Towards inclusive service delivery through social investment in the EU

The case of health services

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Executive summary

This report aims at: (a) providing an overview of the European policy framework for health services; (b) providing a comparative analysis of this service market across the EU; and (c) performing a comparative analysis of the situations and trends in the health care sector in the eight RE-InVEST countries, so as to identify the approaches they take to health care. Finally, we provide some policy recommendations, in order to develop a rights-based/capability-oriented approach to health care.

This report mixes qualitative and quantitative research methods. First, we analyse the scientific literature and policy documents (especially documents drafted by EU institutions). Second, we perform a quantitative analysis of relevant indicators from a variety of data sets.

An analysis of international conventions and EU processes concerning health care allows us to identify the main understandings of this policy domain. First, a '*rights-based' approach* can be taken to health care, emphasising access, affordability and quality of the systems. A second, possible approach is based on the understanding of *health care as a 'productive factor'*, i.e. a sector potentially able to promote economic growth and competitiveness. This approach is in line with the development of the internal market in health care, and focuses particularly on efficiency and the promotion of preventive care. Third, health care can be seen as a cost factor, in which case particular attention is devoted to the need to preserve fiscal sustainability and enhance the cost-effectiveness of health care systems.

The three different EU approaches to health care, as expressed in official documents and statements, are reflected in EU policies related to the health sector, which developed, in particular, from the late 1990s. Firstly, the principles of the EU internal market, aiming to boost economic growth by removing barriers to the free movement of goods, services and persons and encouraging competition between market actors, have been increasingly applied to health services. Secondly, this approach was gradually complemented with EU policies aimed at encouraging Member States to improve affordability, access to care and quality, through voluntary governance mechanisms such as the Open Method of Coordination. Thirdly, since the 2008 economic crisis, the EU institutions have acquired unprecedented powers – especially in the Eurozone countries – to supervise national budgetary and economic policies. Within this context, health care systems are a particular target.

When looking at national health care policies across Europe, the following picture emerges. First, in spite of the fact that most EU countries provide nearly universal population coverage for a relatively broad range of health care services, there remain important gaps in access to health care in many countries, in particular for vulnerable groups such as the unemployed, people on a low income and those with mental health problems. Second, the 2008 economic crisis, and in particular the ensuing austerity measures, exacerbated the situation. After years of continuous growth, health spending slowed significantly across Europe, often under forceful EU guidance to improve the state of public finances. Austerity measures included increasing user charges and reducing prices, salaries of health staff and the number of hospital beds. Rising unemployment and costs for other basic services resulted in reduced household budgets available for health care. Furthermore, health care needs increased. Budgets for mental health care services were cut in several countries, despite increased need for this provision. All this led to a serious reduction in access to health care, as measured through self-reported unmet needs for medical care. Third, since 2015, a gradual recovery can be observed in many countries, both in terms of self-reported unmet needs for medical care, and with regard to investments in the health system. Mental health care provision, however, continues to be a 'Cinderella' element of health care systems, in terms of access, affordability and quality.

Further developing our analysis of the key features of health care systems in the EU, we then identify four possible approaches to health care (Figure 1). The first is a purely *rights-based approach* (RBA) to health care, emphasising the dimensions of affordability, effective access, quality, and participation. Second, there is an *EU social investment approach* (EUSI) that, while not neglecting aspects such as affordability, effective access, and quality, gives prime importance to the fiscal sustainability of health care systems, their efficiency and cost-effectiveness, and commodification/marketisation. Taken to an extreme, this approach could turn into an *austerity-oriented social investment approach* (AOSI), characterised by an excessive focus on fiscal sustainability and cost-effectiveness. Finally, we define a good balance between a rights-based and social investment approach, simultaneously promoting the key dimensions of these two approaches, as a *rights-based social investment approach* (RBSI).

Figure 1 Approaches to health care in the Member States

RBA	**RBSI**	**EUSI**	**AOSI**

Keeping this classification in mind, we have performed a comparative analysis of the situations and trends in the eight RE-InVEST countries under scrutiny: Belgium, England, Scotland, Italy, Portugal, Romania, the Netherlands and Ireland. Interesting findings have emerged from this cross-country analysis. With regard to the affordability of health care, it should be first noted that all the countries under scrutiny except Romania have virtually universal population coverage, although in Ireland, over half of the covered population is entitled to only a limited benefit package, in particular to hospital care. This said, user charges have increased in all the countries over the last decade. Also, self-reported unmet needs for health care due to high cost increased in all countries during 2010-2013, except in the UK and the Netherlands, where the figure remained at a low level. Nevertheless, specific measures to protect the most vulnerable groups have been implemented in all the countries. On the point of effective access, the situation is problematic - especially due to high waiting times - in Ireland, Italy, Portugal and the UK, and the situation has deteriorated over the crisis years. Concerning waiting times, however, the situation is good in both Belgium and the Netherlands. The situation in Romania is unclear. As for quality, a subjective indicator, the perception of the quality of health care shows varied situations, with high values for Belgium and the Netherlands and a lower level of satisfaction in Ireland, Italy and Romania. Values close to the EU average emerge for Portugal and the UK. More objective indicators, such as the potentially avoidable mortality and infant mortality rates, show good results in all countries with the exception of Romania. All the countries under scrutiny have implemented measures aimed at ensuring the fiscal sustainability of health care systems, in particular through cuts to the health care budget or a marked reduction in its growth. In most cases (e.g. Ireland, Italy, and Romania), recruitment of health professionals has been frozen or wages have been cut (especially in Ireland and, for a long period, in Romania). There have been reductions in the number of hospital beds in Italy, Portugal and Romania. A varied set of measures have been implemented in order to increase the cost-effectiveness of health care systems. First, one common trend has been the reduction of expenditure on pharmaceuticals. Second, a number of countries have tried to encourage a shift from specialist and hospital care to primary and ambulatory care, a tendency more pronounced in the Netherlands. These attempts have been less effective in Ireland and Romania. Third, measures have been taken to increase the use of e-health technologies, and thus improve cost-effectiveness, especially in Italy, the Netherlands and the UK, but also in Belgium, Ireland, and Portugal. In this respect, however, a negative picture emerges in Romania. Finally, and in contrast to the social investment approach, expenditure on preventive care has decreased in all the countries under scrutiny with the exception of Romania and the UK. Unfortunately, relatively little data and information was found for a limited number of countries on aspects relating to efficiency and marketisation.

The empirical evidence above has allowed us to identify the approaches to health care followed in the RE-InVEST countries. Most of the countries under scrutiny (Ireland, Italy, Portugal and Romania) have implemented a strongly austerity- oriented social investment approach, with a focus on fiscal sustainability and cost-effectiveness and an overall deterioration of affordability and effective access to health care. This said, Belgium, the Netherlands and the UK show the main features of a balanced EU social investment approach attempting to combine all the dimensions above. However, among this group of countries, the Netherlands appears most successful in balancing the various dimensions, and thus closest to a rights-based social investment approach.

In addition to the overall comparative analysis, we have performed two in-depth case studies, on health services in Italy and mental health care services in England. In the former case, the study first points at a feeling of uncertainty and dissatisfaction with the quality of the Italian health care system, also with difficulties of access for some vulnerable groups, such as undocumented migrants. In a context characterised by severe cost-containment measures, we note a growth of the private sector, providing services that have to be paid out-of-pocket, in addition to long and increasing waiting lists. Finally, the Italian health system is characterised by a 'double fragmentation'. There is serious fragmentation in the quality of health care, with clear North-South disparities in health policy making, expenditure, public satisfaction and health care services organisation. The continuity of care is undermined by fragmentation and a lack of integration between different domains of care: prevention and rehabilitation; outpatient care; specialist or inpatient care and social care.

As for mental health care in England, these services are provided by a mix of publicly funded providers including the NHS, local governments, voluntary and private sector providers. The period since the 2008 crisis has been characterised by significant funding constraints and uncertainties produced by ongoing institutional change, with considerable disinvestment in mental health services as part of wider, austerity-related public spending reductions since 2010 and reforms of the mechanism for financing NHS mental health provision. Overall, we see an overarching trend towards disinvestment and liberalisation in the mental health sector in England. Marketisation has become more intense in both primary and secondary care, through a new emphasis on outsourcing support services.

The analysis in this report allows us to provide a number of policy recommendations for a move towards a more rights-based social investment approach in health care. These include:
- ensure adequate levels of health system funding;
- increase investment in health promotion, disease prevention and primary care services integrated with social care, at regional and local level. In these fields, set up initiatives to specifically target vulnerable groups;
- ensure health care coverage for the whole population, including for the unemployed, asylum seekers and ethnic minorities such as Roma. Undocumented people should be guaranteed access to health care;
- reduce user charges to a minimum and protect vulnerable groups from user charges;
- provide a sufficient supply of a broad range of health services as well as a balanced geographical spread of facilities. In particular, coverage for mental health services should be improved. Health professionals should be paid adequate salaries and be provided with good working conditions;
- marketisation and performance management in mental health care should be stopped;
- patients and service users should be empowered;
- access to health care should be regularly and better monitored, both at EU and national level. In particular, the health care needs and usage of health care services by vulnerable and difficult-to-reach population groups should be monitored;
- Member States that invest insufficient resources in their health system should be flagged in the context of the European semester.

Funding from the European structural funds for health care should be increased, and should be geared towards reforms that ensure improved patient access to care, that focus on health promotion and disease prevention and that promote primary and integrated care.

Contents

List of tables

List of figures

Introduction

RE-InVEST

This report was prepared as part of the Horizon 2020 research project 'Rebuilding an inclusive, value-based Europe of solidarity and trust through social investments' (RE-InVEST). The RE-InVEST project aims to contribute to greater European solidarity and reliability, through an inclusive, powerful and effective social investment strategy at the EU level. Moreover, the project itself adopts a participative approach that lends a voice to vulnerable groups and civil society organisations. The RE-InVEST consortium consists of members of the informal network 'the Alliances to fight Poverty', a network of civil society organisations, trade unions, policy makers and academics co-ordinated by the Flemish Christian labour movement 'beweging.net', and committed to a more inclusive Europe. The consortium covers a broad range of European countries, both geographically (12 countries, 13 regions) and in terms of representation of different welfare and labour market traditions. The analyses are carried out by the local partners, who consist of NGOs and/or researchers.

In particular, this report is one of the five sectoral reports in the context of Work Package 6 of the RE-InVEST project that examine the operation of *basic service sectors* from a social investment perspective. Each of the sectoral reports consists of both the European-level analysis of the sector and several particular national social investment policies. This report details social investment in Europe for health care and mental health services.

Theoretical framework

Our model builds on *human rights and capabilities* as building blocks for the social inclusion/wellbeing of individuals. Formal human rights (e.g. right to a minimum living standard, right to health care) are values, social norms which do not automatically result in improved wellbeing. For the implementation of such rights (mainly in the field of economic, social and cultural rights), different types of policy measures need to be implemented: legislation, organisation of (public) services, subsidies, social transfers, inspection, judicial enforcement, etc. Although some legal measures may establish effective rights (e.g. a guaranteed access to water, guaranteed places for children in childcare), most policies necessitate additional 'social investment' in individual and collective agency through public or subsidised service provision (e.g. ECEC, health care, ...) and the transfer of power and resources – either directly to individuals/households (e.g. through free-of-charge minimum packages or social tariffs), or to companies and civil society organisations (e.g. subsidies to housing companies, water distribution, ECEC providers). These 'collectives' in turn interact with households and may invest in their capabilities.[1]

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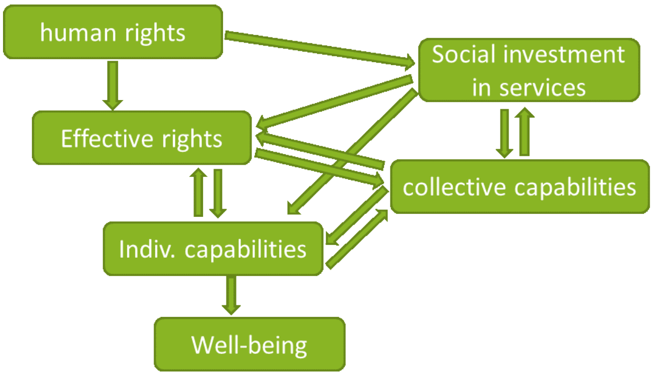
[1] Individuals in turn can invest in collective agency through contributions and/or voluntary action. All capabilities are actually combined capabilities, i.e. a mix of individual and collective action. In other words, there is no such thing as capability without the joint action of individuals and collectives.

Figure 2 **From human rights and capabilities to individual well-being**



Bonvin and Laruffa (2017) reconsider the capabilities of a (vulnerable) individual from a different angle, distinguishing between three roles: *receiver, doer* and *judge*. The first role reflects his/her need for adequate support (in terms of resources or services); the second role refers to his/her agency in transforming resources into valuable activities (including work, leisure, domestic activities, social participation etc.); finally, the role of 'judge' reflects his/her freedom to make choices and his/her voice in various 'collectives' to which s/he belongs.

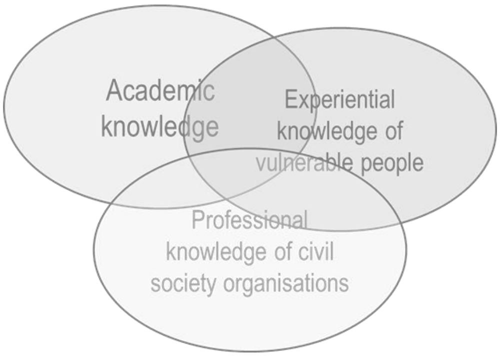
In this context, *social investment*-related measures may affect individual capabilities in many ways: by investing in (tangible or intangible) assets, by transferring financial resources that allow households to invest in themselves, by strengthening their rights and freedoms through regulations, or indirectly, by strengthening the agency of collectives that interact with vulnerable people.

Participatory action research

RE-InVEST aims at giving vulnerable people a voice through participatory action research that can be used in policy recommendations and advocacy at local, national and EU level. Participatory action research views participants as co-researchers who have special knowledge about their own situation. Rather than being just interviewed about their experiences or views, vulnerable people are enabled to take part in examining, interpreting, and reflecting on their own social world, shaping their sense of identity, and getting a voice in public deliberation (another key dimension of capabilities).

