 8% | 3% | 5% | 2% | 1% | 2% | 5% | 56% |
| Poland | 14% | 26% | 2% | 2% | 3% | 10% | 2% | 10% | 4% | 1% | 2% | 4% | 48% |
| Romania | 4% | 24% | 5% | 4% | 7% | 1% | 3% | 8% | 5% | 6% | 4% | 5% | 49% |
| Slovakia | 3% | 32% | 7% | 3% | 1% | 5% | 2% | 3% | 2% | 3% | 3% | 10% | 38% |
| Spain | 13% | 35% | 10% | 6% | 3% | 8% | 4% | 12% | 3% | 7% | 5% | 2% | 36% |
| Sweden | 7% | 32% | 2% | 2% | 1% | 3% | 2% | 5% | 4% | 2% | 1% | 3% | 56% |
| United Kingdom | 10% | 17% | 2% | 3% | 5% | 4% | 4% | 5% | 3% | 4% | 2% | 6% | 57% |

*Base: all respondents (n = 4.187)*

A third aspect under investigation is the ***access to medication***[21] (Figure 25). The findings show that almost half of all respondents reported at least one problem that stopped them from getting their medication in the last 12 months (45%). When people encountered problems, however, these were mainly related to the costs of the medication (i.e., 26% of respondents could not afford the medication).

**Figure 25 Problems when trying to get medication**




*Base: all respondents (n = 4.187)*

The prevalence of this problem differed across the target groups (see Table 23). In particular, members of vulnerable families (39%), respondents living in isolated and/or vulnerable areas (36%), respondents with unstable housing situations (35%), older respondents who are vulnerable and/or isolated (32%) and in-work poor (31%) were more likely to not buy medication because of its high costs. In contrast, only respondents with physical, mental and learning disabilities reported this problem less often than average (21% vs. 26%).

[21] Based on Question 7

**Table 23 Problems when trying to get medication for target groups (all respondents)**

| | I couldn't afford it | Due to a lack of transportation | There wasn't a pharmacy or other source of medication in my community | I did not know if it would be covered by the healthcare service | I did not know where to get advice | The wait was too long | I did not trust pharmacists or other medical practitioners | I changed my mind and decided not to obtain it | Other reason | No |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **26%** | **6%** | **5%** | **7%** | **4%** | **6%** | **2%** | **3%** | **4%** | **55%** |
| Families who are in a vulnerable situation | 39% | 13% | 14% | 18% | 8% | 9% | 4% | 7% | 4% | 38% |
| Physical, mental and learning disabilities | 21% | 7% | 6% | 8% | 4% | 5% | 2% | 3% | 7% | 57% |
| In-work poor | 31% | 5% | 6% | 8% | 7% | 7% | 2% | 5% | 1% | 52% |
| Older people who are vulnerable/isolated | 32% | 5% | 5% | 9% | 3% | 5% | 1% | 3% | 2% | 50% |
| People with unstable housing situations | 35% | 5% | 4% | 9% | 7% | 6% | 2% | 5% | 4% | 48% |
| Prisoners | 20% | 3% | 20% | 11% | 5% | 15% | 4% | 9% | 14% | 47% |
| Persons living in rural/isolated areas | 36% | 17% | 17% | 18% | 4% | 7% | 2% | 7% | 4% | 41% |
| Long-term unemployed / inactive | 24% | 5% | 4% | 9% | 3% | 4% | 1% | 3% | 4% | 62% |
| Victims of domestic violence | 27% | 10% | 9% | 10% | 10% | 6% | 5% | 8% | 5% | 48% |

*Base: all respondents (n = 4.187)*

Similar to the access to dental care, women experienced slightly more problems with the costs of medication than men (28% vs. 24%). Moreover, the occurrence of this problem was also related to both the education and the financial situation of the respondents. As such, respondents with a basic education had more problems with the costs of medication (37%) than respondents with a medium education (24%) or a high education (21%). As expected, respondents in a difficult financial situation also reported this problem more often (34%) than respondents in an easy financial situation (12%). Nevertheless, for all socio-demographic profiles, the unaffordability of the medications was the main reason for respondents to not get the medication they need (see Table 24 for an overview).

Consistent with the findings for the reasons for not getting medical attention or dental care, Italian and Lithuanian respondents also found it more difficult than average to afford medications (respectively 44% and 35%). In addition, medication was also more often difficult to afford by respondents from Poland (36%) and Greece (32%). Also consistent with the previous results, respondents from the UK had the least problems with affording medication (only 9% choose this reason). In France, the Netherlands (both 18%), Spain (20%) and Sweden (21%) this proportion was also lower than average. However, in these countries, still about one fifth of respondents could not afford their medications.

**Table 24 Problems when trying to get medication for socio-demographic groups (all respondents)**

| | I couldn't afford it | Due to a lack of transportation | There wasn't a pharmacy or other source of medication in my community | I did not know if it would be covered by the healthcare service | I did not know where to get advice | The wait was too long | I did not trust pharmacists or other medical practitioners | I changed my mind and decided not to obtain it | Other reason | No |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **26%** | **6%** | **5%** | **7%** | **4%** | **6%** | **2%** | **3%** | **4%** | **55%** |
| Male | 24% | 6% | 5% | 7% | 6% | 7% | 2% | 4% | 5% | 56% |
| Female | 28% | 5% | 4% | 7% | 3% | 4% | 1% | 3% | 4% | 55% |
| 18-34 | 27% | 7% | 7% | 9% | 5% | 8% | 3% | 5% | 4% | 51% |
| 35-54 | 26% | 5% | 5% | 8% | 4% | 5% | 1% | 3% | 4% | 56% |
| 55+ | 24% | 5% | 3% | 5% | 3% | 4% | 1% | 2% | 4% | 58% |
| Basis education | 37% | 8% | 7% | 9% | 4% | 6% | 1% | 4% | 4% | 43% |
| Medium education | 24% | 5% | 4% | 7% | 4% | 5% | 2% | 3% | 4% | 58% |
| High education | 21% | 5% | 5% | 6% | 4% | 6% | 2% | 5% | 4% | 60% |
| (Very) difficult financial situation | 34% | 6% | 5% | 8% | 4% | 5% | 1% | 3% | 4% | 48% |
| (Very) easy financial situation | 12% | 5% | 5% | 5% | 5% | 7% | 2% | 4% | 4% | 67% |

*Base: all respondents (n = 4.187)*

**Table 25 Problems when trying to get medication for socio-demographic groups (all respondents)**

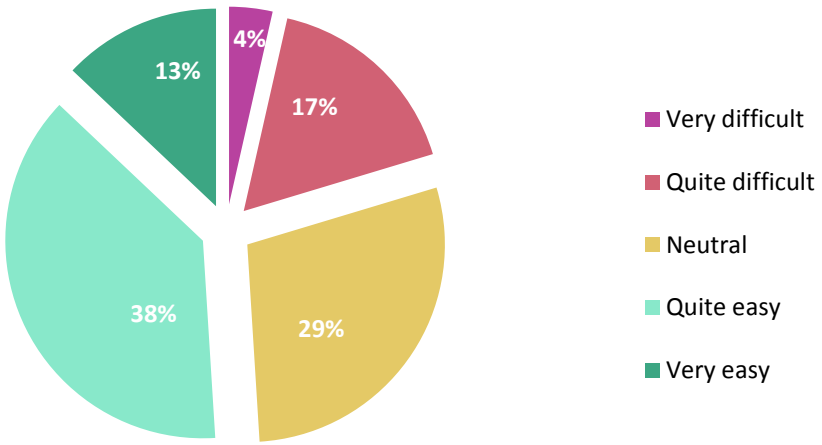
| | I couldn't afford it | Due to a lack of transportation | There wasn't a pharmacy or other source of medication in my community | I did not know if it would be covered by the healthcare service | I did not know where to get advice | The wait was too long | I did not trust pharmacists or other medical practitioners | I changed my mind and decided not to obtain it | Other reason | No |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **26%** | **6%** | **5%** | **7%** | **4%** | **6%** | **2%** | **3%** | **4%** | **55%** |
| France | 18% | 4% | 2% | 9% | 1% | 2% | 2% | 3% | 3% | 68% |
| Germany | 25% | 7% | 7% | 9% | 6% | 9% | 3% | 6% | 1% | 59% |
| Greece | 32% | 9% | 12% | 24% | 3% | 4% | 3% | 4% | 6% | 59% |
| Italy | 44% | 5% | 1% | 6% | 12% | 3% | 1% | 1% | 2% | 38% |
| Lithuania | 35% | 2% | 3% | 3% | 4% | 5% | 2% | 6% | 2% | 53% |
| Netherlands | 18% | 8% | 5% | 8% | 7% | 7% | 3% | 3% | 3% | 60% |
| Poland | 36% | 2% | 1% | 8% | 1% | 9% | 1% | 2% | 2% | 45% |
| Romania | 30% | 7% | 5% | 4% | 1% | 6% | 0% | 1% | 8% | 53% |
| Slovakia | 29% | 3% | 6% | 8% | 2% | 4% | 0% | 1% | 9% | 39% |
| Spain | 20% | 8% | 7% | 8% | 7% | 11% | 3% | 6% | 1% | 53% |
| Sweden | 21% | 4% | 4% | 3% | 2% | 2% | 1% | 1% | 6% | 64% |
| United Kingdom | 9% | 8% | 4% | 2% | 6% | 3% | 2% | 5% | 7% | 67% |

*Base: all respondents (n = 4.187)*

Finally, another factor that might affect vulnerable and isolated people's abilities to access healthcare is ***understanding the health information***[22] that respondents may receive from doctors, nurses or other healthcare support providers. Health information can be complex and difficult to understand and, therefore, form a barrier for vulnerable and isolated people to access healthcare.

The findings show that the majority of all respondents (51%) found it quite or very easy to understand health information. However, a relatively large proportion of 21% of the respondents found understanding health information also quite or very difficult (Figure 26).

