ENSURING AFFORDABLE ACCESS TO HEALTHCARE FOR EVERYONE IN THE EUROPEAN UNION: WHAT GAPS REMAIN AND HOW CAN THE EU SUPPORT MEMBER STATES TO OVERCOME THEM?

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Summary: European Union (EU) Member States have made multiple commitments to progress towards universal health coverage (UHC), so that everyone can access quality healthcare without experiencing financial hardship. Yet, significant gaps in all three dimensions of health coverage (population coverage, user charges, and benefits packages) remain. This article highlights some of these gaps, looks at how access to healthcare has been addressed through the EU's socio-economic governance and funding instruments, and suggests ways in which the EU can further support national progress towards UHC.

Keywords: *Healthcare Access, Coverage Policy, European Pillar of Social Rights, European Semester, Universal Health Coverage*

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Introduction

The COVID-19 pandemic highlighted the importance of affordable access to quality healthcare in ensuring economic and social resilience. Before the pandemic, European Union (EU) Member States had already agreed that everyone should have access to quality healthcare without experiencing financial hardship and committed to move towards "universal health coverage" (UHC) through the Council conclusions on common values and principles in EU health systems (2006), the Tallinn Charter on Health Systems for Health and Wealth (2008), the Sustainable Development Goals (SDGs, 2015) and the European Pillar of Social Rights (2017). Yet, many Member States still have significant gaps in health coverage, indicating a need for greater effort to make progress towards UHC.

This article explores what the EU can do to help Member States improve affordable access to healthcare. Part 1 focuses on some of the main gaps in coverage in EU countries. Part 2 looks at how access to

healthcare has been addressed through the EU's socio-economic governance and funding instruments. The conclusion suggests proposals for more effective EU engagement with Member States.

What are the main gaps in affordable access to healthcare in the EU?

Many EU health systems still rely heavily on out-of-pocket payments. These undermine affordable access to healthcare (financial protection) in two ways. First, they can create a financial barrier to access, often leading to unmet need for healthcare. Second, they can cause financial hardship for people using healthcare, leading to impoverishing or catastrophic health spending (**see Box 1**). Analysis shows that households on low incomes consistently experience higher levels of unmet need and catastrophic health spending than richer households.[3] This deepens poverty, erodes health and well-being, and increases social inequalities within and across EU countries.[4]

Box 1: Out-of-pocket payments contribute to unmet need and catastrophic health spending in the EU

Out-of-pocket payments are formal and informal payments made at the time of using any type of healthcare delivered by any healthcare provider. They include user charges for covered care and payments for non-covered care. In 2019, the out-of-pocket payment share of current spending on health ranged from 9% in France to over 25% in Bulgaria, Cyprus, Greece, Hungary, Latvia, Lithuania, Malta and Portugal.[1]

These payments can lead to *unmet need for healthcare*, meaning that people forego or delay healthcare due to cost, distance or waiting time. The incidence of self-reported unmet need for healthcare in 2019 ranged from 0% of the population in Malta to 15.5% in Estonia. These data come from household surveys; people are asked if there was a time in the last 12 months when they needed healthcare but did not receive it because of the cost of care, the distance involved or the presence of waiting lists.[2]

Out-of-pocket payments can also cause impoverishing or *catastrophic health spending*. The latter refers to out-of-pocket payments that are greater than 40% of a household's capacity to pay for healthcare, with capacity to pay defined as total household consumption minus a standard amount to cover basic needs (food, housing, and utilities). This indicator is calculated using data from household budget surveys. The incidence of catastrophic health spending in 2019 ranged from under 2% of households in Ireland, Spain, Slovenia and Sweden, to over 8% in Bulgaria, Greece, Hungary, Italy, Latvia, Lithuania, Poland, Portugal and Romania.[3]

UHC should be monitored using quantitative and qualitative analysis

Indicators of affordable access to healthcare – unmet need and catastrophic health spending – show that there are important gaps in health coverage in many EU countries. These indicators are helpful in identifying the types of healthcare that undermine financial protection and the types of people most in need of better protection. However, to understand what countries can do to improve affordable access to healthcare, it is also useful to consider qualitative information on coverage policy (the way in which health coverage is designed and implemented), a key determinant of the level and distribution of out-of-pocket payments (**see Figure 1**).

We focus on two dimensions of coverage policy: the basis for entitlement to publicly financed healthcare, which determines population coverage, and the design of user charges for covered healthcare. Many EU health systems also have gaps in the publicly financed benefits package, especially for dental care,[5] and experience problems with the availability and quality of services. These factors contribute to timely and affordable access to healthcare, but we do not consider them further in this article.