This necessitates an iterative process of knowledge generation that includes several steps of mutual trust building, knowledge production and sharing, empowerment, newly generated knowledge and action that builds upon this knowledge. Crucial for this kind of knowledge generation is the 'merging of knowledge' (ATD Fourth World, 2007) that comes from three parts: academic knowledge developed by researchers; experiential knowledge acquired by vulnerable people throughout their lives; and the knowledge of professionals and civil society organisations that work with them (Figuur 3). Every research team at local level includes members from these three different backgrounds.

Figure 3 Merging of knowledge



This methodology was applied for producing the national reports on the five sectors in focus (ECEC, water, financial services, housing, health care). The RE-InVEST team joined forces with pre-existing dialogue processes at grassroots level, produced the national reports covering all sectors. We thank all parties for their active contribution to this report. The work done on ECEC is compiled in this report with extra sections regarding the European policies.

1. Normative framework: Health care in international conventions and EU (social) policy documents

The *right to health care* is recognised by key international conventions, which generally stress the dimensions of *adequacy* and *quality* of health care. To start with, the United Nation *Universal Declaration of Human Rights* (1948) states that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and *medical care* and necessary social services [...]' (Article 25 (1) – emphasis added). The right to the highest attainable standard of health is recognised as a 'fundamental right' in the *Constitution of the World Health Organisation* (WHO). The WHO attributes to governments '[...] a *responsibility for the health of their peoples* which can be fulfilled only by the provision of *adequate health* and social measures' (emphasis added). At the European level, the *European Social Charter* (1961) drafted by the Council of Europe states that 'Everyone the right to benefit from any measures enabling him to enjoy *the highest possible standard of health attainable*' (Part 1, Article 11, emphasis added) and that '*Anyone without adequate resources* has the *right to social and medical assistance*' (Part 1, Article 13, emphasis added)[2]. Compared to the previous documents, the Charter adds a more explicit reference to *access* as a key dimension of the right to health care (together with adequacy and quality).

At the EU level, the *Charter of Fundamental Rights* of the EU (2000) recognises that 'Everyone has the right of access to preventive health care and the right to benefit from medical treatment [...] (Article 35), while the *Treaty on the Functioning of the European Union* states that 'A high level of health protection shall be ensured in the definition and implementation of all Union policies and activities' (Title 14, Article 168).

In the international conventions above, health care is considered as a right, and three key dimensions of this right appear predominant: *adequacy*, *quality*, and *access*. The situation is however more complex when looking at how the right to health care has been translated into EU policies and activities. To start with, health care was included, in 2005, among the strands of the *Open Method of co-ordination for social protection and social inclusion* (together with the fight against poverty and social exclusion and pensions). As noted by Armstrong (2010), two policy paradigms coexisted in the social OMC. On the one hand, social policy was seen as a 'productive factor', contributing to economic growth and employment. Furthermore, particular attention is devoted to the need to preserve the *sustainability* and enhance the *efficiency* of social protection systems, in order to ensure that the systems are both viable and financially sustainable in the long term. On the other hand, social protection is treated as a fundamental right ('citizenship paradigm') '[...] with the emphasis placed on '*access'* to social protection rather than the 'sustainability' of social protection systems' (Armstrong, 2010: 75, emphasis added). The approach to health care in the Social OMC appears closer to the citizenship paradigm, at least at the discursive level. Indeed, in the *Nice Common Objectives* (which underpin the Social OMC), the Member States were asked to 'put in place policies which aim to provide access for all to health care appropriate to their situation, including situations of dependency'. The coexistence of the two paradigms is particularly evident in the Common Objectives of the Social OMC (SPC, 2006), which call (objective 1) for '[...] adequate, accessible and financially sustainable, adaptable and efficient social protection systems [...].'

This being said, the more 'economically-oriented' EU approach to health care had already emerged in the 1990s (cf. Greer & Vanhercke, 2010). Health care was progressively made subject to the EU internal

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[2] Furthermore, the European Social Charter devotes a whole article (Part 2, Article 13) to the right to social and medical assistance. These principles and rights were then restated in the revised European Social Charter of 1996.

market rules, and controlling public expenditure on health has long been a theme in EU co-ordination of macroeconomic policies. We will discuss this further in Chapter 2.

The two approaches to health care developed simultaneously in the Social OMC. In the *Council Conclusions on Common Values and Principles in European Union Health Systems* (Council, 2006) - which built on discussions taking place in the context of the Social OMC - besides the principles of *universality*, access to good quality care, *equity* and *solidarity*, financial sustainability is also seen as a 'fundamental feature' of health care systems. An exemplification of this is the understanding of 'preventive care', depicted as '[...] an integral part of Member States' strategy to reduce the economic burden on the national health care systems, as prevention significantly contributes to cost reduction in health care and therefore to financial sustainability by avoiding disease and therefore follow-up costs' (Council of the European Union, 2006).[3]

The need to preserve both access to high quality health care and an *efficient use of resources* characterises the 'social investment approach' as understood in the Commission Social Investment Package (SIP) (European Commission, 2013a). This said, in this document - as well as in the Commission Staff Working Document 'Investing in Health' accompanying the SIP (European Commission, 2013b) - a population with a good health status is mainly seen as a productive factor. As the Staff Working Document makes clear, besides being 'a value in itself', health '[...] is also a precondition for economic prosperity [insofar as] people's health influences economic outcomes in terms of productivity, labour supply, human capital and public spending' (European Commission, 2013b:1).[4] Health expenditure is recognised as 'growth-friendly expenditure' (ibid). Consequently, the Commission '[...] recommends reforming health systems to ensure their cost-effectiveness and sustainability and assessing their performances against the twin aims of providing access to high-quality health care and using public resources more efficiently' (ibid).

Interestingly enough, in the most important EU initiative in the social domain undertaken in the most recent period - the *European Pillar of Social Rights* (EPSR) - a more marked rights-based approach to health care emerges. Indeed, the Recommendation on the EPSR (European Commission, 2017b) simply and clearly states (Principle 16 - 'Health care') that '*Everyone has the right to timely access to affordable, preventive and curative health care of good quality'*. Does this indicate a U-turn of the EU towards a purely rights-based approach to health care? The situation is more complex. Reflecting on the Social protection and Inclusion chapter of the Pillar, Sabato and Corti (forth.) identify a 'rights-based social investment' approach, i.e. an approach in which the primary objective is the promotion of social rights but, when it comes to the actual measures and policy orientations through which these rights should be defined and made effective, the reference point is social investment. In this perspective, issues characterising the social investment approach, such as sustainability, cost-effectiveness and the growth-enhancing function of social policy, come back (although attenuated from a discursive point of view). Looking at the contents of the Annual Growth Survey 2018 (European Commission, 2017a), this seems the case for health care. Indeed, the Survey states that '*Europeans need affordable, accessible and quality services'* (ibid 6, bold in the original). This said, one of the functions of investment in health is to increase both productivity and employment (ibid 3). Furthermore, reforms of health care systems should enhance their cost-effectiveness, ensure their fiscal sustainability and ensure quality, affordable access (ibid: 11).

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[3] Patient involvement is a further principle stressed in the Council Conclusion.

[4] In the words of De Munck and Lits (2017), in the SIP '[…] most often the idea of strengthening capacities (or here capabilities) is connected to capacities that allow individuals to participate in the 'labour market'. They are labour market oriented capacities'. Conversely, from a full human capabilities approach, '[…] social investment should not only aim at integrating people in the labour market (or augmenting their production possibilities), but rather focus on enhancing the 'substantive freedom' – the ability for every individual to 'lead the lives they have reason to value and to enhance the real choice they have' (ibid: X). On this aspect, see also López – Casasnovas and Maynou (2018).

2. EU policy framework on health care

Health care systems within the European Union differ widely, and a great deal of public money is involved in this sector. Therefore, Member States have always watched jealously to keep the competence on health care within their national borders. Article 168 (7) of the Treaty on the functioning of the EU states that *'Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care.'*

Despite this, European integration affects national health care policies in different ways.

First, the European Single Market rules impact health care systems.

It has always been clear that the free movement rules applied to certain segments of the health care sector, for instance to ensure the right to free movement of health professionals. Progressively, the EU internal market rules have also been declared applicable to other aspects of publicly funded health care systems. This is mainly driven by case law of the Court of Justice of the EU. This application of the EU Single Market rules limits the possibilities for public intervention and regulation in the health care sector.

The Court made it clear that a health care service, when it is provided for remuneration, is an economic activity to which the Treaty provisions on the free movement of services apply.[5] The free movement rules apply when the health provider wants to provide care on a temporary or permanent basis in another Member State or when a patient wants to receive care from a provider established in another EU country. As a consequence, health care providers can challenge regulation if it is considered as potentially hindering their free movement (Gekiere *et al.,* 2010). Health authorities can justify their regulation if it is deemed necessary to protect a public interest objective, such as the protection of public health or the financial balance of the social protection system.[6] Justified measures must furthermore be proportional, which means that it has to be demonstrated that there are no other actions possible to reach the same public interest objective that are less of a hindrance to free movement.

After a lengthy policy process looking for answers to the legal uncertainty created by the Court rulings, a Directive on the application of Patients' Rights in Cross-border Health care was adopted in 2011.[7] This Directive aims to clarify the rights and entitlements of patients to reimbursement for health care they receive in another EU country. However, it does not address the deregulatory effects that could result from the application of the free movement principles to providers wishing to temporarily or permanently provide health services in another Member State (Baeten & Palm, 2012).

EU competition law comes into play when public intervention is likely to favour certain market actors to the detriment of others. When actors in the health care sector have a certain degree of freedom e.g. to negotiate, to fix prices or to allocate their budgets, these practices are likely to be subject to competition law (Lear & Mossialos, 2010). This means that if public authorities decide to give more (financial) responsibilities to actors in the health system, to introduce market elements and 'regulated' competition in an attempt to control public spending, then competition law might apply. The application of competition law in turn limits the possibilities for public intervention and regulation of the activities of these actors.

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[5] The main cases are: CJEU, Case C-120/95 Decker v. Caisse de Maladie des Employés Privés [1998] ECR I-1831; CJEU, Case C-158/96 Kohll v. Union des Caisses de Maladie [1998] ECR I-1931; CJEU, Case C-157/99 Geraets-Smits and Peerbooms [2001] ECR I-5473; CJEU, Case C-385/99 Müller-Fauré and Van Riet [2003] ECR I-4509; CJEU, Case C-372/04 Watts [2006] ECR I-4325; CJEU, Case C-444/05 Stamatelaki [2007] ECR I-3185.

[6] See e.g. Case C-158/96 Kohll [1998] ECR 1931.

[7] Directive 2011/24/EU of 9 March 2011 on the application of patients' rights in cross-border health care, O.J. L88/45-65, 4 April 2011.

Public funding to health care providers and purchasers also has to be compatible with the EU Treaty rules on state aid and public procurement. Funding of health care services is justified if it is a compensation for the mission of general interest the providers carry out and provided that this mission has been entrusted to them by an official act.[8]

In sum, the application of the EU Single Market rules thus challenges health care regulation. However, health care regulation, established at national and regional level, is crucial to ensure universal access to health care, to redress the important market imperfections in this sector and to guarantee that the limited available budgets are used in the most cost-effective way. Commercial providers and purchasers can make use of the internal market principles to enter new markets, which can lead to more diversity in health care provision and more fragmented health care systems. Moreover, increased choice for patients and providers might undermine public support for the equity and solidarity principles underpinning European health care systems.

Second, health care policies are also addressed in voluntary EU-level governance mechanisms, which are aimed at supporting Member States in their national policies. Since 2005, health care has been part of the open method of co-ordination for social protection and social inclusion (Social OMC) (see Section Introduction – RE-InVEST). A number of other voluntary co-operation mechanisms have also been set up on specific issues such as e-health and health technology assessment.

Third, the European sovereign debt crisis provoked a radical change in the way the EU engages in national health system reforms. EU institutions acquired unprecedented powers - especially in the Eurozone countries - to supervise national budgetary and economic policies. Within this context, health care systems are a particular target. Whereas, traditionally, EU involvement in this policy area was limited to supporting voluntary co-operation between member states, henceforth EU institutions are calling for major health care reforms as a means of consolidating public expenditure. Not only have the countries in receipt of financial assistance been required to implement the detailed list of reforms stipulated in their respective Memorandums of Understanding (MoUs); other Member States too have been encouraged to undertake reforms to their national health care systems and the EU has continuously strengthened its tools to enforce compliance (Baeten & Vanhercke, 2016).

Under the European Semester for Economic Policy Coordination, an important number of Country-Specific Recommendations (CSRs) on health care have been issued and have grown in scope and detail. The focus of CSRs is mainly, but not exclusively, on fiscal consolidation; the call is for long-term structural reforms aimed at improving cost-effectiveness. The reforms stipulated under the MoUs, on the other hand, were not exclusively aimed at a more cost-effective use of financial resources, but also include measures designed simply to decrease costs in the short term, thus shifting costs from the public system to patients and workers.

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[8] Commission Decision of 20 December 2011 on the application of Article 106(2) of the Treaty on the Functioning of the European Union to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest, Official Journal L7, 11.01.2012, p. 3-10.

3. Comparative analysis of health care and mental health services across the EU

3.1 EU-wide comparative analysis: health care

Access to health care is essential to ensure equity in health and to improve or redress health for each individual. It should nevertheless be noted that the health status at population level does not only depend on the efficacy of health care systems. Policies that address the socio-economic determinants of health can have a more important impact on population health than clinical care services (CSDH, 2008).

Although most European health systems provide nearly universal population coverage for a wide range of benefits, people on a low income and vulnerable groups, in nearly all countries, have more difficulties obtaining access to care (Eurofound, 2014). At the same time, vulnerable and marginalised groups in societies tend to have more health problems and thus have more health care needs. Groups that experience particular difficulties in accessing health services include: people living in poverty, homeless people, long-term unemployed people, people with poor education, poor health literacy, mental health problems or intellectual disabilities, people living in isolated rural areas, older people, ethnic minorities, migrants, destitute or undocumented EU citizens, asylum seekers and refugees and members of traveller communities (EXPH, 2016, European Commission, 2016).