**Figure 26 The ease of understanding health information**

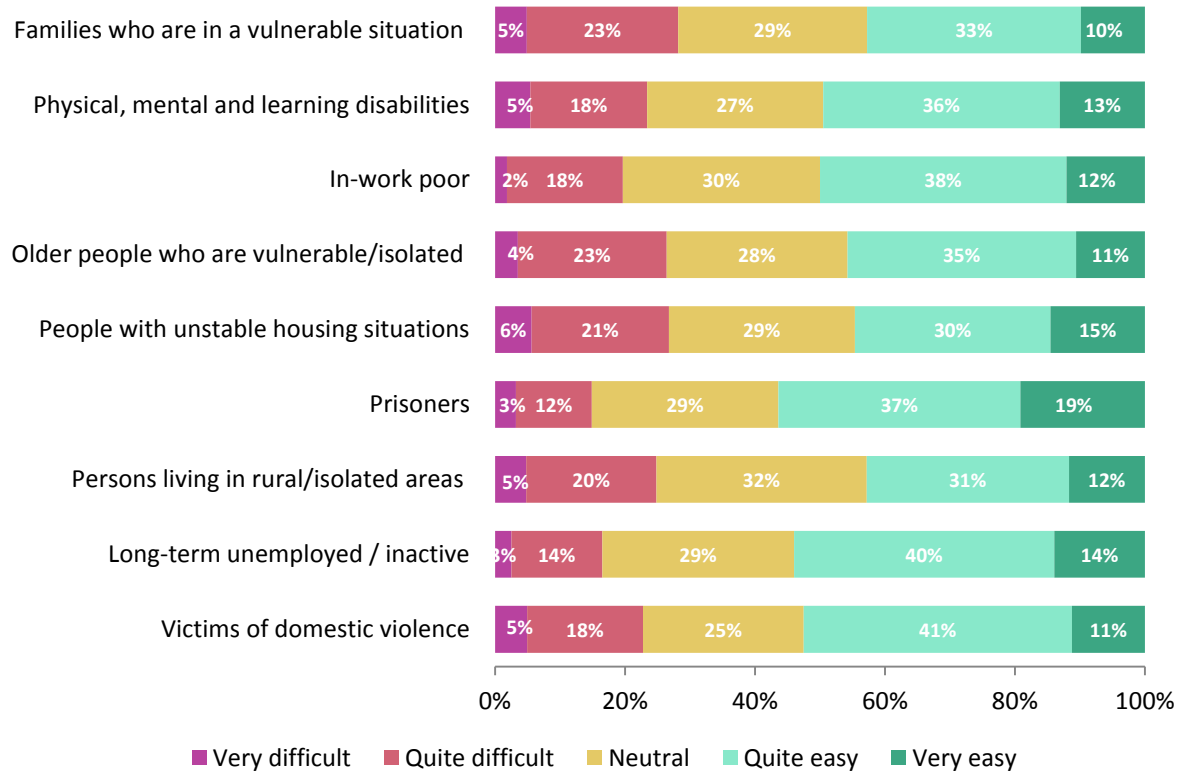



*Base: all respondents (n = 4.187)*

Figure 27 provides an overview of the findings for the different target groups. The findings show that members of vulnerable families, respondents with unstable housing situations and older people living in vulnerable and/or circumstances found understanding health information somewhat more difficult. Compared to the average results, vulnerable family members found it more ('quite') difficult (23% vs. 17%) and less ('quite' and 'very') easy (43% vs. 51%) to understand this information. Similarly, respondents living in unstable housing situations found this information more difficult ('quite' & 'very' difficult; 27% vs. 21%) and less easy ('quite' easy; 30% vs. 38%) to understand than average. Vulnerable and/or isolated older respondents also found it more difficult to understand (23% vs. 17%). In contrast, long-term unemployed respondents found it less difficult ('very' and 'quite' difficult; 17% vs. 21%).

[22] Based on Question 10

**Figure 27 The ease of understanding health information for target groups**




*Base: all respondents (n = 4.187)*

The ease with which health information is understood by the respondents is illustrated for the socio-demographic profiles in Table 26. The results show a relationship between the ease of understanding health information and the level of education and financial background of the respondents. The results suggest that respondents with only a basic education had a harder time understanding health information (33% found it very or quite difficult) than respondents with a medium education (19%) or high education (14%). In contrast, respondents with a medium education were significantly more likely to have a neutral opinion compared to the average results (31% vs. 29%) and highly educated respondents were more likely to find understanding quite or very easy as compared to the average results (61% vs. 51%).

The financial background of respondents is also related to the ease of understanding health information, as demonstrated by the survey results. Concretely, respondents in a difficult financial situation found this information more ('very' and 'quite') difficult to understand than respondents in an easy financial situation (25% vs. 13%). In contrast, respondents in an easy financial situation found this information ('quite' and 'very') easier to understand than respondents in a difficult financial situation (59% vs. 47%).

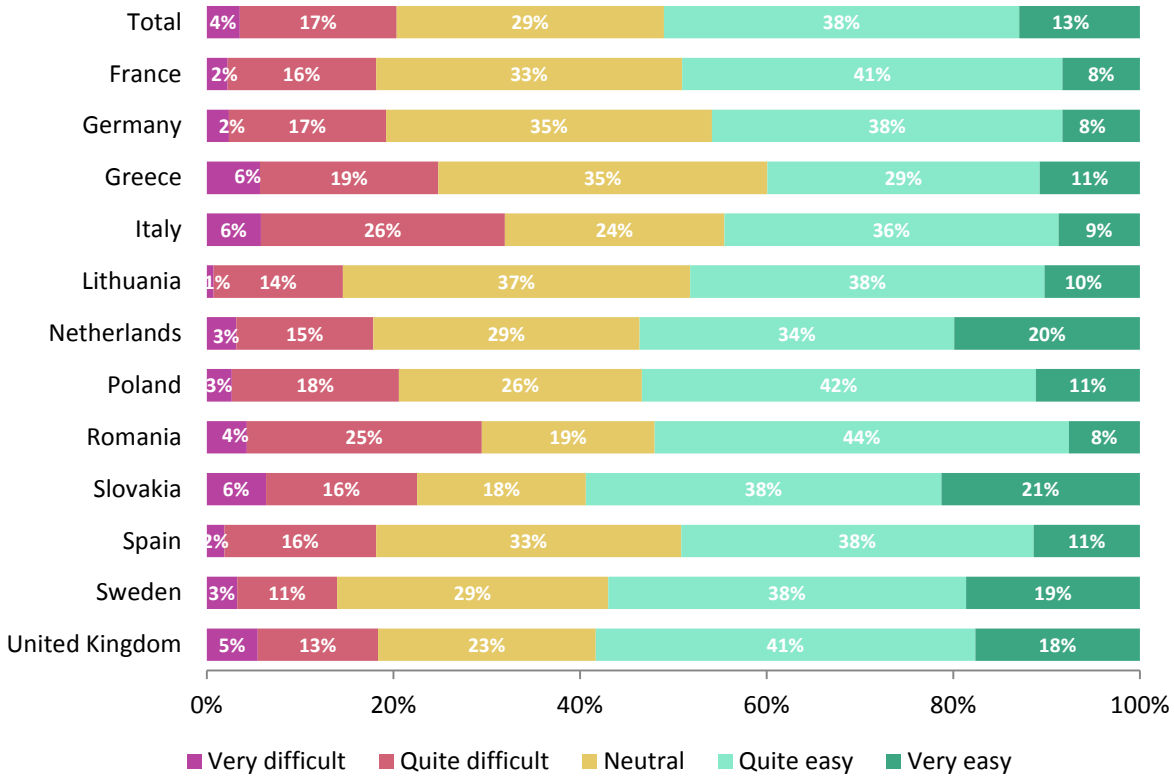
**Table 26 The ease of understanding health information for socio-demographic profiles**

| | Very difficult | Quite difficult | Neutral | Quite easy | Very easy |
|---|---|---|---|---|---|
| **Total** | **4%** | **17%** | **29%** | **38%** | **13%** |
| Male | 3% | 16% | 30% | 38% | 12% |
| Female | 4% | 17% | 28% | 38% | 13% |
| 18-34 | 4% | 17% | 31% | 37% | 12% |
| 35-54 | 3% | 16% | 29% | 38% | 13% |
| 55+ | 4% | 17% | 25% | 39% | 14% |
| Basis education | 7% | 26% | 27% | 28% | 12% |
| Medium education | 3% | 16% | 31% | 39% | 12% |
| High education | 2% | 12% | 25% | 44% | 17% |
| (Very) difficult financial situation | 5% | 20% | 29% | 36% | 11% |
| (Very) easy financial situation | 2% | 11% | 28% | 42% | 17% |

*Base: all respondents (n = 4.187)*

The anlyses also reveal differences between the surveyed countries. Respondents in Slovakia (59%), the UK (59%), Sweden (57%) and the Netherlands (54%) found it significantly easier (i.e. found it more often 'quite easy' or 'very easy') to understand information communicated by health care professionals. In contrast, a higher proportion of Italian respondents (32%) and Romanian respondents (29%) found it ('very' or 'quite') difficult to understand this health information.

**Figure 28 The ease of understanding health information per country**



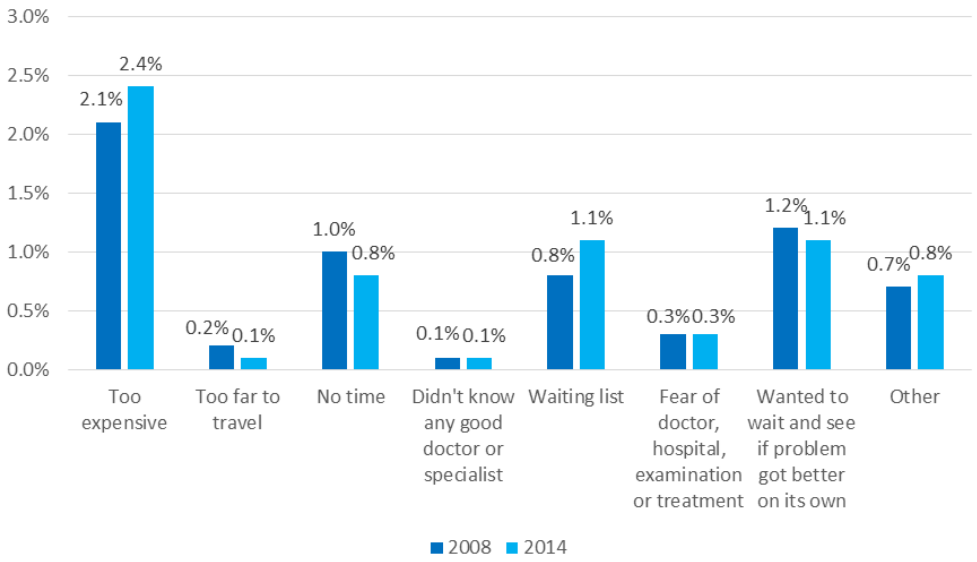

*Base: all respondents (n = 4.187)*

**Differences in the access to health care: Comparisons with the general population**

This subchapter presented the reasons that vulnerable people give for not meeting their healthcare needs. One reoccuring reason, for all three investigated health care services (medical care, dental care and medications) was the high costs of health care. This result is consistent with Eurostat[23] findings for the general population (see Figure 29), though the percentage experiencing high costs as a problem is much lower. Consistent with the current findings for vulnerable people, a noticeable share of respondents also reported long waiting lists as a problem for getting health care.