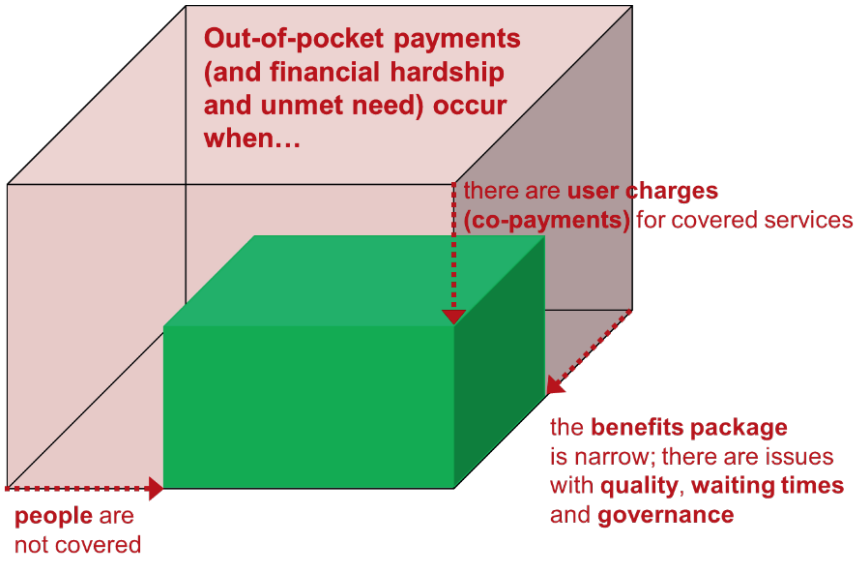
Gaps in population coverage occur when entitlement is linked to narrow criteria

To achieve UHC goals, the basis for entitlement to publicly financed healthcare should encompass everyone living in a country. In practice, it almost always relies on narrower criteria such as payment of contributions to a social health insurance (SHI) scheme, or legal residence, which leaves some groups of people lacking access to some or all publicly financed healthcare.

The share of the population not covered by the SHI scheme or other forms of mandatory health insurance is relatively small in countries like Austria and Germany (under 0.1%), but much more significant in other countries, ranging from over 1% in Belgium to over 5% in Estonia, Hungary, Lithuania and Poland, and over 10% in Bulgaria and Romania.[6] Those most likely to lack SHI coverage are people working in the informal economy or in other forms of precarious employment, as well as unemployed or self-employed people; many of these groups cannot afford to pay SHI contributions or find it difficult to pay due to administrative complexity.[4] To reduce population coverage gaps, the French government changed the basis for entitlement from employment and payment of contributions to residence in 2000 and gave all adults an automatic and permanent right to healthcare in 2016. France maintains an SHI scheme financed through earmarked contributions (and taxes), but all legal residents are now covered.

Concerning the criterion of legal residence, most EU countries exclude undocumented migrants from access to publicly financed non-urgent healthcare, including many countries which report to cover the whole population.[6] Spain is one of the only EU countries that offers undocumented migrants access to the same health benefits as legal residents after they have been in the country for 90 days.[7]

Figure 1: Gaps in health coverage undermine affordable access to healthcare



Source: adapted from [4]

> Countries with stronger financial protection tend to limit user charges

Gaps are also caused by weaknesses in the design of user charges for covered healthcare

All EU countries apply user charges to some types of healthcare, even though a large body of evidence shows that user charges are not a good instrument for directing people to use resources more efficiently and can have negative effects on equity and efficiency.[8] User charges are most often applied to outpatient prescribed medicines, dental care and medical products; evidence shows that these types of care are among the main drivers of catastrophic health spending.[4 6]

Countries with stronger financial protection tend to limit user charges and have protection mechanisms designed to reduce their negative effects – for example, exemptions from user charges for people on low incomes and income-based monthly or annual caps on user charges.[4] Spain's low incidence of catastrophic health spending can be attributed to very limited use of user charges – they are only applied to outpatient prescribed medicines and medical products – and to the fact that people on low incomes and some other groups (around 16% of the population in total) are exempt from user charges for outpatient medicines.[7] Austria has an income-based cap on user charges for outpatient prescribed medicines, while Belgium has an income-based cap on almost all user charges for covered healthcare – an approach that reduces financial uncertainty for people.[9 10]