Access to care can be hindered by various hurdles, which can be financial, organisational or personal. Financial hurdles relate to the extent to which the needed health services are financially covered, organisational hurdles can relate to waiting times, availability of quality care, the level of provider choice, or available information. Individual patient-characteristics which can hinder access to care include poor literacy, language or culture and low levels of trust between the provider and the patient (Busse *et al.,* 2006). Access to care thus also includes the quality of the care covered.

Many challenges in access to health care services are unrelated to the crisis. Nevertheless, as argued by Dubois and Molinuevo (Eurofound, 2014), the 2008/2009 financial and economic crisis affected access to health care in several ways. First, health care financing has come under pressure and service provision has been reduced, in particular as a result of reduced public budgets. Second, household budgets available for paying for health care may have decreased, due to reduced income levels and increased prices for other basic goods and services. Thirdly, it is likely that health care needs increased due to deteriorating health, including mental health.

We will now discuss the different aspects that may have an impact on access to health care.

3.1.1 Public funding[9]

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

Overall, more than three-quarters of health spending in European countries comes from public sources (OECD/EU, 2016). There is a strong relationship between the overall income level of a country and how much that country spends on health.

Following the economic crisis in 2008, health spending slowed significantly across Europe, after years of continuous growth. Many European health systems have undergone radical reforms, often with steep

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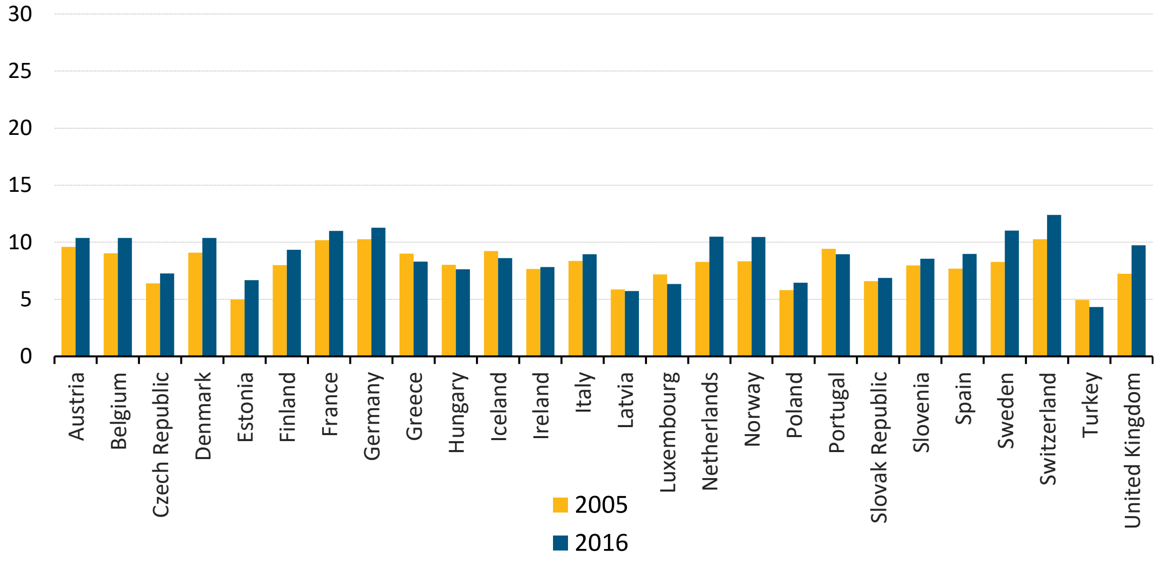
[9] This section includes contributions from Anna Ruelens and Ides Nicaise.

health budget cuts. The countries most heavily hit by the crisis enacted the most stringent reforms, subject to strict conditionality, in exchange for financial assistance from the EU and the IMF (Stamati & Baeten, 2015). Yet many countries, such as Sweden and England, have also been embracing austerity for ideological rather than fiscal reasons (Ruckert *et al.,* 2015; Pavolini, 2015). In several countries, public revenue for the health sector fell as a result of unemployment and falling wages (Jowett *et al.,* 2015).

Figure 3.1 Current expenditure on health, % of gross domestic product, OECD, 2005 and 2015



* Provisional and estimated figures for 2016.
Source OECD, Heath Statistics database, 2017

In the European Union as a whole, health spending increased by only 0.7% each year in real terms between 2009 and 2015, compared with an annual growth rate of 3.1% between 2005 and 2009. In eight EU countries, expenditure on health has declined since 2009 whilst it has significantly slowed in almost all others (OECD/EU, 2016). In some EU countries (Greece, Hungary, Luxembourg, Portugal) current expenditure on health as a percentage of GDP even decreased between 2005 and 2015 (see Figure 3.1).

Table 3.1 provides an overview of the annual growth rate of government and compulsory health insurance schemes (per capita expenditure, in real terms). Greece, but also Portugal, Spain and Ireland, experienced negative annual growth during and after the economic crisis of 2008-2009. The numbers for Greece are particularly staggering, with -17.3 recorded for 2010-2011, -10.0 recorded for 2011-2012, and -13.4 for 2012-2013. During 2015-2016, negative growth is recorded for the Czech Republic (-0.3), Greece (-2.0), Latvia (-0.3), and the United Kingdom (-0.5). The largest positive growth during 2012-2013 is recorded for Hungary (10.1) and Ireland (5.1).

Table 3.1 Annual growth rate of government and compulsory health insurance schemes, per capita expenditure, in real terms

	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Austria	2.5	3.3	4.1	0.9	1.0	0.3	2.4	-0.6	1.0	0.4	1.4
Belgium	-0.2	2.3	6.6	5.2	0.2	1.8	1.0	0.8	1.6	2.0	-0.3
Czech Republic	2.8	0.0	4.4	10.0	-3.0	3.0	-0.4	..	-0.5	-0.8	1.7
Denmark	4.6	2.0	1.3	6.7	-1.3	..	1.0	0.3	1.3	1.7	1.2
Estonia	5.2	15.0	9.9	-1.7	-2.7	-0.3	4.7	3.8	6.4	6.2	4.7
Finland	2.8	2.3	3.5	0.3	1.8	3.8	2.6	0.7	-1.5	-1.0	0.6
France	0.4	0.8	0.5	3.6	0.5	1.4	0.8	1.3	2.1	0.3	0.1
Germany	2.2	2.0	3.5	13.9	2.9	0.8	0.7	2.5	2.5	2.0	2.5
Greece	8.4	1.1	-2.9	..	-4.0	-17.3	-10.0	-13.4	-9.7	8.1	-2.0
Hungary	1.7	-9.4	-0.6	-5.3	2.8	1.4	-3.6	1.2	2.9	4.2	10.1
Ireland	-0.1	6.6	9.5	6.0	0.6	-6.4	-0.3	..	2.0	-1.4	5.1
Italy	3.2	-2.9	3.3	-0.6	1.3	-2.8	..	-3.0	-0.7	-0.3	0.6
Latvia	22.1	5.9	-2.0	-5.8	-1.0	3.6	-2.6	2.8	4.5	4.4	-0.3
Luxembourg	-3.4	1.1	5.7	3.8	-2.2	..	4.5	1.2	..	..	..
Netherlands	25.8	4.5	2.6	4.0	2.7	1.9	1.9	-1.6	0.2	0.0	0.3
Poland	7.0	9.7	15.7	6.2	1.3	0.8	-0.1	5.2	1.3	4.5	2.8
Portugal	-4.8	0.9	2.7	4.7	1.0	-7.4	-8.5	-1.3	-0.6	1.7	1.3
Slovak Republic	4.8	14.9	11.2	5.2	0.7	0.2	2.2	2.8	..	2.5	3.3
Slovenia	2.7	-0.1	11.1	-1.0	1.1	0.2	-2.8	-2.0	0.5	3.2	2.9
Spain	4.3	3.3	6.6	6.1	-0.9	-1.9	-5.3	-3.5	0.9	5.7	0.6
Sweden	2.7	1.6	1.6	1.3	-0.4	..	0.9	1.6	1.9	2.2	3.0
United Kingdom	5.0	2.1	3.4	6.4	-0.2	-0.5	0.0	..	1.9	2.2	-0.5

* Growth rates for Norway calculated using the GDP Deflator for Mainland Norway.
Source Adapted from: OECD, Heath Statistics database, 2017

3.1.2 Health coverage

Health systems provide a specified package of benefits to all members of a society, with the end goal of providing financial risk protection and improved access to health services. Health coverage has three dimensions: the share of the population entitled to publicly financed health services (population coverage), the range of health services covered (benefit package), and the extent to which people have to pay for these services at the point of use (user charges) (WHO, 2010). Services that are wholly or partially excluded from public provision must be paid for out-of-pocket (OOP) by patients through direct private spending or through the purchasing of voluntary health insurance. Below, we address these three dimensions of health coverage, corresponding to the following questions: who is covered (population coverage); what is covered (benefit package); and how much is covered (user charges).

Most European countries have achieved nearly universal population coverage for health care costs for a core set of services. In four European countries, however, the health care costs of at least 10% of the population are not covered (Cyprus, Greece, Romania and Bulgaria). In Bulgaria, Romania and Greece, the share of the population covered has decreased since the onset of the economic crisis (OECD/EU, 2016). In general, moreover, entitlement for migrant workers from countries outside the EU, undocumented migrants and destitute EU citizens is often extremely limited (EXPH, 2016).

EU health systems generally cover a comprehensive range of benefits, including consultations with doctors, tests and examinations and hospital care (OECD/EU, 2016). There is an important variation in coverage of prescribed medicines, medical devices, dental care and mental health services.

Several Member States reduced the benefit package in response to the crisis. Most of these reductions were not based on a cost-effectiveness assessment of the delisted care (Thomson, 2015). Requirements for cuts in the benefit package were part of the MoUs for Greece, Cyprus and Romania. Drugs were the most common target for ad hoc exclusions. Bulgaria and Romania limited access to primary care (Thomson, 2015). On the other hand, several countries expanded the benefit package, usually as part of efforts to strengthen financial protection for specific groups of people (children, the chronically ill) (Thomson, 2015).

User charges refer to the share of the cost of the health service or product to be borne by the patient and not covered by the public scheme. User charges policy design varies substantially across countries. Most EU countries apply user charges to outpatient prescription drugs, many charge for doctors' visits for primary and secondary care, some charge for inpatient stays, and some charge for visits to emergency departments (Thomson, 2015). Out-of-pocket (OOP) payments may furthermore include direct payments for goods or services that are not covered by the public scheme or that are provided by not-covered private providers, who provide quicker access to care or care that is perceived of better quality. Furthermore, this concept also includes the informal (under-the-table) payments required by some health professionals (Eurofound, 2014). Private households directly financed 15% of all EU health spending in 2014 (OECD/EU, 2016). This share is above 30% in Cyprus, Bulgaria, Latvia, Greece and Lithuania.

User charges can constitute significant barriers to accessing health care and have a disproportionately negative effect on access among poorer people (EXPH, 2016). Countries with a higher share of OOP, generally have significantly higher proportions of people reporting difficulties in access to health care due to cost (Eurofound, 2014).

In the wake of the crisis, most EU countries increased user charges (Thomson, 2015). Out-of-pocket spending for health care has continued to grow since 2009 (OECD/EU, 2016). In all countries receiving financial assistance from the EU and the IMF, increasing user charges was one of the conditions set, without a call for measures to protect the most vulnerable.

Services that are excluded from public provision can be paid for through direct private spending or through the purchasing of voluntary health insurance. The nature of voluntary health insurance varies across countries. In most European countries, only a small proportion of the population has additional private health insurance. Voluntary health insurance financed a significant proportion of total health spending in Slovenia (15%), France (14%) and Ireland (13%) (OECD/EU, 2016).

3.1.3 Quality of care

Quality of health care services can be assessed using a number of criteria: first, input into the system, i.e. the resources invested in service provision (professional qualifications, staff numbers, medical equipment, etc.); second, the process of care provision, i.e. the way in which services are provided (medical care based on academic evidence, multidisciplinary co-operation, etc.); third, output, i.e. health outcomes (quality of life, mortality rates, etc.) and, finally, patient/population satisfaction. We provide, firstly, EU-wide survey data on population satisfaction with the quality of care and, second, data on health care related health outcomes, based on an OECD analysis.

In the European Quality of Life Survey-EQLS, 2016 people were asked to rate the quality of the health care services in their country on a scale of 1 to 10, where 1 means very poor quality and 10 means very high quality. EU citizens on average rated the quality of services at 6.7 in 2016. This average masks major differences, from a rate of 8 in Austria, to 4.6 in Greece (Eurofound, 2017). In most EU countries, the perceived quality of health services increased between 2007 and 2016. Perceived quality decreased, however, over time in the three countries that had the lowest rates in 2016: Greece, Latvia and Cyprus (Eurofound, 2017). The ratings may reflect satisfaction with quality of care received, but also satisfaction with access to care, for instance waiting times.

A 2016 survey conducted among vulnerable and isolated people in 12 Member States (European Commission, 2016) questioned over 4,000 respondents (European Commission, 2016). Most of these had physical, mental and learning disabilities, or were long term unemployed/inactive. It found that 43% of respondents were either quite or very satisfied with the results of the health services they had used in the past 12 months, while 22% were quite or very dissatisfied. Satisfaction with health services was lower for people with greater health care needs. Dissatisfied respondents most frequently 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 bad attitude of the health care professional (35%).

In terms of health care related health outcomes, in 2013, close to 1 million deaths in EU countries might have been prevented through more effective public health and prevention policies (preventable deaths), and over 0.6 million deaths might have been avoided through the provision of timely and effective health care (amenable deaths) (OECD/EU, 2016). There are large variations across countries in rates of preventable mortality (OECD/EU, 2016).