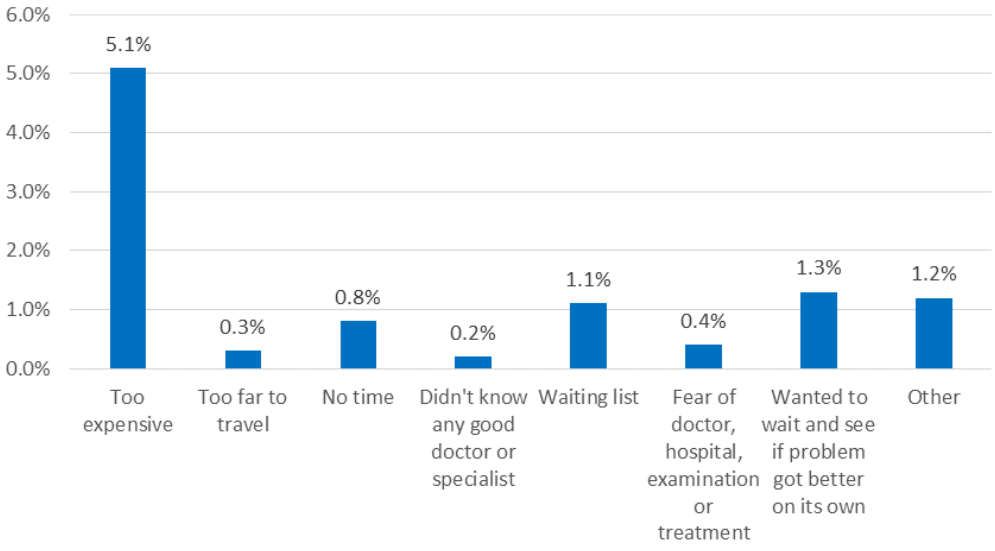
**Figure 29 Reasons for self-reported unmet medical examination needs**

[23] *All data are for EU-27 (excludes Croatia);* Eurostat (2016e), '*Self-reported unmet needs for medical examination by sex, age, detailed reason and income quintile.*' Brussels: European Commission. Available from: http://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_08




In the EU as a whole**,** people with low incomes are the most likely to report having unmet needs due to the cost of healthcare. Self-reported unmet healthcare need that occurs due to the cost of treatment is twice as prevalent among Europeans in the first income quintile (i.e. the least wealthy in society) as among the European population as a whole. This is consistent with the current findings, where respondents in a bad financial situation are more likely to not get health care because it is too expensive. They are even more than twice as likely to be hindered by high costs than respondents with a good financial situation.

**Figure 30 Reasons for self-reported unmet medical examination needs, focus on first income quintile (2014)**




## 4.3 Summary

The aim of this chapter was to assess vulnerable and isolated people's access to healthcare, by focusing on both the perceived ease of accessing healthcare services and the factors or problems that people encounter when trying to obtain the healthcare they need.

The survey results suggest that vulnerable and isolated people have at least some problems with the ***access to health care***. While 37% of respondents found it easy to access health care services when needed, 32% of respondents thought that it was difficult. It is important to note, that respondents with a bad or very bad health found accessing healthcare particularly difficult: 50% of the respondents that reported a bad or very bad health experienced difficulties with accessing healthcare services, while this was only 19% for respondents with a (very) good health.

To understand ***the factors that hinder vulnerable and isolated people from accessing healthcare***, the current survey investigated factors that stopped respondents from accessing *(1)* medical practitioners, *(2)* dental examinations or treatments and *(3)* medication. Moreover, respondents' ability to understand health information provided by doctors, nurses and other healthcare professionals is also studied as a potential barrier to healthcare access by the target group.

It was found that, respectively 65%, 52% and 45% of the respondents encountered at least one problem that stopped them from visiting a medical practitioner, from getting dental examination/treatment or from getting medication. Across all three healthcare facilities, high costs were perceived as the main reason that stopped the respondents from getting the healthcare they needed (mentioned by respectively 25%, 30% & 26% of all respondents). The cost factor was most often mentioned for dental treatments (30%) and the least often for medical practitioners (25%). In addition, for medical treatment, the inability to get an appointment (20%)  long waiting times (19%) were also seen as relevant factors. Finally, the survey also looked at the respondents' ***ability to understand health information*** as another potential factor that might prevent vulnerable and isolated people from getting the necessary healthcare. While the majority of respondents (51%) find understanding health information easy, one fifth of the respondents (21%) still experienced problems with understanding this information.

The findings also revealed interesting differences between the surveyed ***target groups***. Regarding respondents' ***access to healthcare services***, especially *vulnerable and isolated older people* (43%), *persons living in rural or isolated areas* (42%) and *members of vulnerable families* (39%) had more difficulties with accessing healthcare services when they needed them. Almost all target groups reported the costs of healthcare services as the most important ***barriers to healthcare access.*** However, across all three healthcare facilities, the cost factor had an even greater impact for *members of vulnerable families* (39%-45%) *persons living in rural and isolated areas* (36%-40%), *people living in unstable housing situations* (33%-40%) and the in-work poor (31%-42%). The costs for medical practitioners and medication were also significantly more relevant for *vulnerable older people* (33% & 32%) It is also noticeable that the group of people with physical, mental and learning disabilities seems to be consistently less affected by the costs of all three facilities: medical practitioners (21%), dental treatments (27%) and medication (27%). *Members of vulnerable families* (28%), *people with unstable housing* (27%) and *vulnerable and isolated older persons* (27%) found it

more difficult than average (21%) to ***understand the health information*** provided by doctors, nurses and other healthcare professionals.

Somewhat consistent with the findings discussed in the previous paragraphs, access to healthcare is also consistently affected by the ***socio-demographic factors*** education and finances. Firstly, ***access to healthcare*** was more difficult for *low-educated respondents* (46%) and *respondents in a difficult financial situation* (39%) than the average respondents (32%). The unaffordability of the healthcare facilities as a ***barrier to healthcare access*** was also most often reported by these two groups of respondents. Concretely, respondents with only a basis education and respondents in a difficult financial situation had more problems with the costs of medical practitioners (37% & 33%), dental treatments (35% & 39%) and medications (37% & 34%). The unaffordability of dental examinations or treatments were also reported slightly more often by *women* (32%) and *middle-aged respondents* (35-54 years; 33%), while the unaffordability of medication was also reported somewhat more often by *women* (28%).

Finally, the ease of ***understanding health information*** was also affected by educational level and financial status of the respondents. *Respondents with a basis education* (33%) and *respondents in a difficult financial situation* (25%) found it significantly more difficult to understand information provided by healthcare providers than the average respondent of this survey (21%).

The findings about vulnerable people's access to healthcare also ***differed at country-level***. As is discussed above, about one third of the respondents had ***difficulties accessing healthcare***. This number even increases to more than half of the respondents in Italy (55%). Moreover, almost half of the Greek (46%) and Polish (45%) respondents experienced difficulties with accessing healthcare.

The *unaffordability of healthcare* has been the ***main issue that stopped vulnerable people from getting medical treatment***, dental care or medications. The findings show that Italian respondents consistently reported this reason particularly often. Almost half of the Italian respondent found it difficult to pay for medical treatment (41%), dental care (43%) and medication (44%). Lithuanian respondents also often had problems paying for dental care (40%) and medications (35%). In contrast, only relatively few respondents from the UK had problems paying for these three health services (respectively 9%, 17% and 9%). Respondents that needed medical treatment were also relatively often stopped because they *could not get an appointment* or because of *long waiting times* (this was not the case for access to dental care or access to medication). The results show that these two factors are reported particularly often by Polish respondents: 38% of them could not get an appointment and 31% were stopped by long waiting times. Finally, the results also looked into respondents ability to understand health information. While on average one fifth of respondents *understood the information provided by health care professionals*, this number was higher for Italian respondents (32%) and Romanian respondents (29%).

# 5 Satisfaction with healthcare

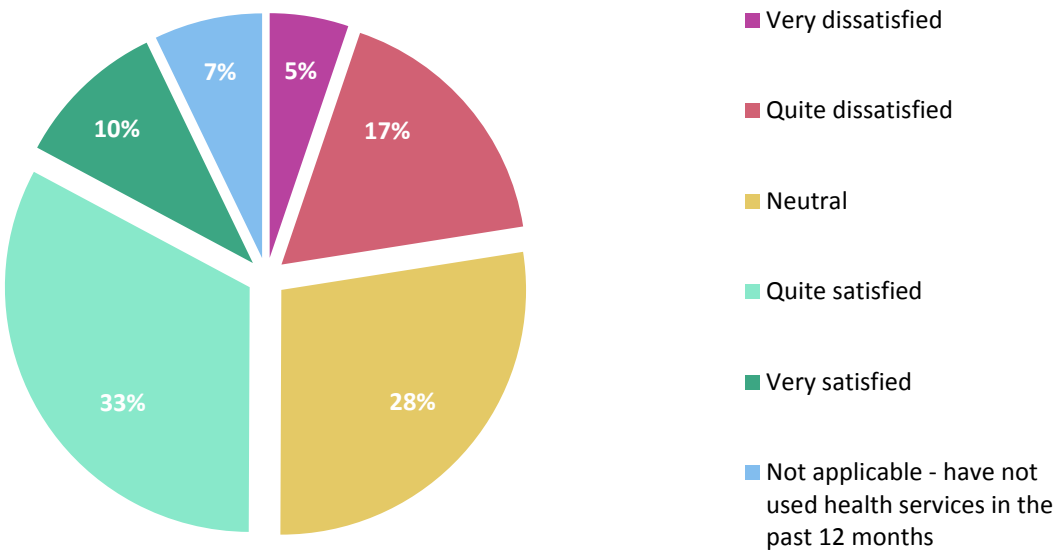
The last empirical chapter of this report explores how satisfied people living in vulnerable and isolated situations are with the healthcare they obtain. Special attention is given to the role of respondents' health on their dissatisfaction and on the reasons for respondents' satisfaction.