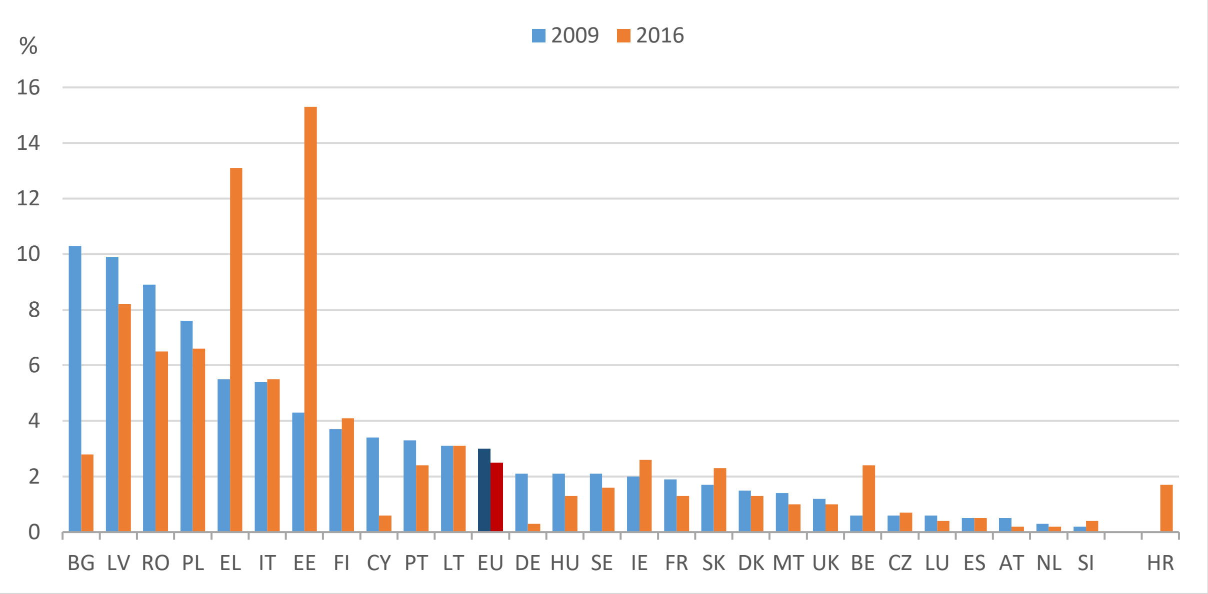
Many health outcome indicators which can be attributed to health care quality, showed substantial progress in the last decade (data available until 2013). Mortality rates for cervical cancer and breast cancer, for instance, declined in nearly all countries between 2003 and 2013. These rates reflect the effect of care over the past years and the impact of screening, as well as changes in incidence (OECD/EU, 2016). There have also been significant decreases in the 30-day case-fatality rate following acute myocardial infarction (AMI or heart attack) in the period 2003-2013 in nearly all EU countries for which data are available, with the exception of Latvia (OECD/EU, 2016). This is a good indicator of acute care quality. Also, 30-day case-fatality rates for ischemic stroke have decreased substantially in this period (OECD/EU, 2016).

The effectiveness and quality of primary care services can be assessed based on hospital admission rates for chronic conditions for which effective treatment can be delivered at the primary care level. The majority of countries reported a reduction in hospital admission rates for chronic obstructive pulmonary disease (COPD), and the EU average dropped slightly between 2008 and 2013. However, little progress has been seen in countries with high rates (OECD/EU, 2016).

3.1.4 Self-reported unmet needs for health care

The EU Statistics on Income and Living Conditions survey (EU-SILC) provides data on self-reported unmet needs for medical care due to cost, travel distance or waiting time. Between 2005 and 2009, EU Member States made huge progress in improving access to health care. The number of people reporting unmet need fell steadily from 5% in 2005 to 3% in 2009 (EXPH, 2016). Since 2009, however, the effects of the economic and financial crisis have become particularly evident. The share of the population in the EU reporting that they were unable to receive necessary care increased again gradually to 3.6% in 2014. This may be explained by budget cuts in health care in many countries and, at the same time, an increasing need for health care, rising unemployment and reduced income during the crisis years. During 2015 and 2016 we witness again a gradual recovery, and in 2016, unmet need, at 2.5%, is for the first time below the 2009 level (3%) (see Figure 3.2).

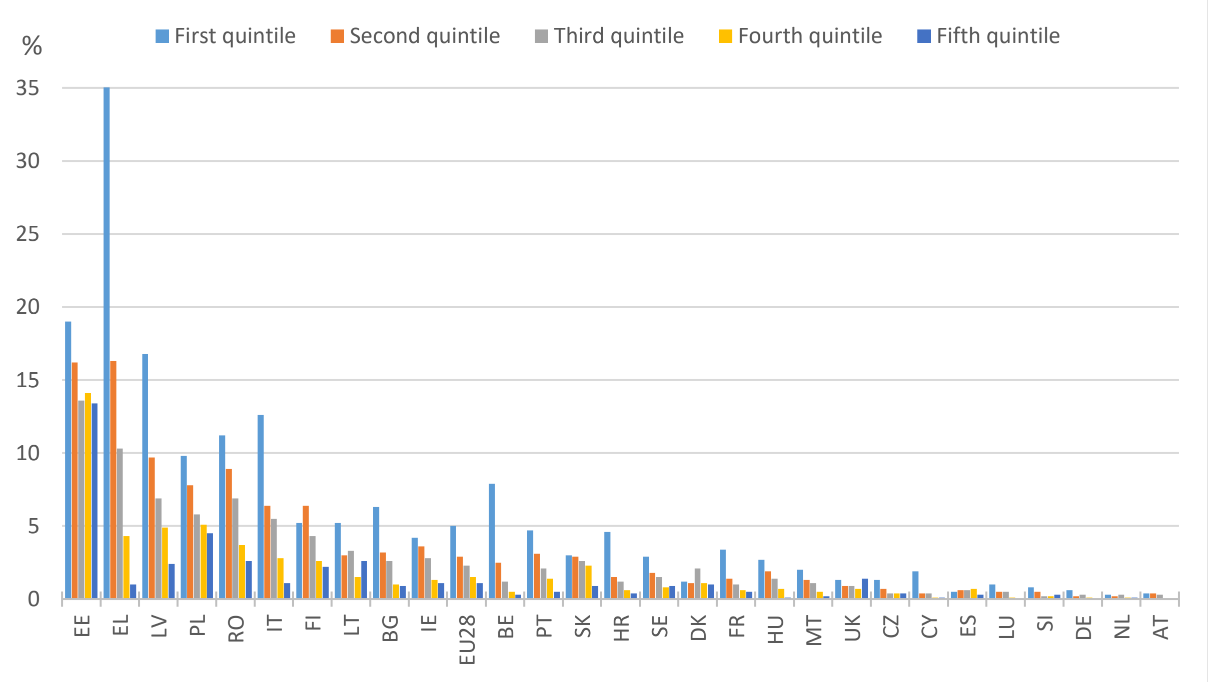
Figure 3.2 **Self-reported unmet needs for medical examination due to cost, distance and waiting time**



Source Eurostat [hlth_silc_08]; *No data for HR in 2009

There remain, however, important differences between countries and between income groups. In Estonia and Greece, more than 10% of the population reported an unmet need for a medical examination in 2016. Compared with the situation in 2009, a substantial improvement can be observed in Bulgaria and Romania, and the situation also improved in Lithuania, Latvia, Cyprus, Sweden, Hungary and Germany. However, in other countries the situation further deteriorated in this period. This is in particular the case in Estonia and Greece, and furthermore in Finland, Belgium, Ireland and Slovakia.

Figure 3.3 **Self-reported unmet needs for medical examination by income quintile (2016)**



Source Eurostat [hlth_silc_08]

In the lowest income quintile, 5 % of EU citizens reported unmet care needs, with more than 15 % of people on a low income reporting unmet needs for health care in Greece, Estonia and Latvia (see Figure 3.3). Financial barriers to access are the largest single driver of unmet need for health care in the European Union. This is also the aspect of unmet need that has risen most sharply in recent years (EXPH, 2016). Access problems due to high costs can be due to low income as well as high formal and informal costs (Eurofound, 2014).

The European Quality of Life Survey-EQLS, 2016 asked people to what extent costs, waiting times, a delay in getting an appointment, lack of time or distance to the doctor's office made it difficult or not to see a GP (Eurofound, 2017). The most frequent reported difficulty was the waiting time to see the doctor, reported by 42% of the respondents (and reported by 9% as being 'very difficult'). The proportion of people reporting that 'cost' caused difficulties was 16%. It remained a 'very difficult' issue for 10% or more of respondents in Cyprus, Greece, Ireland, Malta and Romania. People in the lowest income quartile were more likely to experience difficulties to see a GP, for most of the reasons suggested (Eurofound, 2017).

The above-mentioned 2016 survey conducted among vulnerable and isolated people (European Commission, 2016) found that while 37% of respondents found it easy to get access to the needed health care services, a considerable share of respondents (32%) perceived this as very or quite difficult. Access to health care was more difficult for respondents with poor health than for respondents with good health (50% vs. 19%). High cost of health care facilities was the biggest barrier to accessing care, alongside long waiting times and inability to get an appointment with a health care professional. Furthermore, respondents with lower educational levels and lower income levels found it more difficult to understand health information provided by health care professionals. Vulnerable families, people living in rural or isolated areas, and vulnerable older people reported the most problems with accessing health care.

3.1.5 Box 1: Italian case study: key messages[10]

This case study presents research conducted in the area of mental illness and substance abuse services, investigating participants' perceptions and evaluations of Italian health services. A focus group was set up among women aged between 25 and 52, with various psychosocial vulnerability factors, while a medical specialist in the field of health policies and the director of a health service for pathological addiction were interviewed.

Quality and access - The study points to a feeling of uncertainty and dissatisfaction with the quality of the Italian health care system, a result corroborated by national surveys reporting that 45.1% of Italians think that the NHS has deteriorated in the last two years. Self-reported unmet needs for medical examination increased notably between 2012 and 2013, especially for the first income quintile. Although legislation guarantees the eligibility of immigrants to receive public health care, integration policies for this vulnerable group are still regarded as inefficient and suboptimal. In certain cases the unemployed are exempted from co-payments, but the benefit declines as income increases.

Private expenditure - The increase in private health care spending is reported as being critical and disadvantageous for the group interviewed, characterised by economic difficulties. While the crises reduced disposable income, families had to face higher co-payments or fully private alternatives as a result of cost-containment policies. The interviews acknowledge the value of new low-cost initiatives, especially in the field of private dental care.

Waiting lists - The growth of the private sector, providing services that have to be paid out-of-pocket, is associated with long waiting lists, a phenomenon that is still growing. A reduction in waiting times is highlighted as a priority for the national system by 54% of the population.

In this context, availability of financial resources becomes fundamental in order to access health care. In fact, the vulnerable women interviewed pointed to a reduction of protection and opportunities in health services, often deciding not to seek treatment for themselves, in order to be able to pay essential expenditures, including for health care, for their family members. The research also points to the erosion of the social-relational tissue of the community.

Cost containment measures led to the establishment of larger health care organisations, aimed at centralising processes to increase efficiency and improve quality. The promotion of a new Code of Conduct and Concessions on Procurement should increase transparency and strengthen anti-corruption monitoring. Some steps have also been taken to limit the two main sources of waste in the Italian health care system: the use of ineffective or inappropriate health services and the vast fraud network.

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[10] This section was drafted in collaboration with Alberto Rovere.

Considerable *vertical fragmentation* exists in the quality of health care, with clear North-South disparities in health policy making, expenditure, public satisfaction and organisation of health services. The continuity of care is undermined by *horizontal fragmentation*, e.g. the division between prevention and rehabilitation, outpatient and specialist/inpatient care, social care and health services.
Policy Recommendations to counter social disinvestment include the promotion of generic medicines, investing in prevention, the promotion of e-health tools, reducing contracting-related fraud and waste in the health sector, the promotion of empowerment strategies, especially for patients with chronic illnesses.

3.2 EU-wide comparative analysis: mental health services

3.2.1 Outline

There has been increasing interest in the links between mental health and wellbeing, mental health services and paid work across Europe in the twenty-first century, and the issue has become more critical following the financial crisis and subsequent recovery. The financial crisis of 2007/08 has had a complex range of effects on the health of the population and health care provision, but the central impact has been to increase the pressures on individuals, health care systems and public finances. These issues will be explored with reference to mental health policy development, the impact of the economic crisis and recovery on mental health and services, before considering the focus on work for improving mental health in the post-crisis period.

3.2.2 Policy background

Improving the mental health and wellbeing of the population of Europe has been a World Health Organisation policy goal since the European Declaration on mental health was signed by European health ministers in Helsinki in 2005. The Declaration acknowledged that mental health and mental wellbeing are '... fundamental to the quality of life and productivity of individuals, families, communities and nations ... (WHO, 2005a:1)' and committed signatories to social inclusion and equity. To achieve this the Declaration advocated the promotion of mental wellbeing, the tackling of stigma and discrimination, the prevention of mental health problems, the provision of care for people with mental health problems, offering service users and carers involvement and choice to aid recovery. It also recognised that '... there is no health without mental health ... (ibid 3)' and the need for comprehensive evidence-based mental health policies.

The subsequent mental health action plan identified the challenge of inadequate and inequitable resources compared to other areas of provision and noted that in some health care systems the level of insurance coverage hindered access to services and rights to treatment. The action plan called for mental health service funding to be increased and for it be allocated equitably and proportionately, with the largest share going to those in the greatest need (WHO, 2005b: 10).

European states face a rapid growth in chronic disease and mental disorders, lack of social cohesion, environmental threats and financial uncertainties that threaten the sustainability of existing health and welfare systems. One in four people across the European region will experience some type of mental health problem during their lives, with common mental disorders, such as anxiety and depression, a particularly serious challenge. It is estimated that 50% of people living with mental disorders do not receive any form of treatment due to stigma and discrimination (WHO, 2013).

The long-term economic and social impact of the financial crisis is both complex and continuing to develop. As Stuckler and Basu noted: '... economic choices are not only matters of growth rates and deficits, but matters of life and death ... When governments invest more in social welfare programmes ... health improves (Stuckler & Basu, 2013: x-xiv).' There is a continuing need to consider critically the impacts of the financial crisis on mental health and the services available to support people experiencing mental health conditions.

3.2.3 The impact of the financial crisis and recovery on mental health and services

The financial crisis of 2007/08 had a profound impact on the social determinants of health, with significant increases in unemployment and poverty (Eurofound, 2013; Karanikolos *et al.,* 2013; Stuckler *et al.,* 2017). Unemployment has a direct effect on health, with a strong association with increased mortality risk and risky behaviours such as heavy drinking. It also has indirect effects, as the financial consequences of being unemployed can lead to psychological distress and an increase in mental disorders (WHO, 2015). The impact of long-term unemployment on younger people continues to increase across Europe, but particularly in states such as Ireland, Greece, Portugal, Spain and Ireland, deeply affected by the financial crisis. Young people who experience long-term unemployment are more likely than their peers to be materially deprived, to have lower levels of life satisfaction, greater risks of social exclusion and are more likely to have mental health problems (Eurofound, 2018; Mascherini, 2018). Mental health disorders can develop at any age, but the time during adolescence and the transition to young adulthood is a period of elevated risk, and the long-term 'scarring' effects of the economic crisis on the mental health and wellbeing of this group is of particular concern now and in the future.

Suicide is often used as a proxy indicator for the mental health status of a population, although there are issues around the stigma that is associated with the act, and data issues with reporting that lead to underestimations in some countries. There were approximately 55,000 suicides in EU states in 2008, with the lowest rates in Greece, Cyprus, Italy, Malta and the United Kingdom. There was a ten-fold difference between Greece and Lithuania, with Hungary, Latvia, Finland and Slovenia also experiencing high rates of suicide (OECD, 2010). There is a link between higher levels of suicide and adverse economic conditions (van Gool and Pearson, 2014 in OECD, 2016); suicide rates rose slightly at the start of the economic crisis in 2008 but this trend did not persist in most countries. There were approximately 60,000 suicides in EU states in 2013, but, importantly, the rate was 20% lower than in 2000; this suggests that national suicide prevention strategies that provide public health education and support to at-risk groups, such as people who are unemployed and those living with a psychiatric disorder, can be effective (OECD, 2016). Suicide is a significant cause of death across EU member states. However, it has limited value as an indicator of the mental health status of a population, and has been supplemented by other measures that provide a more nuanced perspective to inform policy and practice (Gunnel *et al.,* 2015). Depression is a common mental disorder across all EU states, with rates varying from one in thirteen people in Austria through one in eleven in the UK to more than one in ten in Germany and Sweden (EU country health profiles, 2017). Prevention and treatment of depression and other common mental health disorders is essential to continuing economic and social progress.

The financial crisis produced a situation in which some European governments cut spending on health care services, with many others tightly restricting the rate of expenditure growth, at a time when rising unemployment, population ageing and financial strain on households made access to health care both more difficult and important. Budgets for mental health care services were cut in the Netherlands, Slovenia and Sweden despite increased need for this provision (Eurofound, 2014). In England, the Coalition government made a commitment to parity of esteem between physical and mental health in 2011 (Department of Health, 2011) followed by a pledge of £1.25 billion for child and adolescent mental health, along with a national strategy for adult mental health and a social investment of £1 billion to support delivery. However, an analysis of the accounts of NHS mental health trusts showed that 40% had received a reduction in their budgets in cash terms in 2012/13-2013/14 and 2013/14-2014/15, rising to almost 50% of trusts in 2014/15-2015/16. The situation has improved with the introduction of the Mental Health Investment Standard: data for 2016/17 show that 84% of mental health trusts had received an increase in cash terms with only 16% recording a decrease in cash funding (Gilburt, 2018). Clearly, it is important to critically analyse mental health service policies and the wider social policy context, particularly active labour market policies and social protection.

3.2.4 **Policy responses in the post-crisis period**

The European Mental Health Action Plan 2013-2020 (WHO, 2015) acknowledged the diverse challenges affecting the mental wellbeing of the population and the provision of care for people with mental health disorders - the second largest contributor to the burden of disease, at 19%, as measured by Disability Adjusted Life Years in the European region (WHO, 2013). The Action Plan's vision for mental health is based on European values of fairness, empowerment, safety and effectiveness. Fairness means that everyone is enabled to reach the highest possible level of mental wellbeing and offered support proportional to their needs, while empowerment should ensure that all people with mental health problems have the right to be autonomous and have the opportunity to take responsibility for and to share in all decisions that affect their lives. All people should be able to trust that all activities and interventions to improve population mental health and the wellbeing of people with mental health problems are safe and effective. The broad consensus is that mental health care services should be provided in local community settings, as part of multi-disciplinary primary care, rather than in large mental hospitals (WHO, 2015).

A major challenge is that a large proportion of people with mental health disorders do not receive treatment at all or experience long delays. The treatment gap, the difference between the true prevalence of a specific disorder and the proportion of affected individuals actually receiving treatment, may be due to individuals not engaging with services due to low perceived need. This can result from attitudinal beliefs such as stigma or discrimination, as well as issues of access, affordability and quality (WHO, 2015). However, accurately assessing the scale of the treatment gap is difficult, given the lack of comparable data on mental health services and interpretation difficulties due to differences in service definition, methods of data collection and the quality of data (Barbato *et al.,* 2016).

Access to mental health care, broadly defined as contact with any health care service or professional for mental health problems, varies across EU states, with a median period of 7 to 30 days to receive a psychiatric assessment and appropriate psychotropic medication, and longer waiting times of more than two months for access to psychotherapy (Barbato *et al.,* 2016). For example, in Belgium in 2013, 37% of patients had to wait one month or more for a first face-to-face contact with ambulatory mental health care services (Vrijens *et al*, 2016). There is very little reliable data to enable comparative assessment of the quality of mental health care services (Barbato *et al.,* 2016). The major barriers to adequate mental health care services were insufficient funding, shortages of mental health professionals, and attitudinal factors such as lack of trust and a preference to handle problems without formal support. Financial barriers are likely to be more important in health care systems requiring out-of-pocket payment for access to services such as counselling and psychotherapy, which are not always covered by social or private health insurance (EU Compass, 2016).

Mental health care provision, despite numerous European and national policy statements, continues to be a 'Cinderella' element of health care systems in terms of access, affordability and quality. As Barbato and colleagues noted: 'Overall, despite the limited research base, the available information shows, with few exceptions, that too often people seeking help for their mental health problems receive ineffective treatment for their mental health problems' (Barbato *et al.,* 2016:15).

3.2.5 **The focus on work for mental health in the post-crisis period**

The European economic recovery has been partially matched by progress in people's quality of life: there has been progress from 2011 to 2016 with regard to some dimensions, such as self-reported health, which has recovered to the pre-crisis levels of 2007. However, there are persistent inequalities, with low-income groups, particularly women and the long-term unemployed, having an elevated risk of poor mental health and wellbeing. One social indicator revealing the persistence of inequalities is the number of people at risk of depression; this stood at 22% of people in the EU in 2016, compared to 25%t in 2011, and was actually lower in 2007 (24%). While this improvement is encouraging, there are still many people at risk, and for people in the bottom income quartile, the risk of depression was twice that of people in the top income quartile: 32% compared to 16% (Eurofound, 2017).

With the employment rate in the EU at 72.3%, the highest ever level, in the third quarter of 2017, there are positive signs of further economic and social recovery. However, the majority of these employment gains have been concentrated in the UK and Germany, while most of the jobs lost in Greece and Spain have yet to be recovered. Almost half of unemployed people (9.5 million) in the EU are long-term unemployed (more than a year) and the majority (6 million) have been out of work for more than two years (Eurofound, 2018). The impact of long-term unemployment on people's mental health and wellbeing is significant; it will continue to blight the lives of individuals, families and societies for many years.

The impact of chronic health problems, such as cardiovascular diseases and common mental disorders, on the labour market is significant. Older workers (aged 50-59) suffering from severe depression are more than twice as likely to leave the labour market as their peers, and the costs of ill health for social security benefits averages 1.7% of GDP across EU member states. This has prompted calls for greater efforts to prevent chronic health problems and better integration between health and labour market policies (OECD/EU, 2016). WHO Europe's Health 2020 framework and strategy for the twenty-first century emphasised the growing interest in the interface between employment and mental health, and noted '...good-quality employment is good for health and its determinants (such as a good standard of living, self-esteem, social participation) (WHO, 2013:94).' While advocating a rights-based approach to mental health care services, the strategy also called for better links between sectors, such as benefit offices and community mental health services, which rely on each other but do not traditionally work together (ibid).

The links between health and work are complex because of its two-way causal relationship (OECD, 2016) but there is no doubt that paid work is an important social determinant of health. Good quality paid work often underpins good health, by securing a decent level of income, a sense of purpose and social interaction. Conversely, a lack of contact with the labour market, due to unemployment or disability and insecure poor-quality paid work, can contribute to ill health, particularly poor mental health (Marmot, 2010; Marmot, 2013). Active labour market policies to move people from welfare to work, improved psychosocial conditions in workplaces characterised by unhealthy stress, along with better prevention of work-related ill health and improved rehabilitation through occupational and other forms of employment support can help to eradicate exposure to unhealthy, unsafe work and strengthen access to employment and good quality work (ibid). The balance between incentives and sanctions in this process for people with mental health issues is of crucial importance.

The United Kingdom has been at the forefront of this process for more than a decade, and in recent years has, through the Work Programme, increased the requirements and responsibilities on people who are out of the labour market to actively seek work. It has also sought to support people with disabilities and poor health, through Access to Work (Timmins, 2017; Toynbee & Walker, 2017; O'Hara, 2015). This has involved a significant increase in welfare conditionality in policy design, and a substantial increase, in practice, in the use of benefit sanctions. Benefit sanctions peaked at more than a million in 2012/13 and although they have fallen, to around 350,000 per year (DWP, 2018), they remain a much more prominent feature of the system than they have ever been. The National Audit Office, the independent public spending watchdog, was critical of the fact that the Department for Work and Pensions was unaware of the extra costs of sanctions, although the regime had been identified as having negative impacts on mental health, and several organisations had reported a link between sanctions and the increased use of food banks (NAO, 2016). The Welfare Conditionality research project recently concluded: 'Benefit sanctions do little to enhance people's motivation to prepare for, seek, or enter paid work. They routinely trigger profoundly negative personal, financial, health and behavioural outcomes and push some people away from collectivised welfare provisions...The application of welfare conditionality exacerbates many disabled people's existing illnesses and impairments. Its detrimental impact on those with mental health issues is a particular concern' (Dwyer *et al.,* 2018:4-31).

3.2.6 Box 2: Case study on mental health services in England: key messages

While provision of mental health services in England is primarily through the NHS (80%), community care policies in the 1990s accelerated moves towards a publicly funded mixed economy constituted by NHS, local government, voluntary and private sector providers. This legislative agenda also increased the pace of deinstitutionalisation during this period, creating a model of in-patient provision through units on district general hospital sites and community mental health services delivered mainly through the NHS but jointly funded by NHS and local government. This model has, broadly speaking, endured in this form into the present (Knapp and McDaid, 2007; Gilburt, 2016).

The period since the 2008 crisis has been characterised by significant funding constraints and uncertainties produced by ongoing institutional change. There has been considerable disinvestment in mental health services as part of wider austerity-related public spending reductions since 2010 (Gilburt, 2016). One significant area of disinvestment has been in-patient beds, with a 15% reduction in the total between 2012 and 2016, alongside reductions in the availability of community support (Centre for Mental Health, 2017; NHS Benchmarking Network, 2016). While secondary care saw funding restrictions, the Improving Access to Psychological Therapies (IAPT) short-term counselling programme, located within primary care, is one area that has seen increasing investment (NHS England, 2016).

The mechanism for financing NHS mental health provision is also undergoing reform to further embed market mechanisms, with a shift in 2013 from retrospective reimbursement through block contracts towards prospective reimbursement utilising the Mental Health Payments (formerly known as Payment by Results) system (Jacobs, 2014). The Health & Social Care Act 2012 also increased the incentivisation of competition in NHS procurement to encourage further diversification (Timmins, 2012), with the independent (private) sector now accounting for 29% of in-patient bed provision (LaingBuisson, 2016).

As well as structures of service provision, consideration of mental health requires acknowledgement of how the mental wellbeing of individuals and groups is significantly shaped by their social, economic and material environment. For instance, risk factors for many mental health issues are heavily associated with social inequalities related to poverty, income and characteristics such as gender, race, and sexuality amongst others (WHO and Calouste Gulbenkian Foundation, 2014). A further social determinant is access to services. In the UK, only 25% of those with mental health needs receive treatment, compared to 75% of those with physical health issues, largely due to relative and historical under-investment in mental health services (Ormel *et al.,* 2008; Docherty and Thornicroft, 2015), but with mental health stigma and discrimination also contributory factors (Clement *et al.,* 2014).

Findings from the empirical study highlighted a number of themes related to these overarching disinvestment and liberalisation trends. The introduction of internal markets in the NHS in the 1990s led to a changing role for clinicians and practitioners, whose tasks became progressively more focused on management of care (i.e. assessment, monitoring and review of care packages and contracts), with a consequent reduction of opportunities for a valued role in delivering therapeutic support. This period also saw a ‘punitive turn’ characterised by a shift from addressing need to negative risk management as a central pre-occupation in mental health services, with attributions of risk increasingly operating as a means to assess entitlements and allocate scarce resources.

During the early 2000s, a further intensification of marketisation proceeded in both primary and secondary care via a renewed emphasis on outsourcing support services, the creation of quasi-market bodies such as Foundation Trusts (Price *et al*., 2011; Bevan and Hood, 2006), and the introduction and proliferation of an array of market-oriented targets and performance indicators. Participants described these bureaucratic regimes as facilitating marketisation but having little clinical relevance to service users or workers. Moreover these reconfigurations constrained practitioner autonomy in ways that frustrated workers or generated stress for them, that consequently impacted detrimentally on service users.

Since the Coalition government introduced its austerity programme, service trends identified by participants include decaying infrastructure and shrinking community teams; the removal and relative neglect of support services for users with longer-term needs; intensification of the embedding of market logics in provision; and the detrimental impacts of draconian reforms to the welfare system on service users (‘benefits distress’ – Moth and Lavalette, 2017) generating increased demands on practitioners to offer support in this arena.