## 5.1 Satisfaction with health services

Respondents were asked to identify how satisfied they were with the results of the medical treatment, considering all of their experiences of using health services in the past year.

The results show that only 7% of respondents had not used health services in the past year. For the remaining respondents, the results show that people living in vulnerable and isolated situations were rather satisfied with the health services they got[24]. 43% of all respondents were quite or very satisfied and 28% are neutral. However, 22% of respondents were to some degree dissatisfied and 5% dissatisfied.

**Figure 31 Satisfaction with health services**




*Base: all respondents (n = 4.187)*

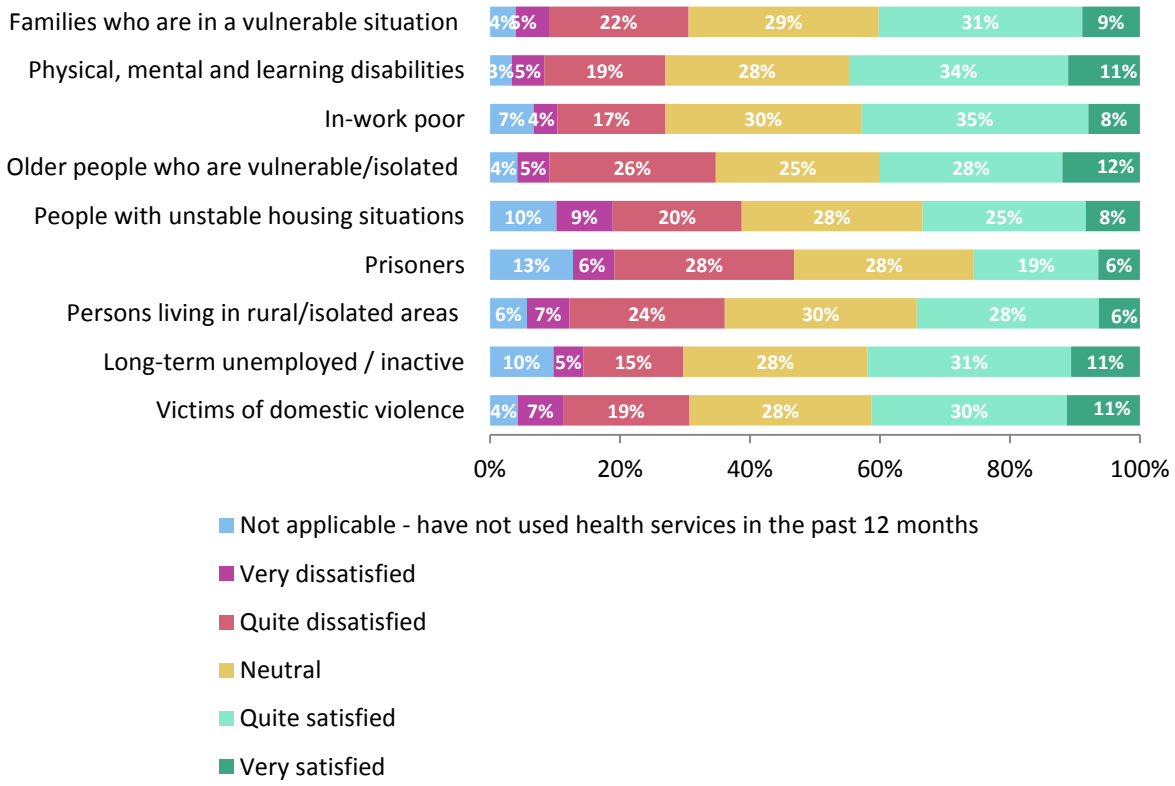
Satisfaction with health services differs for some target groups, as shown in Figure 32. First, prisoners (13%), people with unstable housing situations (10%) and long-term unemployed people where the least likely to have used health services in the past year,

[24] Based on Question 8

while physically and mentally disabled (3%), vulnerable and isolated older people (4%), vulnerable families (4%) and victims of domestic violence (4%) were the most likely.

Focusing on differences in satisfaction with the results of their medical treatment between target groups, people living in unstable housing situations were more 'very dissatisfied' than the average (9% vs. 5%), while prisoners (28% vs. 17%), vulnerable and isolated older people (26% vs. 17%), people living in rural and/or isolated areas (24% vs. 17%) and members of vulnerable families (22% vs. 17%) were more 'quite dissatisfied'. In contrast, long-term unemployed or inactive people are less often 'quite dissatisfied' (15% vs. 17%).

**Figure 32 Satisfaction with health services for target groups**




*Base: all respondents (n = 4.187)*

The socio-demographic analysis reveals some differences across the included profiles, mostly related to the educational level and the financial situation of the respondents. Respondents with only a basis education were more dissatisfied with the health services: 29% of them were either quite or very dissatisfied, compared to the 22% average, while only 28% were quite satisfied, compared to the 33% average.

The results in Table 27 below also show that while both men and women were rather satisfied with health services, men were somewhat more likely to be very satisfied (12% vs. 9%), while women were somewhat more likely to be quite satisfied (35% vs. 33%). Respondents in a difficult financial situation were more dissatisfied with the health services than respondents in an easy financial situation (28% vs. 14% was either 'very'

or 'quite' dissatisfied), while they were less satisfied with the health services (36% vs. 54% was either 'very' or 'quite' satisfied).

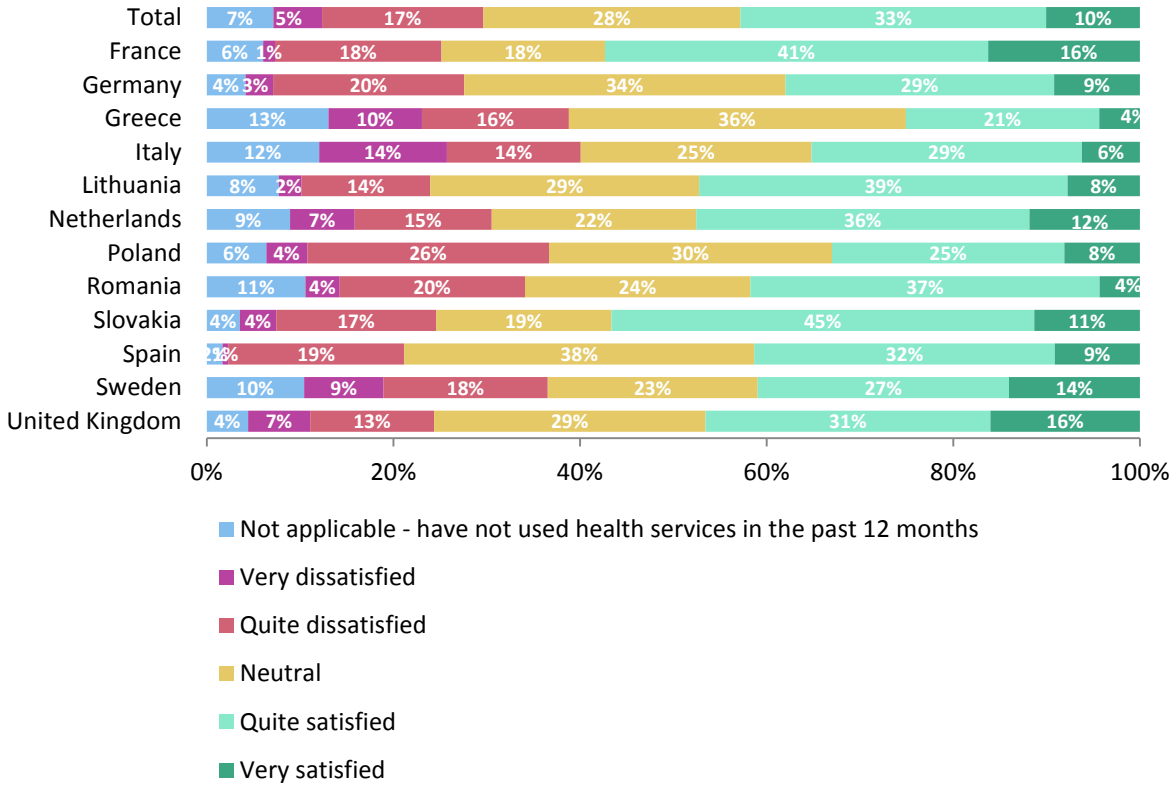
**Table 27 Satisfaction with health services for socio-demographic profiles**

| | Very dissatisfied | Quite dissatisfied | Neutral | Quite satisfied | Very satisfied | Not applicable |
|---|---|---|---|---|---|---|
| **Total** | **5%** | **17%** | **28%** | **33%** | **10%** | **7%** |
| Male | 5% | 17% | 26% | 31% | 12% | 9% |
| Female | 5% | 17% | 28% | 35% | 9% | 6% |
| 18-34 | 5% | 17% | 30% | 31% | 9% | 9% |
| 35-54 | 5% | 17% | 28% | 33% | 9% | 7% |
| 55+ | 5% | 18% | 24% | 35% | 12% | 6% |
| Basis education | 7% | 22% | 25% | 28% | 12% | 6% |
| Medium education | 5% | 16% | 28% | 34% | 9% | 8% |
| High education | 5% | 15% | 27% | 34% | 11% | 7% |
| (Very) difficult financial situation | 7% | 21% | 29% | 29% | 7% | 7% |
| (Very) easy financial situation | 3% | 11% | 25% | 39% | 15% | 8% |

*Base: all respondents (n = 4.187)*

Satisfaction with medical treatment also differed across the countries. Across all included countries, satisfaction was highest among French and Slovakian respondents (for both 57% were 'quite' or 'very' satisfied), followed by Lithuanian respondents (47%). In contrast, satisfaction was lowest in Greece (25%) and in Italy (35%). In all countries, however, maximum about half of the respondents were satisfied with the health services they have received.