We now turn to consideration of the impact of dis/investment and liberalisation trends in mental health services through a human rights lens. In terms of participation, we found that an ethos and culture of supporting user participation had begun to emerge in the NHS during the 1990s in the wake of deinstitutionalisation, but noted a more recent countervailing trend towards increased paternalism and reduced user involvement in a context of cuts and managerialist reform. In relation to non-discrimination, our respondents highlighted concerns about a significant increase in involuntary and coercive forms of detention under the Mental Health Act 2007 in recent years, with a concomitant increase in the number of Community Treatment Orders (CTOs). Also noted was continuation of a longstanding trend of over-representation of BAME service users subjected to involuntary forms of treatment. The next principle is accessibility, and our findings suggest reductions in access to support due to austerity. This is true both geographically, for instance a dramatic increase in the number of out-of-area (in-patient hospital) placements (OAPs) due to local bed shortages, and financially, e.g. increased out-of-pocket charges for local authority day centre support acting as a disincentive to utilise provision. The issue of availability was articulated both through reduced levels of service provision as a result of austerity measures, and also an increasing prevalence of time-limited services, for instance the six-week ‘reablement’ model. Meanwhile, quality was negatively impacted due to austerity-related funding constraints in a number of areas, including deteriorating buildings infrastructure, inconsistency in staffing that undermined relationship-based practice, and down skilling/down banding of practitioners. The final principle is that of acceptability: our service user participants tended to value holistic and social approaches for understanding and responding to mental distress, however these were being marginalised by 'biomedical residualism' in services generated by resource constraints (Moth, 2018).

The main findings in relation to the capabilities of respondents in the context of dis/investment and liberalisation trends were as follows: preventative forms of support were far less prominent, with diminishing acknowledgement at the policy level of the role of services in supporting users to maintain stable mental health; and a reduction in resources to enhance social inclusion. Overall, the study indicated that, as a result of dis/investment and liberalisation, comprehensive levels of mental health service provision were being significantly eroded with a move towards more residualised provision. Respondents identified a number of harmful implications of this trend for both service users and practitioners.

3.3 An in-depth analysis of eight case studies

3.3.1 Key dimensions for the analysis

As emerges from the review in Chapter 1 above, two approaches to health care coexist (and compete) in EU discourses and initiatives: *health care as a human right* (with an emphasis on access and quality) and *health care as a productive factor*, with an emphasis on efficiency and fiscal sustainability. The latter approach is prevalent in the Commission understanding of social investment (cf. also Bonvin and Laruffa, 2017). A further element relevant to the health care sector and characterising the SIP is the emphasis on the *involvement of private for profit and third sector actors* in the funding, provision and delivery of social policy (ibid).

In the present analysis, we will thus identify and define the key aspects of the two approaches to health care. This will serve as a reference for the country comparison below. For the purpose of our analysis, and with an aim to ensuring uniformity among the reports on the different service sectors, we will make a distinction between two important aspects of access to health services: first, financial access, which we will analyse with reference to affordability, and, second, effective access, which covers the organisational aspects of access to health care.

First, we consider the following key dimensions as constitutive elements of a purely *rights-based approach* (RBA) to health care: (a) affordability; (b) effective access (c) quality; and (d) participation. Each of these dimensions has a number of sub-dimensions (Table 3.2).

Table 3.2 Dimensions and sub-dimensions of a rights-based approach to health care

Dimensions	Sub-dimensions
Affordability	**Population coverage** Benefit packages **User charges** Means testing **Coverage of statutory and voluntary health insurance** Measures for vulnerable groups
Effective access	**Availability of services** **Timely/waiting times** **Distance** Provider choice Physical access (e.g. for disabled people) **Transparency (and accessibility) of information** De-facto distribution of take-up Measures for vulnerable groups
Quality	**Improved health outcomes** Safety Effectiveness (based on scientific knowledge) Patient-centeredness Respectful treatment **Level of satisfaction**
Participation	Patients' empowerment

* In bold the sub-dimension included in the cross-country analysis.

Second, we consider the following as key dimensions of what can be called an EU social investment approach (EUSI) to health care: (a) fiscal sustainability; (b) cost-effectiveness; (c) efficiency; and (d) commodification/marketisation/managerialism. Again, each of these dimensions has a number of sub-dimensions (Table 3.3). In this approach, access and affordability are not neglected, but there is an emphasis on fiscal sustainability, cost-effectiveness, efficiency and commodification/marketisation/managerialism. In addition to the two approaches above, an excessive focus on fiscal sustainability and cost-effectiveness could however be classified as an *austerity-oriented social investment approach* (AOSI).

Table 3.3 Dimensions and sub-dimensions of an EU social investment approach to health care

Dimensions	Sub-dimensions
Cost-effectiveness	**Shift from specialist and hospital care to primary and ambulatory care** Financing system Coordination/integration of care **Cost-effective provision and use of health services** Balanced mix of staff skills and anticipating staff needs **Disease prevention and health promotion** **Digitalisation** Health technology assessment **Cost-effective use of medicines** Centralisation of procurement
Efficiency	**Transparency (corruption, fraud, ...)** Inefficiencies Bureaucracy **Quality control**
Commodification/marketisation/managerialism	Opening up to competition Increased level of patient choice Performance-based payment systems Use of private care providers Accountability of service users/patients
Macro-economic and fiscal sustainability	**Cost-containment** **Budget caps** **Reduction of staff** **Increased co-payments** **Cuts in salaries, fees, benefit packages, number of health care facilities**

* In bold the sub-dimensions included in the cross-country analysis.

To be clear, the dimensions outlined above are over-simplified (though useful for comparison). The dimensions are in fact inter-linked. On the one hand, it would be difficult to ensure the right to health care in the long-term if, for instance, it is not financially sustainable. On the other hand, EU discourses on social investment do not ignore the fact that health care is a right (cf. Section Introduction - RE-InVEST). Yet, in many cases these two sets of dimensions come into conflict. The dimension to be prioritised (e.g. financial sustainability vs. quality) is a matter of political choice. Of course, the ideal situation would be an approach simultaneously combining and striking a balance between the eight dimensions above. In line with Sabato and Corti (forth.), we define such an ideal approach as a *rights-based social investment approach* (RBSI). Compared to EUSI, this approach fully succeeds in balancing the rights-based (capability-oriented) approach with a social investment approach, by simultaneously promoting the dimensions characterising the latter two approaches.

In sum, the approaches to and developments of health care policies in EU countries can be classified on a continuum going from RBA, to RBSI, to RCSI, to EUSI according to the dimensions prioritised in each countries and the ways these are combined (Figure 3.4).

Figure 3.4 Approaches to health care in the Member States

RBA	RBSI	EUSI	AOSI

3.3.2 Comparative analysis of eight case studies

In this section, we present a comparative analysis of the situation in the eight RE-InVEST countries analysed, (Belgium, England, Scotland, Italy, Portugal, Romania, the Netherlands and Ireland), with respect to some of the key dimensions identified in Section 3.3.1. Besides comparing the situations in the eight countries, the aim of this analysis is to identify the specific approach to health care taken in each (in the Conclusions).

3.3.2.1 Affordability

Most of the countries considered provide universal or near-universal *coverage* of health care costs for a core set of services. 100% of the population is eligible for a defined set of health care goods and services under public programmes in Ireland, Italy, Portugal and the United Kingdom, 99.9% in the Netherlands, 99% in Belgium.[11] This is not the case in Romania where, although social insurance is compulsory, health coverage is de facto not universal. The percentage of the population covered by health insurance in Romania has been declining (77.02% in 2016, 86.1% in 2014), with significant urban-rural differences in coverage, the vulnerable population being the most affected (Farcasanu, 2018).[12] In Ireland, over half of the population covered, in particular those on higher incomes, are entitled only to hospital care (Daly, 2018) In Belgium, concerns relate to the coverage of vulnerable groups such as asylum seekers and undocumented migrants, as they are not allowed to register with a sickness fund (Buffel & Nicaise, 2018).

Several of the countries under scrutiny have a significant *voluntary/private health insurance* market. In Belgium, a large and increasing proportion of the population makes use of complementary insurance (77.3% in 2008, 82.7% in 2016), which reimburses any cost sharing left after basic coverage. In the Netherlands, the supplementary market providing additional services has been decreasing (92% in 2008, 87.3% in 2016). In Ireland, duplicate health insurance offers faster private-sector access to medical services for which there are waiting times in public systems, to a large share of the population (52% in 2008, 45.4% in 2016).[13] It is interesting to note that, in Ireland, voluntary health insurance schemes accounted for over 12% of current health care expenditure (CHE) in 2015, compared to around 5.8% in the Netherlands, 5.2% in Portugal, 4.8% in Belgium, 3.4% in the United Kingdom, 1.5% in Italy and 0.3% in Romania.[14] The duplicate market is becoming increasingly significant in Portugal, covering over a quarter of the population (18.5% in 2008, 26% in 2016), whereas it has been declining in the United Kingdom (12.3% in 2008, 10.5% in 2016).[15] Data are not available for Romania, where voluntary health insurance is poorly regulated and underdeveloped, and Italy, where there is a growth in occupational health insurance (Farcasanu, 2018, Jessoula *et al.,* 2018). Voluntary and private health insurance usually provide access to care for those in a better employment situation, leaving behind the vulnerable groups.

Several of the countries under scrutiny adopted cost-containment measures in the wake of the economic crisis. The *depth of coverage* decreased as a result of reduced benefit packages and increased co-payments. In Italy, a robust new set of co-payments for pharmaceutical goods and health care services was introduced in 2014, while in Ireland charges increased for prescriptions and hospital care, including for those on low incomes (Daly, 2018). In Portugal, health expenses paid by users have increased, despite an expansion in the share of people exempted from user charges. In Belgium, user charges for health services increased, in

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[11] OECD Health Statistics 2018.

[12] The report suggests a need for caution in interpreting these figures, as a large number of Romanians working abroad may still be counted as living in the country.

[13] OECD Health Statistics 2018

[14] Eurostat [hlth_sha11_hf]

[15] OECD Health Statistics 2018; Eurostat [hlth_sha11_hchf]

particular supplements that can be charged over and above the reimbursement tariff. In the Netherlands, the financial burden borne by the insured or users of care has been repeatedly increased, with higher insurance contributions for employers (from 7.1% to 7.5%) and employees (from 5% to 5.56%). Mandatory co-payments were introduced in 2008 in order to control costs (up to €170 per person in 2008, increasing to €385 in 2018); several medicines, treatments and (walking) aids were removed from the standard benefits package and are only reimbursed in severe cases or for long-term use (Anderson, 2018). In the UK, budget cuts eroded public health activity and reduced social care, affecting hospital discharges and reducing patient throughput (Bradshaw *et al.,* 2018).

Cutbacks caused cost shifting from public to private funding in several countries. In Portugal, out-of-pocket payments (OOPs) are almost double the EU average (27.65% of Current Health Expenditure compared to the EU average of 15%); such payments are high also in Italy (22.83%), Romania (21.18%, where the share of informal payments may also be considerable) and Belgium (17.57%). OOPs are close to the EU average in Ireland and the UK, while in the Netherlands out-of-pocket costs are among the lowest in the EU (12.25%).[16]

High costs are the main cause for self-reported unmet needs for health care in several of the countries under scrutiny. Between 2010 and 2013, the share of the population reporting *unmet needs for medical examination due to cost* increased significantly in Italy (+2.2%), Belgium (+1.4%), Portugal (+0.8%), and Ireland (+0.7%). In Italy, Portugal and Ireland, this trend has been reversed in 2015-2016, but not in Belgium. In 2016, unmet needs due to cost were higher than the EU average of 1.6% in Romania (5.3%, although decreasing from 10% in 2013), Italy (4.9%), Belgium (2.2%) and Portugal (2%). Conversely, the Netherlands and the United Kingdom perform well on this indicator, with only 0.1% of reported unmet needs due to cost. High costs for medical examination and treatment can prevent vulnerable groups from accessing health care if they are not adequately protected. Among the lowest income quintile, unmet needs due to cost affect a large share of the population (in 2016) in Italy (11.6%), Romania (9.9%), Belgium (7.7%) and Portugal (4.1%).[17]

The data discussed above reveal great differences in the protection of *vulnerable groups* across the countries under scrutiny. According to Farcasanu (2018), Romania has recently introduced reform measures targeting increasing access of older people to appropriate health care services, while local and national interventions have been implemented to increase Roma health care coverage. In the Netherlands, tax allowances have protected the most vulnerable population groups from cost-shifting measures, and in Italy, vulnerable groups such as the unemployed are exempted from co-payments in certain situations, although this benefit declines as soon as income increases. In Belgium, several mechanisms have been introduced in an attempt to improve the affordability of health care, such as increased reimbursement status, the maximum billing system, the third-party payer measure and chronic illness status (Buffel and Nicaise, 2018). In Ireland, the medical card scheme is a crucial safety net which exempts certain groups of the population from having to directly meet health care costs. As income decreased during the crisis, the share of the population covered by this scheme increased from just over 30% of the population in 2008 to just under 40% by 2013. However, automatic entitlement to the medical card was abolished for those aged 70 years and over. In Scotland, personal and nursing care is provided free of charge for people aged 65 and over, whereas it is subject to a means test in England. Additional measures ensure coverage of vulnerable groups such as irregular migrants and Roma in Portugal. Similarly, in Italy both legal and temporarily undocumented immigrants are eligible to receive the same public health-care services that are available to Italian citizens.

3.3.2.2 **Effective access**

After high costs, waiting times are the second most important cause of self-reported unmet needs across the EU. During the crisis, self-reported *unmet needs due to waiting lists* increased in most of the countries under

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[16] Eurostat [hlth_sha11_hchf]

[17] Eurostat [hlth_silc_08]

scrutiny and then diminished in recent years.[18] Problems concerning waiting times are limited in Belgium (0% in 2016) and the Netherlands (0.1%). Although this indicator shows a low value for Portugal (0.3%), a national report highlights long waiting times for speciality appointments and for surgery (Perista, 2018). In Italy, unmet needs due to waiting times have been decreasing, from 1.4% in 2010 to 0.5% in 2016; however the RE-InVEST report points to a growth of private health care, likely caused by the length of waiting lists. In Ireland, this indicator did not improve after the crisis (0.5% in 2010, 1% in 2013, and 1.1% in 2016), as efforts to cut waiting times have been undermined by severe cutbacks and underfunding (Daly 2018). Waiting times are high also in the UK, where they are the main cause of unmet needs, affecting 0.9% of the population in 2016.

Several of the countries under scrutiny express concerns as to shortages of health professionals (see below – Fiscal sustainability).

3.3.2.3 **Quality**

According to the European Quality of Life Survey 2016 (Eurofound, 2017), the *quality of health services* in the EU is rated at 6.7 on a scale from 1 to 10. In the countries under scrutiny, satisfaction as to the quality of health services is quite low in Italy (5.8), Romania (5.9) and Ireland (5.9), is close to the EU average in Portugal (6.3) and the United Kingdom (6.9), while it is higher in the Netherlands (7.3) and Belgium (7.6).

Measures of *potentially avoidable mortality* have been improving in the EU in recent years. Preventable mortality rates in the EU decreased from 226.3 per 100,000 inhabitants in 2011 to 216.3 in 2015, while amenable mortality rates decreased from 137.9 to 127.1 in the same period. Both indicators register a slight increase in potentially avoidable mortality between 2014 and 2015. Preventable death rates are below the EU average in Italy (151 per 100,000 inhabitants in 2015), Portugal (186.4), Ireland (188.5), the Netherlands (188.8), and the UK (211.3). Preventable mortality rates are close to the EU average in Belgium (216.4 in 2015), while they remain extremely high in Romania (362.7). Similarly, amenable death rates are quite low in the Netherlands (90.6 per 100,000 inhabitants in 2015), Italy (93), Belgium (94), Ireland (110.5), Portugal (111) and the UK (117.4), while they are considerably higher in Romania (318).[19] Hospital admissions for congestive heart failure (CHF), a condition whose effective treatment could be delivered at the primary care level, have been decreasing. There is considerable variation across EU countries, in 2015 (or nearest year). CHF hospital admission rates varied from 100.6 per 100,000 population in the UK to 225.9 in Italy. In the same year, hospital admissions for asthma and chronic obstructive pulmonary disease ranged from 63.3 per 100,000 population in Italy to 411.3 in Ireland.[20]

All the countries under scrutiny show lower *infant mortality rates* in 2016 than in 2008. The sharpest decrease took place in Romania, where the rate decreased from 11 deaths per 1,000 live births in 2008 to 7 in 2016. This rate remains much higher in Romania than the EU average of 3.6 deaths. The remaining countries show rates close to the EU average or lower: 3.8 in the UK, 3.5 in the Netherlands, 3.2 in Belgium and Portugal, 3 in Ireland, 2.8 in Italy.[21]

3.3.2.4 **Fiscal sustainability**

Looking at *health expenditure* as a share of GDP in 2015 (or nearest year),[22] most of the countries under scrutiny present values close to the EU 28 average (9.9%), ranging from 10.8% in the Netherlands to 9.1% in Italy. Exceptions are Portugal (8.9%) and, especially, Romania (5.0%). This said, during the crisis health care expenditure slowed significantly in the European Union, with an average growth of only 0.7% each year in real terms (adjusted for inflation) between 2009-2015 (OECD/EU, 2016: 114). As for the countries under scrutiny, the situation is varied. In one group of countries, the average annual growth was slightly

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[18] Eurostat [hlth_silc_08]

[19] Eurostat [hlth_cd_apr].

[20] OECD Health Statistics 2018, no data available for Romania.

[21] Eurostat [demo_minfind].

[22] Authors' own elaboration based on OECD/EU (2016), Health at a Glance: Europe 2016, Figure 5.11 Current health expenditure by type of financing, 2014, p.123.

positive over the above period: 1.2% in the Netherlands, 0.9% in Belgium, 0.7% in Romania, and 0.5% in the UK. In other countries expenditure decreased: -0.2% in Ireland, -1.1% in Italy and -2.0% in Portugal. This said, differences in average growth between 2005-2009 and 2009-2015 are striking -1.9 p.p. in the Netherlands, -2.3 p.p. in Belgium, -3.4 p.p. in Romania,[23] -2.8 p.p. in the UK, -7.1 p.p. in Ireland, -1.6 p.p. in Italy, and -3.3 p.p. in Portugal. All in all, cost-containment measures have been undertaken in all the countries under analysis, and especially in those receiving conditional financial assistance from the EU subject to detailed conditions defined in a Memorandum of Understanding (Ireland, Portugal and Romania). For instance, in Belgium, following EU pressure, the growth cap for the annual health budget was reduced from 4.5% in 2012 to 1.5% in 2016, and in 2017 to 0.5% for the budget year 2018 (Buffel and Nicaise, 2018). Similarly in the Netherlands, in 2013 the Ministry of Health reached an agreement with insurers and health care providers to limit annual growth in hospital and primary care expenditure to 1.5% in 2014 and 1% in 2015-2017. According to Bradshaw *et al.* (2018), the public health budget in the UK was cut by 234 million euros in 2015, with further cuts foreseen for 2018/2019 and 2019/2020. The same applies to local government budgets, which were cut by 23.4% in real terms between 2009/2010 and 2014/2015, with further cuts planned in the future (ibid). In Italy, the turning point was the 2011 budget law, which introduced, for the years 2013-2014, expenditure cuts of about 8 billion euros.

Among the most used cost-containment measures is the *freezing of recruitment* of medical staff and/or the *freezing/reduction of their wages*. On recruitment freezes, data are not available for all the countries under scrutiny. Those countries for which data are available[24] show an overall increase in health personnel in hospitals[25] between 2008 and 2015 (the Netherlands, Belgium, Ireland), and between 2010 and 2015 (Romania). However, these overall trends hide important fluctuations over time. In particular, in Romania and Ireland there was a sharp decrease between 2010 and 2014 and a recovery in 2014 and 2015. Data on nursing and caring professionals are only available for the Netherlands, Romania, Italy and the UK.[26] In the Netherlands, data show a significant staff reduction, from 430,703 in 2008 to 382,040 in 2016. On the contrary, the number of practicing nursing and caring professionals has increased in Romania (from 180,106 in 2008 to 200,630 in 2016), Italy (from 851,779 in 2013 to 975,802 in 2016) and in the UK (from 1,480,417 in 2012 to 1,587,022 in 2016). Data from the RE-InVEST reports, however, show a different picture. According to those sources, freezes on staff recruitment or promotion have been implemented in Ireland (alongside a 10% reduction in the number of people working in health care), Romania (since 2010), and Italy (since 2014). Reductions of wages were implemented in Ireland, the UK and Romania (-25% in 2010 before rising again in 2012 to 2010 levels). In the latter country, there is a severe shortage of medical staff as a consequence of marked migration due, among other things, to the low level of wages. In order to address this phenomenon, in 2017-2018 the salaries of medical staff were significantly increased (+25%). In the UK, a national public sector pay gap policy tightly constrained the rate of wage growth in the National Health Service and across the wider public sector.

As for *facilities*, in some countries, measures implemented have led to a reduction in the number of hospitals (notably Romania), while there is a common trend to reduce hospital beds. The latter provides a good indication of the resources available for delivering services to inpatients in hospitals (OECD/EU, 2016): 166). Between 2000 and 2014 (or nearest year), the number of hospital beds per 1000 population[27] were reduced in Romania (-1), Portugal (-0.4) and, especially, in Italy (-1.4).

The share of *out-of-pocket* expenditure by type of health care expenditure varies among the countries considered in this analysis (see above ‘Access’).

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[23] This said, according to ESPN report (Farcasanu 2018), in 2017 the public health budget increased by approximately 6% compared to the previous year.

[24] Eurostat (hlth_rs_prshp1).

[25] Full time equivalent (FTE) per 100,000.

[26] Eurostat [hlth_rs_prsns].

[27] Authors’ own elaboration based on OECD/EU (2016), Health at a Glance: Europe 2016, Figure 7.21 Hospital beds per 1 000 population, 2000 and 2014 (or nearest year), p. 167.

3.3.2.5 **Cost-effectiveness**

Improving the cost-effectiveness of health care services is one way of controlling costs. This is in line with the Commission Social Investment Package, which stresses the need 'to do more' with equivalent or even fewer resources.

As reported by OECD/EU (2016: 120), after inpatient and outpatient care, **pharmaceuticals** represent the third largest expenditure item for health care spending and accounted for around a sixth of health expenditure in the European Union in 2014. As reported by the OECD/EU (2016:120), 'the growth in spending on pharmaceuticals has remained below total health spending growth over the last decade, with average annual growth rates in the 2009-2014 period much lower compared to pre-crisis years'. Between 2009 and 2014, expenditure on pharmaceuticals dropped by 1.1% in real terms on average in the EU (especially due to cuts in public spending), while it increased by 1.4% each year in the 2005-2009 period (ibid). A more cost-effective use of medicines is also a trend characterising the countries under scrutiny. In the period 2009-2014, pharmaceutical expenditure per capita in real terms dropped by 7.5% in Portugal and 4.0% in the Netherlands. Less marked decreases took place in Ireland (-2.7%), Italy (-2.1&) and Belgium (-1.9%). Similarly, although quantitative data are not available, measures to rationalise pharmaceutical spending have been implemented in the United Kingdom. One of the most widespread measures implemented in the RE-InVEST countries, is the attempt to increase the use of generics.

Promoting the shift from specialist and hospital care to primary and ambulatory care is one of the most common cost-effectiveness enhancing measures implemented in the countries under scrutiny. Typical measures are: a) a reduction of hospital beds and of the duration of the stay in hospitals, and b) a more important role attributed to general practitioners (GPs), the latter typically acting as gate-keepers for referrals to specialists or hospitals.

The number of hospital beds has been decreasing across the EU (514 per 100,000 inhabitants in 2015, compared to 558 in 2008).

Some examples can illustrate this latter trend. In Belgium, attending an emergency department without being referred there by a general practitioner can lead to a charge of 100 euros. Successful efforts to replace secondary care with primary care have also been undertaken in the Netherlands. On the contrary, in Ireland, the hospitalisation rate for activities that could be treated in primary care settings is relatively high, a circumstance that, coupled with the rather low availability of beds, contributes to a very high occupancy rate of hospital beds. In Romania, the payment system for general practitioners does not penalise referral to hospital specialists. This said, the success of the strategy implemented in the countries under scrutiny is linked to having access to the services provided by primary care physicians. In this respect, the situation varies. Against an EU (26) average of 26.7%, both in Portugal and England the proportion of patients who visited an emergency department because the primary care physician was not available is relatively high (30.6% and 38.7% respectively) (OECD/EU, 2016:45). In other countries, this proportion is close to the EU average: 28.7% in the Netherlands and 23.3% in Italy. The situation is better in other countries, with values well below the EU average: 10.7% in Belgium, 14.9% in Romania and 15.5% in Ireland.

Another way to enhance the cost-effectiveness of the health care system is to increase *co-ordination/ integration between health-related services*. Only a little qualitative information on this aspect emerges from the RE-InVEST case studies, so it is difficult to single out trends. In England, some attempts have been made to better integrate and co-ordinate health and social care through the 'Better Care Fund', pooling a growing sum of resources from the National Health Service with local authorities. Scotland has increased integration of health and social care through the 'Public Bodies Scotland Act' (April 2014), requiring National Health Service and local authorities to establish local integrated partnership and governance arrangements, a pooled budget and joint responsibility for strategic and locality planning.

Promoting *digitalisation* is another measure aimed at enhancing the cost-effectiveness of health care. In 2013, the European Commission conducted a survey examining the adoption of e-health in general practices. A composite index of e-Health adoption among general practitioners was produced, giving countries a possible score from 0 to 4. A number of RE-InVEST countries performed better than the EU average (1.88) (OECD/EU, 2016): the Netherlands (2.12), the UK (2.07) and Italy (1.97). Ireland (1.85) and Portugal

(1.84) are close to the EU average, while Belgium (1.75) and Romania (1.70) were below. A similar survey was conducted on e-Health adoption in hospitals, with two composite indicators concerning, respectively, deployment and availability and use[28] (OECD/EU, 2016). The highest possible score for each composite indicator was 1. In terms of deployment, a number of RE-InVEST countries were above the EU average (0.44): the UK (0.58), the Netherlands (0.57), Belgium (0.55), and Ireland (0.47). Besides two countries close to the EU average (Portugal and Italy, scoring respectively 0.40 and 0.46), Romania only scored 0.34. As for availability and use, the EU average was 0.30. Four RE-InVEST countries had lower scores: Italy (0.27), the UK (0.22), Romania (0.20) and Ireland (0.16). Three countries performed better than the EU average: the Netherlands (0.48), Belgium (0.37) and Portugal (0.37).

Finally, a key dimension of cost-effectiveness is the importance of *preventive health actions*. This is a key aspect of the social investment approach, as it enables an improvement of the health status of citizens (also allowing for longer working careers) and to save money in the future. However, data show that these kinds of actions have been hit during the crisis, with a reduction in importance and funding. Expenditure on preventive care as a percentage of Current Health Expenditure (CHE) decreased between 2007 and 2015 by 0.10 p.p. in Belgium, 0.39 p.p. in Portugal, and 0.65 p.p. in the Netherlands.[29] As for Italy, Romania, the UK and Ireland, only data for 2013 and 2015 are available, showing a slight decrease in Italy (-0.02 p.p.) and Ireland (-0.07p.p.) and an increase in Romania (0.33 p.p.) and the UK (0.24 p.p.). This said, a decline in immunisation levels can be seen in Romania.

3.3.2.6 **4.3.2.6 Efficiency**

Initiatives aimed at improving the efficiency of health care systems may concern different aspects, such as enhancing their transparency, reducing bureaucratic burdens and improving quality control.