**Figure 33 Satisfaction with health services for target groups**




*Base: all respondents (n = 4.187)*

It is plausible that ***respondents' general health***[25] has an effect on how satisfied respondents are with health services. After all, respondents with reported bad health could require health services more often and the quality of the health services may also be more consequential for them. The findings in Table 28 suggest a possible relationship between the two variables[26]. Concretely, respondents with reported bad health were more dissatisfied with the health services they experienced in the past 12 months than respondents with a good health (40% vs. 10% were 'very' and 'quite' dissatisfied). In contrast, respondents with a good health were more satisfied with the health services than respondents with a bad health (54% vs. 29%). This suggests a positive relationship between the respondents' health and the satisfaction with health services. Hence, respondents who were likely to need healthcare the most were also the least satisfied with it.

[25] See Question 1

[26] It is impossible to test causal relationships with survey data. Hence, the findings only reveal a relationship between the two variables, without implying a direction of this relationship.

**Table 28 The effect of the general health situation on the satisfaction with health services**

| | | Satisfaction with medical treatment | | | | | |
|---|---|---|---|---|---|---|---|
| | | Very dissatisfied | Quite dissatisfied | Neutral | Quite satisfied | Very satisfied | N/a |
| **Total** | | **5%** | **17%** | **28%** | **33%** | **10%** | **7%** |
| General health situation | (Very) bad | 11% | 29% | 28% | 22% | 7% | 3% |
| | Fair | 4% | 17% | 31% | 36% | 7% | 5% |
| | (Very) good | 2% | 8% | 22% | 38% | 16% | 13% |

*Base: all respondents (n = 4.187)*

To further investigate the relationship between the respondent's health and the satisfaction with health services, Table 29 presents a cross-check between ***specific health issues*** and the satisfaction with the medical treatment. The findings of this analysis suggest that when respondents had problems with vision (26% vs. 22% are 'quite dissatisfied'), dexterity (26% vs. 22%), memory (26% vs. 22%) stamina, breathing or fatigue (25% vs. 22%) or social or behavioural problems (28% vs. 22%), they were less satisfied with the medical treatment. As the column 'occurrence of problems' indicates, these are not necessarily the problem areas that were affected most often.

**Table 29 The effect of health issues on the satisfaction with health services[27]**

| | | | Satisfaction with medical treatment | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Occurrence of problem | Very dissatisfied | Quite dissatisfied | Neutral | Quite satisfied | Very satisfied | N/a |
| **Total** | | | **7%** | **22%** | **28%** | **31%** | **10%** | **3%** |
| General health situation | Vision | 21% | 7% | 26% | 29% | 27% | 8% | 2% |
| | Hearing | 12% | 6% | 25% | 30% | 27% | 10% | 2% |
| | Mobility | 42% | 8% | 23% | 27% | 31% | 9% | 3% |
| | Dexterity | 22% | 8% | 26% | 26% | 30% | 9% | 2% |
| | Learning or understanding or | 14% | 9% | 25% | 25% | 28% | 10% | 4% |

[27] See Question 3; the total percentages differ from the previous tables, since this overview only included respondents with a long-standing illness, disability or infirmity (respondents that answered 'yes' to question 2).

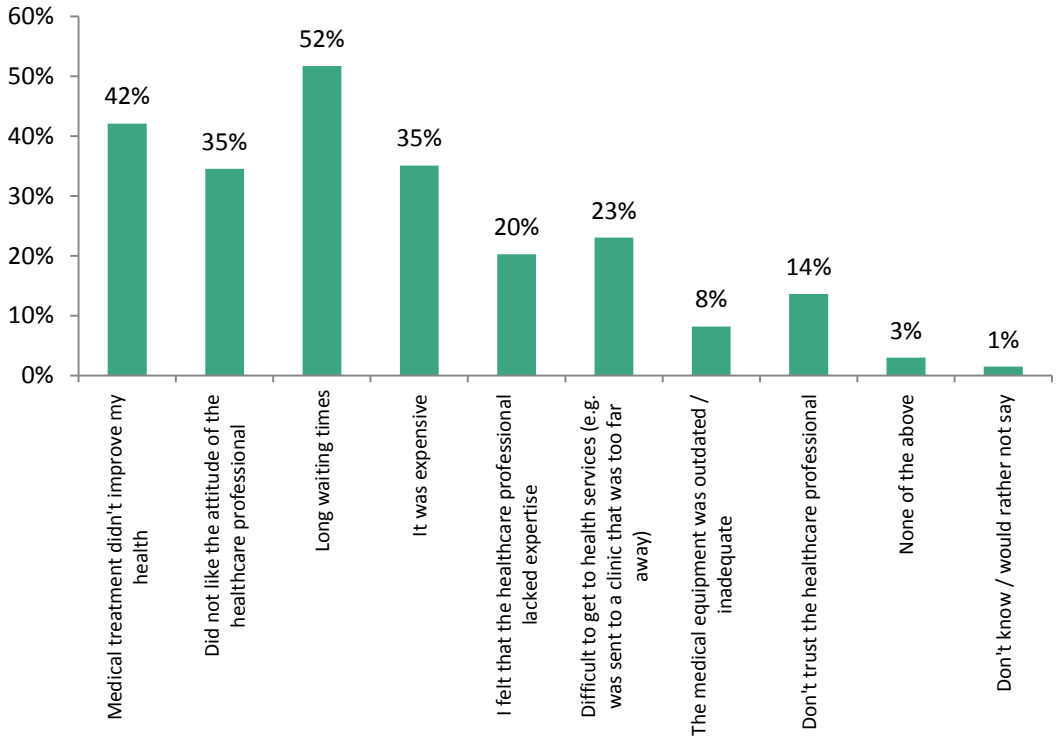
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | concentrating | | | | | | | |
| | Memory | 18% | 8% | 26% | 26% | 28% | 9% | 2% |
| | Mental health | 31% | 8% | 22% | 28% | 30% | 10% | 2% |
| | Stamina, breathing or fatigue | 37% | 7% | 25% | 29% | 30% | 7% | 2% |
| | Socially or behaviourally | 8% | 9% | 28% | 24% | 24% | 10% | 4% |
| | Other | 21% | 8% | 23% | 27% | 29% | 9% | 4% |
| | None of the above | 3% | 3% | 15% | 30% | 32% | 19% | 1% |
| | Would rather not say | 1% | 4% | 16% | 28% | 40% | 12% | 0% |

*Base: respondents that reported long-standing illnesses, disabilities or infirmity (Q2) and answered Q8 (n = 2.557)*

Given the noticeable proportion of respondents that was at least somewhat dissatisfied with the health services, it is important to focus on the ***reasons for this dissatisfaction***[28] (see Figure 34). The survey results show, that the majority of respondents were dissatisfied because of the long waiting times (52%). However, many respondents also reported that they felt that the medical treatment did not improve their health (42%), that they found the health services too expensive (35%) and that they did not like the attitude of the healthcare professional (35%).

[28] Based on Question 9

**Figure 34 Reasons of dissatisfaction with medical treatment**




*Base: respondents that were 'very dissatisfied' or 'quite dissatisfied' with their health service experience (Q8; n = 938)*

The findings differ across the surveyed target groups (see Table 30). ***Long waiting lines*** were most often mentioned by respondents from rural and/or isolated areas (65%), vulnerable and/or isolated older respondents (63%), the in-work poor (61%) and respondents with physical, mental and learning disabilities (57%). Long-term unemployed or inactive respondents (43%) were relatively less likely to complain about long waiting times.

The second most mentioned reason for respondents' dissatisfaction with the results of their medical treatments was their perception that the ***medical treatment did not improve their health***. While all target groups reported this reason quite often, people with physical, mental and learning disabilities (53%) and long-term unemployed respondents (49%) found most often that medical treatments did not improve their health. For long-term unemployed respondents, this was even the most prevalent driver of dissatisfaction with healthcare received. On the contrary, respondents living in an unstable housing situation (32%) reported that medical treatment did improve their health.

The target group of disabled people reported a more than average dissatisfaction with the ***attitude of the healthcare professionals*** (43% vs. 35%). Older respondents living in vulnerable and/or isolated circumstances (47% vs. 35%), the in-work poor (44% vs. 35%) and members of vulnerable families (43% vs. 35%) were more dissatisfied because of the ***costs of the medical treatment***.

**Table 30 Reasons of dissatisfaction with medical treatment for socio-demographic profiles**

| | Medical treatment didn't improve my health | Did not like the attitude of the healthcare professional | Long waiting times | It was expensive | I felt that the healthcare professional lacked expertise | Difficult to get to health services (e.g. was sent to a clinic that was too far away) | The medical equipment was outdated / inadequate | Don't trust the healthcare professional | None of the above | Don't know / would rather not say |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **42%** | **35%** | **52%** | **35%** | **20%** | **23%** | **8%** | **14%** | **3%** | **1%** |
| Families who are in a vulnerable situation | 37% | 33% | 50% | 43% | 14% | 38% | 11% | 11% | 1% | 1% |
| Physical, mental and learning disabilities | 53% | 43% | 57% | 35% | 25% | 27% | 7% | 16% | 3% | 1% |
| In-work poor | 42% | 30% | 61% | 44% | 20% | 23% | 11% | 9% | 2% | 4% |
| Older people who are vulnerable/isolated | 48% | 32% | 63% | 47% | 13% | 26% | 8% | 5% | 1% | 0% |
| People with unstable housing situations | 32% | 32% | 55% | 38% | 21% | 26% | 5% | 13% | 2% | 1% |
| Prisoners | 41% | 31% | 63% | 22% | 44% | 38% | 34% | 22% | 0% | 0% |
| Persons living in rural/isolated areas | 42% | 40% | 65% | 43% | 21% | 30% | 11% | 15% | 2% | 2% |
| Long-term unemployed / inactive | 49% | 39% | 43% | 32% | 26% | 20% | 9% | 20% | 4% | 0% |
| Victims of domestic violence | 36% | 40% | 43% | 28% | 18% | 24% | 4% | 28% | 1% | 3% |

*Base: respondents that were 'very dissatisfied' or 'quite dissatisfied' with their health service experience (Q8; n = 938)*

The socio-demographic analysis revealed that ***long waiting times*** were the most important reason across all socio-demographic profiles. Furthermore, compared to the average results, older respondents (55+ years) were also particularly often dissatisfied with health services, because they believed that the ***medical treatment did not improve their health*** (48% vs. 42%). The financial situation of respondents had an impact on the prevalence of the other two prevalent reasons. In particular, respondents in a difficult financial situation were less likely to complain about the ***attitude of the healthcare professionals*** (32% vs. 42%), but more likely to complain about the ***costs of the medical treatment*** (39% vs. 21%) than respondents in a good financial situation. To support this, table 31 below provides an overview of the findings across all socio-demographic profiles.