With regard to the *transparency* of the system, most of the RE-InVEST reports have focused on the fight against corruption and fraud. Available quantitative data (Special Eurobarometer 374, 2012) show that, in 2012, 41 % of EU (27) citizens believed that there was corruption in health care, while 2% referred to health care bribes. The situation in the RE-InVEST countries varies. In terms of perceived corruption, a number of countries were (in 2012) above the EU average: Romania (71%), Portugal (58%), Ireland (53%), and Italy (46%). Other countries were below it: the United Kingdom (37%), Belgium (31%), and the Netherlands (11%). Bribery appears rather limited in the countries under scrutiny: in 2012, citizens' perception of this phenomenon ranged (Special Eurobarometer 374, 2012) between 0% (Ireland, UK, Belgium and the Netherlands) and 1% (Portugal and Italy). The only exception is Romania (17%). On Romania, the RE-InVEST report emphasises that the phenomenon of informal payments is widespread and can also be considered as an unofficial way to address the issue of doctors' low pay, to the extent that, in 2015, the government proposed to legalise and tax these 'under the table' payments. In 2017-2018 new policy measures have tried to address this phenomenon (Farcasanu, 2018).

Against this backdrop, measures to fight corruption and fraud have been implemented in some of the countries under scrutiny. In Italy, reforms have especially targeted procurement. As of 2016, the new Code of Conduct on Concessions for Procurement obliges the government to streamline procedures, making them more transparent and strengthening control by the National Anti-Corruption Authority. In Portugal, in 2016, the government established strategies and coalitions to reduce corruption in pharmaceuticals procurement.

Little information is available in the reports on strengthening *quality control*. In the UK, health care commissioners and providers are monitored by regulatory organisations including the Care Quality Commission, which licences and inspects all public and private health and social care providers in England (Bradshaw *et*

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[28] As explained by OECD/EU 2016: 178 'Deployment' refers to four dimensions: 1) digital infrastructure; 2) application and integration; 3) information flows and health information exchange; and 4) security and privacy. 'Availability and use' concern digital applications and functionalities, the EHR, clinical decisions support tools, and TeleHealth.

[29] Eurostat [hlth_sha11_hchp].

al., 2018). In Scotland, in May 2010, the Health care Quality strategy was introduced, with the aim of developing safe, effective and person-centred health care with greater integration of health and social care provisions.

3.3.2.7 **Marketisation**

Competition in the health care sector plays a varying role in the countries under scrutiny. In countries where competition and free choice are not a key characteristic of the system, a greater degree of choice is reserved for those who purchase private insurance or can afford OOPs.

The Belgian system, based on compulsory national health insurance, builds upon the principle of free choice of health care provider for the patients, while remuneration is predominantly based on fee-for-service payments. In the Netherlands, where insurance is compulsory and the health care system is run by insurance companies, managed competition between suppliers was introduced in 2006 to promote efficiency. According to the RE-InVEST report, the introduction of such managed competition in the country led to an increase in choice, although choices in health behaviour appear to be significantly limited by affordability concerns. A different report (Anderson, 2018) suggests that competition in the Netherlands remains controversial: it resulted in very good outcomes in terms of access, but it also led to mergers among insurers and providers, thus weakening the basis for a well-functioning market. In Ireland, the proposal to introduce a market-based compulsory health insurance, which envisaged suppliers competing to provide value for money, was abandoned in 2015 due to potential increase in costs. An analysis suggested that the proposed reform would have increased health care expenditure by between 3.5% and 10.7% per annum (Daly, 2018). In England, increasing use is being made of the private sector through the Private Finance Initiative for major capital projects (Pollock, 2004; Lister, 2008), and Independent Sector Treatment Centres are brought in to increase capacity and reduce waiting times for diagnostic tests and a range of elective surgical procedures (Toynbee & Walker, 2017). Both of these forms of provision were notably more expensive than the publicly financed NHS option and represented a relatively small scale but significant form of privatisation.

As reported by OECD/EU (2016): 51, innovative *payment systems* that reward the quality and value of care can improve care delivery by aligning provider incentives with health policy objectives. Greater accountability for patients' outcomes could also be achieved with such innovations. The introduction in the Netherlands in 2007 of bundled payments to improve the delivery of care for patients with chronic conditions is reported as an example of good practice, showing promising results in process and outcome indicators (OECD/EU, 2016: 50).

Some national reports point to problematic payment systems. In Ireland, a differential reimbursement system of GPs, hospital consultants and public hospitals favours private patients over public patients, providing a fee-for-service for the former patients and fixed remuneration for the latter patients (Daly, 2018). In Romania, the current payment system encourages primary care doctors to maximise the number of registered patients, but there are no incentives to provide a full package of primary and preventive care services. Referrals to hospital specialists or high-cost pharmaceutical prescriptions are not penalised, resulting in excessive use of hospitals and over-prescription of pharmaceuticals (Farcasanu, 2018).

3.3.3 **Summing up: countries' approaches** [30]

Interesting findings emerge from the cross-country analysis (see Table 3.4). In terms of the *affordability* of health care, it should first be noted that all the countries under scrutiny except Romania have virtually universal population coverage, although in Ireland, over half of the population covered is entitled to only a limited benefit package, in particular hospital care. This said, user charges have increased in all the countries. Self-reported unmet need due to high cost also increased in all countries during 2010-2013, except in the

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[30] Although some specific information for England and Scotland has been presented in the previous section, most of that information concerned the UK. For this reason, in this section we consider the UK.

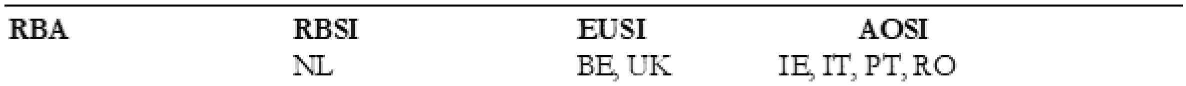
UK and the Netherlands, where it remained at a low level. This said, specific measures to protect the most vulnerable groups have been implemented in all the countries. When it comes to *effective access*, the situation is problematic - especially due to high waiting times - in Ireland, Italy, Portugal and the UK, and the situation has deteriorated over the crisis years. Concerning waiting times, however, a good situation emerges in both Belgium and the Netherlands. The situation in Romania is unclear. As for *quality*, a subjective indicator on perception of the quality of health services shows varied situations, with high values for Belgium and the Netherlands and a lower level of satisfaction in Ireland, Italy and Romania. Values close to the EU average emerge for Portugal and the UK. More objective indicators, such as potentially avoidable mortality and the infant mortality rate, show good results in all countries with the exception of Romania. All the countries under scrutiny have implemented measures to ensure the *fiscal sustainability* of health care systems, in particular a reduction of the health care budget or a marked reduction of its growth. In most cases (e.g. Ireland, Italy, and Romania), recruitment of health professionals has been frozen or wages have been cut (especially in Ireland and for a long period, in Romania). The number of hospital beds has been reduced in Italy, Portugal and Romania. A varied set of measures have been implemented in order to increase the cost-effectiveness of health care systems. First, there has been a common trend to reduce expenditure on pharmaceuticals. Second, a number of countries have tried to implement a shift from specialist and hospital care to primary and ambulatory care, a tendency more pronounced in the Netherlands. These attempts have been less effective in Ireland and Romania. Third, measures to increase the use of e-health technologies to improve cost-effectiveness have been implemented especially in Italy, the Netherlands and the UK, but also in Belgium, Ireland, and Portugal. In this respect, however, a negative picture emerges in Romania. Finally, and in contrast with the social investment approach, expenditure on preventive care has decreased in all the countries under scrutiny with the exception of Romania and the UK. Unfortunately, only little data and information has been found on efficiency and marketisation, for a limited number of countries.

Table 3.4 Summary of the results (trends) from the transversal analysis

Dimension/country	BE	IE	IT	NL	PT	RO	UK
Affordability	+/-	-	-	+/-	-	-	+/-
Effective access	+	-	-	+	-	?	-
Quality	+	+/-	+/-	+	+/-	-	+/-
Fiscal sustainability	+/-	+	+	+/-	+	+	+/-
Cost-effectiveness	+/-	+/-	+/-	+	+/-	-	+
Efficiency	?	?	?	?	?	?	?
Marketisation	?	?	?	+	?	?	+
Overall approach	EUSI	AOSI	AOSI	RBSI/EUSI	AOSI	AOSI	EUSI

Against this backdrop, and considering the various approaches to health care identified in Section 3.3.1, we note (Table 3.4 and Figure 3.5) that, unsurprisingly, none of the countries has adopted a pure rights-based approach, prioritising the dimensions of affordability, effective access and quality at the expenses of fiscal sustainability and cost-effectiveness. On the contrary, most of the countries under scrutiny (Ireland, Italy, Portugal and Romania) have implemented a clear austerity- oriented social investment approach, with a focus on fiscal sustainability and cost-effectiveness and an overall deterioration of affordability and effective access to health care. This said, Belgium, the Netherlands and the UK show the main features of a balanced EU social investment approach, attempting to combine all the dimensions above. However, among this group of countries, the Netherlands appears most successful in balancing out the various dimensions, and thus closest to a rights-based social investment approach.

Figure 3.5 Approaches to health care in the Member States



RBA	RBSI	EUSI	AOSI
	NL	BE, UK	IE, IT, PT, RO

4. Conclusions and recommendations

Although most EU countries provide nearly universal population coverage for a relatively broad range of health care services, there remain important gaps in access to health care in many countries, in particular for vulnerable groups such as the unemployed, people on a low income and those with mental health problems. The 2008 economic crisis, and in particular the ensuing austerity measures, exacerbated the situation. Resources invested in the health system have been confined in many countries, often under strong EU guidance, to improving public finances. Increasing unemployment and rising costs for other basic services resulted in reduced household budgets available for health care. Furthermore, health care needs, including for mental health care, increased. All this led to an important reduction in access to health care, as measured through self-reported unmet needs for medical care. Since 2015, a gradual recovery can be observed in many countries, both in levels of self-reported unmet needs for medical care and in investments in the health system. Also, the discourse at EU level shows a subtle reorientation, with more emphasis on access to care and a rights-based approach, although strong attention continues to be paid to the financial viability of the systems.

To move towards a more rights-based social investment approach, ensuring affordable access to high quality health care that empowers patients, we make the following policy recommendations:

4.1 Legislation

Recommendations to the EU

- EU Internal market law should be assessed and reviewed with the aim of ensuring the rights defined in the European Pillar of Social Rights, in particular the right to health care.
- A ‘golden rule’ should be established, allowing Member States to subtract some of the investments in health care from the calculation of their national deficit.

4.2 Funding

Recommendations to Member States

- Adequate levels of health system funding from public sources should be ensured. Without sufficient funding, rationing will take place in the system, either explicitly, by increasing user charges or reducing benefit packages, or implicitly, through reductions in health care supply or funding for service provision. The latter may in turn lead to lead to poorly equipped health institutions, lowly paid and unmotivated health care professionals and long waiting lists.
- At the same time, the available public resources should be spent in the most cost-effective way. With the same level of public resources available, outcomes with regard to access to health care can vary greatly.

Recommendations to the EU

- The EU should monitor Member States’ public expenditure on health care, and Member States that do not invest sufficiently in their health care system should be flagged under the European Semester.

- Funding from the European structural funds for health care should be increased, and should be oriented towards reforms that ensure improved patient access to care, that focus on health promotion and disease prevention and that promote primary and integrated care.
- The EU policies aiming to boost investment in social infrastructure should focus more on initiatives investing in health infrastructure.
- EU funds for social innovation under the 'Employment and Social Innovation programme (EaSI) should be better targeted to innovations in the provision of health care services.

4.3 **Policies**

Recommendations to the Member States

- To ensure the right to health care, it is crucial that the whole population is covered for a comprehensive range of services. Member States should ensure that vulnerable groups such as the unemployed, asylum seekers and ethnic minorities are integrated into the system. Undocumented people should be guaranteed access to health care. Furthermore, health care services should be available in sufficient quantity, and a balanced geographical spread of facilities should be ensured. In particular, sufficient health care services should be provided in socially disadvantaged regions, and coverage for mental health services should be improved. To ensure a sufficient number of health professionals, adequate salaries and good working conditions should be guaranteed.
- Mental health should be valued to the same extent as physical health, so that those with mental health problems benefit from equal access to the most effective and safest care and treatment, and that resources are allocated on a basis commensurate with need
- Investment should by priority be increased in health promotion and disease prevention. Initiatives specifically targeting vulnerable groups should be developed. This should include the promotion of a public health approach to secure social determinants of health and mental health. In mental health, collective and community-based forms of supportive and preventive service provision should be developed, that complement and underpin individualised care and therapy interventions.
- Priority should furthermore be given to stronger resources for primary care, blending with social care and integrated into regional or local service networks and communities. Primary care services should be accessible free at the point of use. In mental health, service philosophy should be refocused to the facilitation of collective interdependencies that support community as well as individual wellbeing.
- User charges should be limited, and, in particular, vulnerable groups should be protected from user charges. Policies should be developed to eliminate informal payments for health care.
- Marketisation and performance management in mental health care should be stopped, since they lead, in practice, to fragmented care and biomedical residualism.

Recommendations to Member States and the EU

- Access to health care should be regularly and better monitored, both at EU and national level. In particular, the health care needs and usage of health care services by vulnerable and difficult-to-reach population groups should be monitored.
- The EU should assess Member States' performance on access to health care as part of the European Semester, and issue country-specific recommendations aiming at the achievement of the right to health care as defined in the European Pillar of Social Rights. The health indicators in the social scoreboard accompanying the European Pillar of Social Rights should be used to underpin European debates and national policies.

4.4 Politics

Recommendations to Member States

- Patients and service users should be empowered; they should become meaningful and inclusive partners in the decision-making process on their health.
- Health promotion activities should be set up with people from vulnerable communities and ethnic minorities.

Recommendations to the EU

- The EU should organise mutual learning and exchange of good practice activities, on the setting up of initiatives with vulnerable groups and ethnic minorities.

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RE-InVEST - Rebuilding an Inclusive, Value-based Europe of Solidarity and Trust through Social Investments

In 2013, as a response to rising inequalities, poverty and distrust in the EU, the Commission launched a major endeavour to rebalance economic and social policies with the Social Investment Package (SIP). RE-InVEST aims to strengthen the philosophical, institutional and empirical underpinnings of the SIP, based on social investment in human rights and capabilities. Our consortium is embedded in the 'Alliances to Fight Poverty'. We will actively involve European citizens severely affected by the crisis in the co-construction of a more powerful and effective social investment agenda with policy recommendations.

http://www.re-invest.eu/

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