Country-level analyses (Table 32) show that especially in Poland (79%) and in Greece (70%) many of the respondents were dissatisfied because of ***long waiting lines***, while in the Sweden (25%) and the Netherlands (29%) this reason was mentioned by "only" about one quarter of the respondents. Almost half of the respondents ***believed that the medical treatment did not improve their health***. In Poland (60%), Germany (56%), France (55%) and Sweden (52%) this number was even higher. In Greece (26%) and particularly in Italy (6%), however, relatively few respondents shared this perception. Half of the UK respondents (52%) ***did not like the attitude of the healthcare professional***. This is noticeable more than the 35% average. In Germany, Italy (both 15%) and the Netherlands (23%) fewer respondents reported this reason. Finally, the high ***costs of the medical treatment*** were particularly a problem in Germany (48%), Greece (47%) and Lithuania (46%), where almost half of the respondents reported this as a reason for dissatisfaction.

**Table 31 Reasons of dissatisfaction with medical treatment for socio-demographic profiles**

| | Medical treatment didn't improve my health | Did not like the attitude of the healthcare professional | Long waiting times | It was expensive | I felt that the healthcare professional lacked expertise | Difficult to get to health services (e.g. was sent to a clinic that was too far away) | The medical equipment was outdated / inadequate | Don't trust the healthcare professional | None of the above | Don't know / would rather not say |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **42%** | **35%** | **52%** | **35%** | **20%** | **23%** | **8%** | **14%** | **3%** | **1%** |
| Male | 41% | 32% | 52% | 36% | 21% | 25% | 9% | 14% | 3% | 1% |
| Female | 44% | 37% | 52% | 34% | 20% | 21% | 8% | 14% | 3% | 2% |
| 18-34 | 40% | 37% | 56% | 35% | 22% | 27% | 10% | 16% | 2% | 2% |
| 35-54 | 40% | 34% | 50% | 33% | 22% | 23% | 10% | 15% | 2% | 2% |
| 55+ | 48% | 34% | 50% | 39% | 16% | 19% | 5% | 10% | 6% | 1% |
| Basis education | 38% | 30% | 48% | 40% | 15% | 23% | 8% | 12% | 2% | 1% |
| Medium education | 43% | 35% | 54% | 34% | 19% | 23% | 8% | 13% | 3% | 1% |
| High education | 48% | 37% | 53% | 34% | 29% | 20% | 9% | 17% | 4% | 1% |
| (Very) difficult financial situation | 42% | 32% | 52% | 39% | 19% | 24% | 8% | 12% | 2% | 2% |
| (Very) easy financial situation | 43% | 42% | 52% | 21% | 24% | 22% | 9% | 17% | 6% | 0% |

*Base: respondents that were 'very dissatisfied' or 'quite dissatisfied' with their health service experience (Q8; n = 938)*

**Table 32 Reasons of dissatisfaction with medical treatment per country**

| | Medical treatment didn't improve my health | Did not like the attitude of the healthcare professional | Long waiting times | It was expensive | I felt that the healthcare professional lacked expertise | Difficult to get to health services (e.g. was sent to a clinic that was too far away) | The medical equipment was outdated / inadequate | Don't trust the healthcare professional | None of the above | Don't know / would rather not say |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **42%** | **35%** | **52%** | **35%** | **20%** | **23%** | **8%** | **14%** | **3%** | **1%** |
| France | 55% | 28% | 42% | 42% | 18% | 17% | 2% | 17% | 0% | 2% |
| Germany | 56% | 15% | 57% | 48% | 14% | 23% | 11% | 11% | 5% | 0% |
| Greece | 26% | 40% | 70% | 47% | 21% | 47% | 25% | 18% | 1% | 0% |
| Italy | 6% | 15% | 44% | 43% | 12% | 23% | 6% | 6% | 0% | 1% |
| Lithuania | 39% | 43% | 63% | 46% | 22% | 19% | 6% | 10% | 3% | 0% |
| Netherlands | 37% | 23% | 29% | 39% | 27% | 24% | 1% | 11% | 4% | 3% |
| Poland | 60% | 42% | 79% | 44% | 17% | 24% | 3% | 10% | 0% | 2% |
| Romania | 41% | 28% | 51% | 44% | 20% | 24% | 21% | 10% | 1% | 0% |
| Slovakia | 51% | 45% | 54% | 32% | 11% | 18% | 6% | 8% | 3% | 5% |
| Spain | 49% | 42% | 62% | 15% | 15% | 20% | 10% | 10% | 2% | 2% |
| Sweden | 52% | 39% | 25% | 24% | 42% | 12% | 3% | 21% | 12% | 0% |
| United Kingdom | 36% | 52% | 44% | 5% | 21% | 26% | 5% | 31% | 2% | 4% |

*Base: respondents that were 'very dissatisfied' or 'quite dissatisfied' with their health service experience (Q8; n = 938)*

## 5.2 Summary

This chapter provided insights into the satisfaction of vulnerable and isolate people with the healthcare services they have received in the past year. Special attention was paid to the role of the respondents' health and the reasons for dissatisfied respondents.

In general, the survey results show that the average ***satisfaction with health services*** is relatively high. Almost half of all respondents were either quite or very satisfied (43%), while less than one quarter of the respondents were dissatisfied (22%) with the health services they received in the past year. However, it is noticeable that ***respondents with a bad health, who probably need to rely on health services most often and for more serious issues, were the least satisfied***. 40% of respondents with a bad health were dissatisfied, compared to only 29% who were satisfied. Dissatisfaction with medical treatment was also ***higher for a number of specific health issues***. The results show that these issues, which include problems with vision, dexterity, memory, stamina, breathing or fatigue and social or behavioural issues, were not only limited to physical or mental issues and included both more and less frequent problems.

In relation to the ***reasons for dissatisfaction with the health*** **services,** respondents (that indicated that they were very or quite dissatisfied) were mostly dissatisfied because of long waiting times (52%), the belief that the medical treatment did not improve the respondents' health (42%), the costs of the treatment (35%) and a bad attitude of the healthcare professional (35%).

The results for the ***target groups*** reveal some interesting differences. As such, the satisfaction with health services is particularly low for *(ex-)prisoners* (34% were very or quite dissatisfied), *vulnerable and isolated older people* (31%) and *persons living in rural isolated areas* (31%).

The ***reasons for dissatisfaction with the results of their medical treatment*** also differed between the target groups. Long waiting times were most often a cause for dissatisfaction for *persons living in isolated areas* (65%), *vulnerable older people* (63%), *the in-work poor* (61%) *and people with physical, mental or learning disabilities* (57%)., *People with disabilities* did also believe most often that the medical treatment did not affect their health (53%) and had most concerns about the attitude of the healthcare professional (43%). *Vulnerable older people* (47%), *the in-work poor* (44%) and *members of vulnerable families* (43%) were also most dissatisfied because of the costs of the medical treatment.

***Socio-demographic breakdowns*** also revealed some notable differences. The ***dissatisfaction with the results of medical treatments*** was higher for *respondents with only a basis education* (29% were very or quite dissatisfied) and for *respondents in a difficult financial situation* (28%).

The ***reasons for dissatisfaction*** with the healthcare services were only somewhat affected by socio-demographic differences. The impact of waiting times did not differ across the different groups of respondents. However, *older respondents* were somewhat

more dissatisfied because they did not believe that the medical treatment affected their health (55+ years; 48%). *Respondents in a difficult financial situation* were more dissatisfied because of the costs of the medical treatment (39%), while *respondents in an easy financial situation* were more dissatisfied because of the bad attitude of a healthcare professional (42%).

The ***results at country-level*** show that particularly few Greek (25%) and Italian (35%) respondents were *satisfied with the health care they have received in the past 12 months*. While respondents from France (57%), Slovakia (57%) and Lithuania (47%) were most satisfied, this was still only about half of the respondents.

As discussed above, *long waiting lines* were the main reason for respondents to be dissatisfied with the health services they have received. While half of all respondents reported this reason, respondents in Poland (79%) and Greece (70%) were even more likely to be dissatisfied because of long waiting times. Polish respondents (60%), together with German (56%), French (55%) and Swedish (52%) respondents were most likely to be dissatisfied with health services, because they did not think these services had a positive impact on their health. In addition, about half of the UK respondents (52%) disliked the attitude of the health care professional and about half of the German (49%), Greek (47%) and Lithuanian (46%) respondents were dissatisfied because of high costs.

# 6 General conclusion

The current survey aims to provide insights into the current health situation of people living in vulnerable and isolated situations in the EU and into their experiences with healthcare. The findings of this survey also provide insights into what may cause health problems for vulnerable and isolated people and into factors that may prevent them from getting the care they need.

This chapter discusses and summarises the main results of the current survey.

## 6.1 Key results

The findings of this survey can be summarised as a number of key results:

**Key result 1: Vulnerable and isolated people often deal with health issues, which are often attributed to the lack of money or the feelings of stress**

The current insights into the ***health situation of vulnerable and isolated people*** show that only about a third of the respondents evaluated their health as good or very good (31%), while a quarter of the respondents reported a bad health (28%). Similarly, more than half of all respondents (61%) reported a long-standing illness, disability or infirmity. These long-standing health issues were often related to problems with mobility (32% of respondents with long-term health issues), problems with stamina, breathing or fatigue (29%) or to mental health problems (25%). Moreover, a noticeable share of the respondents experienced feelings of psychological stress: more than one quarter of respondents felt particularly tense (30%), lonely (27%) and depressed (28%) most or all of the time. Also, less than one quarter of respondents woke up fresh and rested most or all of the time (21%). In summary, the results indicate that health problems are a common issue among people in vulnerable and isolated situations, highlighting the need for activities to improve the health of those people.

In order to design successful strategies for improving the health situation of vulnerable and isolated people, one must know ***what causes these health problems***. The findings of the current survey suggest a variety of factors that affect the respondents' health, including smoking or the consumption of alcohol, the lack of exercise, wrong dietary habits, the lack of good housing conditions or the working environment. The two most important barriers for respondents' health were, however, the lack of money (reported by 62% of respondents) and feelings of stress (53%). The role of the lack of money was further emphasized by socio-demographic breakdowns, which show that a more difficult financial background often correlated with more health issues.

**Key result 2: Vulnerable and isolated people find it often difficult to obtain the healthcare they need, due to the unaffordability of the healthcare services. This is especially the case for people with a bad health.**

About one third of all respondents (32%) found it difficult to obtain the healthcare services they needed in the past year. This number even increased to 50% for respondents with a bad or very bad health (compared to only 19% for respondents with a good health).

Investigating the factors that stopped respondents from visiting medical practitioners, getting dental examination or treatment and getting medication, the survey results suggest that the biggest barrier for all three healthcare facilities were the relatively high costs (mentioned by 25%-30% of respondents). This was further supported by socio-demographic breakdowns, which show that respondents' financial situation had an effect on the ease of accessing healthcare. The findings show that respondents in a difficult financial situation found medical treatment, dental care and medication most expensive. Besides the unaffordability of healthcare facilities, access to medical practitioners was also affected by the respondents' inability to get an appointment (mentioned by 20% of the respondents) and long waiting times (19%).

This survey also investigated if vulnerable and isolated people have difficulties with understanding health information provided by doctors, nurses or other healthcare support providers. Half of the respondents found this information easy to understand (51%), while only one fifth of the respondents (21%) found this difficult. This was particularly the case for respondents with only a basic education, who reported more difficulties with understanding the health information than respondents with a medium and high education. In addition, the financial situation of a respondent had an effect. Respondents in a difficult financial situation had it more difficult to understand health information than respondents in an easy financial situation.

**Key result 3: Satisfaction with health services is dependent on people's health: satisfaction is often lower for people who need healthcare.**

In general, the current findings suggest that vulnerable and isolated peoples' satisfaction with health services is relatively high. While 43% of the respondents were satisfied with the results of the medical treatments they have received in the last 12 months, only 22% was dissatisfied. However, this was not the case for respondents with a bad health. 40% of respondents with a bad health were dissatisfied medical treatments they used, compared to only 29% that were satisfied. This is a particularly interesting finding, given that respondents with a bad health are likely to visit healthcare providers more often (i.e., have more service encounters) and given that the work of the healthcare providers may be of greater impact for the respondents' welfare.

Dissatisfaction with healthcare services was also somewhat dependent on the type of health problem that respondents reported. While dissatisfaction is more or less the same across all tested problem areas, respondents were slightly more dissatisfied when they had problems with their vision (33% was quite or very dissatisfied), dexterity (34%), memory (34%), stamina, breathing or fatigue (32%) and social or behavioural issues (37%).

Dissatisfaction with health services was most often caused by long waiting times (reported by 52% of the dissatisfied respondents), the respondents' disbelief that the medical treatment did improve their' health (42%), the high costs of the treatment (35%) and the attitude of the healthcare professionals (35%).

**Key result 4: Vulnerable and isolated people in different target groups behave similarly yet different.**

The findings also provide insights into differences and similarities between the nine selected target groups[29]. While the findings were overall more or less similar across all target groups, there are certain differences.

For example, people with physical, mental and learning disabilities, older people in vulnerable and isolated situations and victims of domestic violence reported the worst health situation (between 33% and 39% reported a (very) bad health, compared to the 29% average) and/or long-term illnesses, disabilities and infirmity (between 67% and 84%, compared to the 61% average).

The reasons for their health problems were, however, different. While the disabled respondents reported many problems with mobility, stamina, breathing and fatigue (40%) and their mental health (44%), vulnerable older people had mostly problems with mobility 56%) and stamina, breathing or fatigue (48%). In contrast, victims of domestic violence (45%) mostly dealt with mental health issues.

The accessibility to healthcare also differed across the target groups. As such, vulnerable families (39%), people living in rural or isolated areas (42%) and vulnerable older people (43%) reported the most problems with accessing healthcare. The access to healthcare facilities, including medical practitioners, dental examination/treatment and medication, for these groups, but also for people with unstable housing and the in-work poor, was often hindered by the costs of these services. It is noticeable that this was not the case for people with physical, mental and learning disabilities, who were consistently less affected by the costs of healthcare. Looking at respondents' ease of understanding health information provided by doctors and other healthcare providers, members of vulnerable families, people with unstable housing and vulnerable and isolated older people had the most problems with understanding this information.

Finally, the satisfaction with the results of the medical treatments respondents had received in the past year was also somewhat dependent on the specific target group the respondents belonged to. Satisfaction was lowest for (ex-)prisoners (34% were very or quite dissatisfied), vulnerable and isolated older people (31%) and people living in rural and isolated areas (31%). The reasons for dissatisfaction also differed between the target groups. Long waiting times, the most prominent reason for dissatisfied respondents, was

[29] families from disadvantaged backgrounds, those living in rural and isolated areas, those with physical, mental and/or learning disabilities, the long term unemployed and in-active, the in-work poor, older people, victims of domestic violence and intimate partner violence, people with unstable housing situations (homeless) and prisoners (See the methodology for more information about the selection of target groups)

most often reported by persons living in isolated and rural areas (65%), (ex-)prisoners (63%), vulnerable older people (63%) and the in-work poor (61%). The disbelief in the effectiveness of the medical treatment, in contrast, was most often reported by people with disabilities reported dissatisfaction (53%).The costs of the medical treatment was reported most often by vulnerable older people (47%), the in-work poor (44%) and members of vulnerable families (43%), while the issue of a bad attitude of the healthcare worker was raised most often by people with disabilities (43%).

**Key result 5: People's education and financial situation matters.**

While the results differed for various socio-demographic variables, there was a consistent role of the respondents' education and their financial situation in relation to their health situation, access to healthcare and satisfaction with healthcare services.

As such, respondents with only a basic education and respondents in difficult financial situations were more likely to have a bad health (respectively 37% & 36% evaluated their health as bad or very bad) and reported more instances of long-standing illnesses, disabilities or infirmity (69% & 64%). Furthermore, the two socio-demographic factors were also correlated with specific health issues. Respondents with only a basic education (instead of a medium or higher education) reported more often mental health issues (36% vs. 29%-30%). Respondents in a difficult financial situation (instead of an easy financial situation) reported more problems with their stamina, breathing or fatigue (40%-31%). Level of education and financial status were also related to more feelings of psychological stress. As such, respondents with a basis education and respondents in a difficult financial situation were particularly likely to feel tense (respectively 33% & 35% did so most or all of the time), lonely (34% & 32%) and depressed (both 33%), while respondents in a difficult financial situation also experienced fewer instances of waking up well rested 16%).

Both respondents in a difficult financial situation and respondents with only a basis education mention the lack of monetary resources as detrimental for their health particularly often (67% & 78%). Feelings of stress were also mentioned particularly often by respondents in a difficult financial situation (57%), but less often than average by respondents with only a basis education (44%).

A difficult financial situation and only a basic education also had an effect on the access to healthcare respectively 39% & 46% found it quite or very difficult), often due to the unaffordability of medical practitioners (33% & 37%), dental examination/treatment (39% & 35%) or medication (34% & 37%). Both socio-demographic groups also found it more difficult to understand health information provided by doctors, nurses and other healthcare professionals (25% & 33% found it quite or very difficult, compared to the 21% average).

The dissatisfaction with medical treatments was also higher for those two socio-demographic groups: 29% of low-educated respondents and 28% of respondents in a difficult financial situation were dissatisfied. The cost-aspect of healthcare services was reported significantly more often by respondents in a difficult financial situation (39%).

## 6.2 Future research needs

A number of findings warrant further investigation into the health situation of vulnerable and isolated people. Comparing the current findings with what is known about other groups of citizens might help to better understand the magnitude of the findings. Moreover, qualitative studies may help to obtain a more detailed understanding of the current findings. Based on the current findings, a number of specific avenues for future research were identified, discussed below.

While the current survey provides insights into potential causes of health problems, further research may help to connect particular causes to specific health issues. For example, different factors may be responsible for physical versus mental health problems. Moreover, new insights may also be gathered about how the different factors affect health. For example, the lack of money is mentioned as one of the most important reasons for health issues. The current results suggest that the lack of money hinders vulnerable and isolated people from paying for the necessary medical help. However, future studies may help to identify other effects that the lack of money may have on a person's health, including poorer living conditions, a low quality of food and increased stress related to make a living and working.

Future studies may also help to further understand the factors that stop vulnerable and isolated people from accessing healthcare. Special attention should be given to the reasons that make healthcare services, such as medical treatments, dental care or medication, unaffordable for them. Given the negative impact of costs for this group of respondents, further insights might help to develop necessary campaigns and/or policies.

The current findings show that vulnerable and isolated people with a bad health have more problems with accessing the healthcare services and are more dissatisfied about the services they received. Since this people in this target group with a bad health are particularly vulnerable, future studies should focus on the reasons for these findings to develop best practices to improve the conditions of this group..

The findings show certain differences for the surveyed target groups. However, little is yet known about what drives these differences. While certain assumptions can be made based on the profile of each target group, further studies should provide insights into why target groups differ in their health situation, access to healthcare and satisfaction with health services.

Finally, while the level of education of the respondents seems to have an effect on many of the investigated variables, the current results deliver few insights into what drives this effect. While it is possible that the level of education is correlated with professional success and, hence, the financial situation, the findings show some inconsistencies between the effect of education and financial status. Given the strong impact of the level of education throughout the results, further investigation may be relevant.

# 7 Annex 1: Questionnaire

Dear Sir / Madam,

This questionnaire is part of an EU-funded pilot project to better understand your particular health needs, which will provide insights to support the development of actions to improve your access to health services. As thanks for your time, you shall receive an incentive of _____

Answers are provided on a voluntary basis and collected anonymously. We do encourage you to answer all questions within the questionnaire. No link will be made between these answers and any information permitting one to identify their origin. The statistical results will not allow for the identification of a person. Your responses will **always remain confidential**.

Please complete the questionnaire as honestly as possible, there are no 'good' or 'bad' answers.

The questionnaire will take **10 minutes** to fill in.

We thank you very much for your participation!

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**Information on Health & Activities**

Please answer the following questions, which collect information about your own level of health and the activities that you regularly carry out:

**Q1. How is your health in general? Please circle**

**Very bad** **Bad** **Fair** **Good** **Very good**

**Q2. Do you have any long-standing illness, disability or infirmity? By long-standing I mean anything that has troubled you over the past 6 months or that is likely to affect you over the next 6 months.**

| Yes | No |
|---|---|

**IF YOU ANSWERED 'YES' AT THE PREVIOUS QUESTION, PLEASE PROVIDE MORE INFORMATION AT THE FOLLOWING QUESTION.**

**IF YOU ANSWERED 'NO' AT THE PREVIOUS QUESTION, PLEASE SKIP TO THE NEXT SECTION ON 'ACCESS TO HEALTHCARE SERVICES'**

**Q3. Do any of these conditions or illnesses affect you in any of the following areas?**

**PLEASE TICK ALL DIFFICULTIES THAT APPLY**

| | |
|---|---|
| | Vision (for example blindness or partial sight) |
| | Hearing (for example deafness or partial hearing) |
| | Mobility (for example walking only short distances or climbing stairs) |
| | Dexterity (for example lifting and carrying objects, using a keyboard) |
| | Learning or understanding or concentrating |
| | Memory |
| | Mental health |
| | Stamina or breathing or fatigue |
| | Socially or behaviourally (for example associated with autism, attention deficit disorder or Aspergers) |
| | Other |
| | None of the above |
| | Would rather not say |

**ASK ALL**

**Access to Healthcare Services**

The following questions collect information about your experiences of using healthcare services in the past 12 months:

**Q4. In general, how difficult or easy is it for you to access healthcare services when you need them?**

**Very difficult** | **Quite difficult** | **Neutral** | **Quite easy** | **Very easy**

**Q5. Was there a time during the last 12 months when you really needed to visit a medical practitioner (e.g. doctor/nurse) but you did not go? Why?**

**Please circle all answers that apply**

| | |
|---|---|
|  | Yes – because I couldn't get an appointment |
|  | Yes – because I couldn't afford it |
|  | Yes – because I couldn't take time off work |
|  | Yes – due to a lack of transportation |
|  | Yes – because there wasn't a doctor/nurse in my community |
|  | Yes – because I did not know if it would be covered by the healthcare service (e.g. free or paid for by medical insurance) |
|  | Yes – because I did not know where to get help |
|  | Yes – because the wait was too long |
|  | Yes – because I did not trust doctors / nurses |
|  | Yes – because I changed my mind and decided not to go |
|  | Yes – because I was unable to arrange care for a child / adult I am responsible for |
| Yes – other | |
|  | **No – there was no time during the last 12 months when I personally really needed to visit a medical practitioner but did not go** |

**Q6. Was there any time during the last 12 months when you really needed a dental examination or treatment but you did not receive it? Why?**

**Please circle all answers that apply**

| | |
|---|---|
|  | Yes – because I couldn't get an appointment |
|  | Yes – because I couldn't afford it |
|  | Yes – because I couldn't take time off work |
|  | Yes – due to a lack of transportation |
|  | Yes – because there wasn't a dentist in my community |
|  | Yes – because I did not know if it would be covered by the healthcare service (e.g. free or paid for by medical insurance) |
|  | Yes – because I did not know where to get help |
|  | Yes – because the wait was too long |
|  | Yes – because I did not trust dentists |
|  | Yes – because I changed my mind and decided not to go |
|  | Yes – because I was unable to arrange care for a child / adult I am responsible for |
| Yes – other | |
|  | **No – there was no time during the last 12 months when I personally really needed to visit a dental practitioner but did not go** |

**Q7. Was there any time during the last 12 months when you really needed to obtain medication but were not able to do so?**

**Please circle all answers that apply**

| | |
|---|---|
|  | Yes – because I couldn't afford it |
|  | Yes – due to a lack of transportation |
|  | Yes – because there wasn't a pharmacy or other source of medication in my community |
|  | Yes – because I did not know if it would be covered by the healthcare service (e.g. free or paid for by medical insurance) |
|  | Yes – because I did not know where to get advice |
|  | Yes – because the wait was too long |
|  | Yes – because I did not trust pharmacists or other medical practitioners |
|  | Yes – because I changed my mind and decided not to obtain it |
| | Yes – other reason |
|  | **No – there was no time during the last 12 months when I really needed to obtain medication but was not able to do so** |

**Q8. Considering all of your experiences of using health services in the past 12 months, to what extent were you satisfied with the results of your medical treatment?**

| Very dissatisfied | Quite dissatisfied | Neutral | Quite satisfied | Very satisfied | Not applicable – have not used health services in the past 12 months |
|---|---|---|---|---|---|

**IF YOU ANSWERED 'VERY DISSATISFIED' / 'QUITE DISSATISFIED' AT THE PREVIOUS QUESTION, PLEASE PROVIDE MORE INFORMATION AT THE FOLLOWING QUESTION.**

**Q9. Why were you dissatisfied? Please select all that apply**

| | |
|---|---|
| | Medical treatment didn't improve my health |
| | Did not like the attitude of the healthcare professional |
| | Long waiting times |
| | It was expensive |
| | I felt that the healthcare professional lacked expertise |
| | Difficult to get to health services (e.g. was sent to a clinic that was too far away) |
| | The medical equipment was outdated / inadequate |
| | Don't trust the healthcare professional |
| X | None of the above |
| X | Don't know / would rather not say |

**ASK ALL**

**Q10. In general, how difficult or easy do you find it to understand health information (for example, health information that you receive from your doctor, nurse, other healthcare support provider)?**

| Very difficult | Quite difficult | Neutral | Quite easy | Very easy |
|---|---|---|---|---|

## Quality of Life & Opinion Questions

The following questions ask for your views about your own quality of life:

**Q11. Many things can affect your health. Which of the following creates a barrier to your own good health?**

**Please circle all answers that apply**

|  |  |  |  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|
| Lack of Good Housing Conditions | Lack of money | Work (or lack of work) | Concern about Relationships | Lack of exercise | Too much food / too little food / unhealthy diet | Smoking | Alcohol | Drugs | Stress |

|  | None of the above |
|---|---|
| Other – please specify | |

**Q12. Please indicate for each of the four statements which is closest to how you have been**

**feeling over the last two weeks?**

| | At no time | Some of the time | About half of the time | Most of the time | All of the time |
|---|---|---|---|---|---|
| **I woke up feeling fresh and rested** | 1 | 2 | 3 | 4 | 5 |
| **I have felt particularly tense** | 1 | 2 | 3 | 4 | 5 |
| **I have felt lonely** | 1 | 2 | 3 | 4 | 5 |
| **I have felt downhearted and depressed** | 1 | 2 | 3 | 4 | 5 |

## Socio-demographics

**Q13. What is your gende**

| | |
|---|---|
| | Male |
| | Female |
| | Other |
| X | Would rather not say |

**Q14. How old are you?**

**In years**

**Q15. How many children currently live in your household?**

| | |
|---|---|
| | |

**Q16. With regard to occupation, which of the following best describes your situation?**

**Please select all that apply**

| |
|---|
| At work as employee or employer/self-employed |
| Employed, on child-care leave or other leave |
| At work as relative assisting on family farm or business |
| Unemployed less than 12 months |
| Unemployed 12 months or more |
| Not legally permitted to work |
| Unable to work due to long-term illness or disability |
| Retired |
| Full time homemaker/ responsible for ordinary shopping and looking after the home |
| Full time carer |
| In education (at school, university, etc.) / student |
| Other |

**Q17. What is the highest level of education you have successfully completed?**
NATIONALLY-SPECIFIC LIST TO BE DRAWN UP

| | |
|---|---|
| | Basic, for example:<br>• Primary school,<br>• Partial secondary school (left under 15 years old), |
| | Medium, for example:<br>• General National Vocational Qualification Foundation or Intermediate Level (GNVQ, GSVQ) / GCSE/ SCE standard,<br>• NVQ1, NVQ2,<br>• NVQ3 / SCE Higher Grade / Scottish Certificate of Sixth Year Studies / General National Vocational Qualification Advanced Level / GCE Advanced Level (GCE A/AS) |
| | High, for example:<br>• NVQ4 / Higher National Certificate (HNC) / Higher National Diploma (HND) / Diploma in HE (including nurses training) / Bachelor's degree (BA, BSc, BEd, BEng, MB, BDS, BV, etc.)<br>• NVQ5 / Master's degree (MSc, MA, MBA, etc.) / Post-graduate diplomas and certificates / Doctorate (Ph.D.) |

| Q18a. In which country were you born? | Q18b. In which country was your mother born? | Q18c. In which country was your father born? |
|---|---|---|
| (THIS COUNTRY) | (THIS COUNTRY) | (THIS COUNTRY) |
| ANOTHER EU MEMBER STATE | ANOTHER EU MEMBER STATE | ANOTHER EU MEMBER STATE |
| ANOTHER COUNTRY OUTSIDE THE EU | ANOTHER COUNTRY OUTSIDE THE EU | ANOTHER COUNTRY OUTSIDE THE EU |

**Q19. Which of the following best describes your accommodation?**

| |
|---|
| Own without mortgage (i.e. without any loans) |
| Own with mortgage |
| Tenant, paying rent to private landlord |
| Tenant, paying rent in social/voluntary/municipal housing |
| Tenant, living rent free in social/voluntary/municipal/public housing |
| Accommodation is provided rent free |
| Other |

**Q20. Thinking about your household's financial situation would you say that making ends meet every month is …?**

**Very difficult** **Difficult** **Fair** **Easy** **Very Easy**

**Q21. What letter best matches your household's total income, after tax? Use the part of the table that you know best: weekly, monthly or annual income.**

Please answer this question to the best of your ability, including all income sources such as wages, benefits, pensions and any other income sources. Note that you do not need to answer this question if you prefer not to.

| | WEEKLY | MONTHLY | YEARLY |
|---|---|---|---|
| **A** | Less than £59 | Less than £269 | Less than £3.199 |
| **B** | £60 to £159 | £270 to £699 | £3.200 to £8.299 |
| **C** | £160 to £349 | £700 to £1.499 | £8.300 to £17.999 |
| **D** | £350 to £624 | £1.500 to £2.799 | £18.000 to £33.299 |
| **E** | £625 or more | £2.800 or more | £33.300 or more |
| **F** | Don't know / Would rather not say | | |

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## Thank you for your cooperation!

*Your data that was collected by this questionnaire was recorded, stored and further processed.*

*Your data is handled in conformity with Regulation (EC) N° 45/2001 on the protection of individuals with regard to the processing of personal data by Community institutions and bodies and on the free movement of such data.*

*By providing your data related to the 'VulnerABLE' project, you unambiguously gave your consent to the above-mentioned processing of your personal data, according to article 5(d) of Regulation (EC) No 45/2001.*