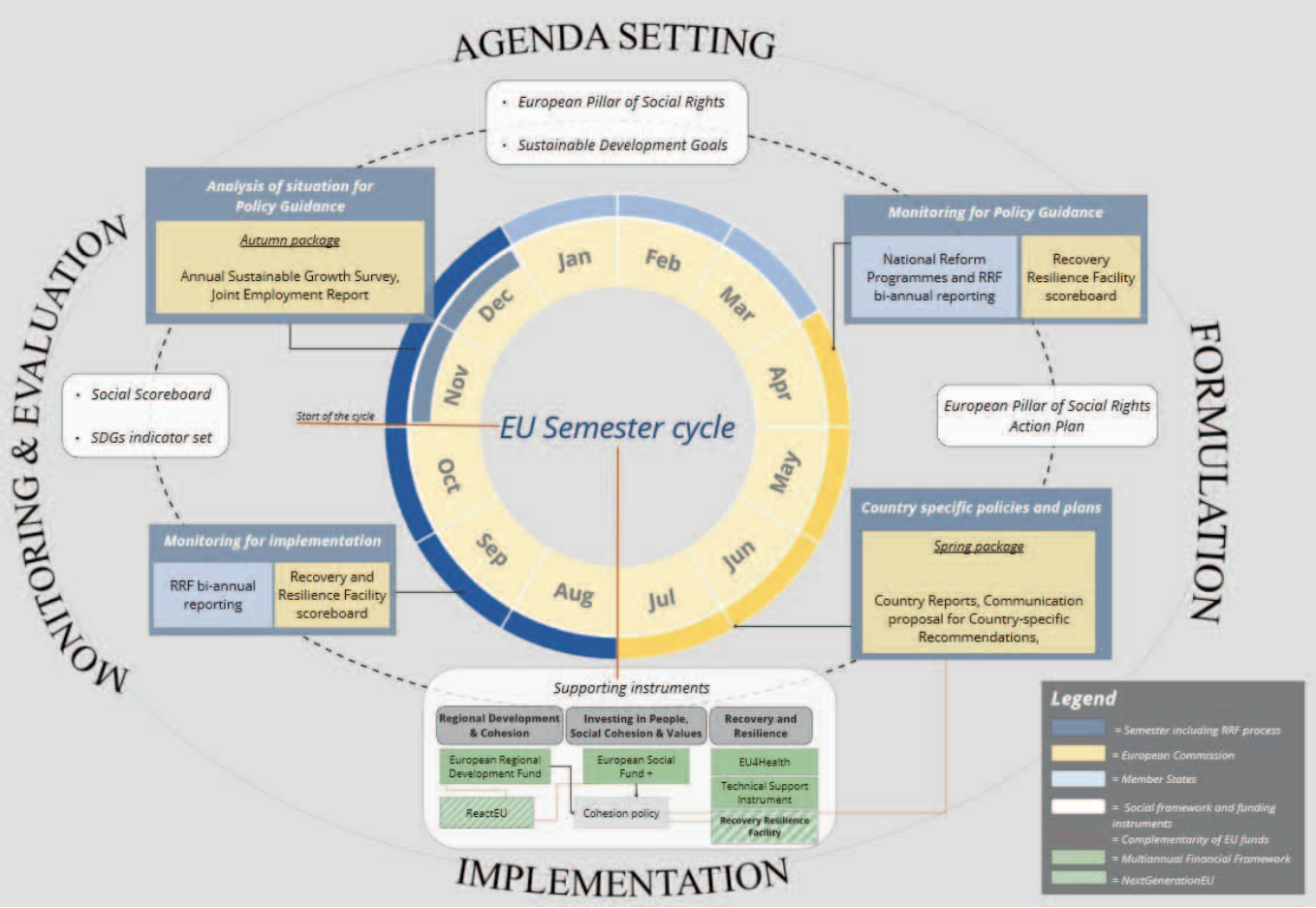
While all EU countries exempt some groups of people from certain user charges, demonstrating widespread acknowledgement of the shortcomings of such charges, only a third exempt people on low incomes, and very few have income-based caps or caps on all user charges.[4] This suggests that there is significant scope for improving affordable access to healthcare through better design of user charges. Prioritising the reduction of out-of-pocket payments for low-income people – an approach known as progressive universalism[11] – is essential, particularly where public resources are under pressure. This also builds resilience: if coverage policy enhances protection for the most vulnerable to unmet need and financial hardship, health systems and households can better withstand economic and health shocks.[3 4]

How has the European Union addressed affordable access to healthcare?

The organisation and financing of national health systems, including coverage policy, come under the competence of Member States. Consequently, the EU's most visible role in affordable access to healthcare is through data collection and analysis. For example, the EU supports a common approach to national data collection on unmet need for healthcare, through two household surveys: EU Statistics on Income and Living Conditions (EU-SILC), collected annually, and the European Health Interview Survey (EHIS), carried out every six years. The EU also: assesses access to healthcare in its series of "State of Health in the EU" reports on each Member State, published every two years; supports national health system performance assessment (HSPA) through the HSPA Expert Group; and, via the EU4Health programme, provides grants to enable systematic monitoring of affordable access to healthcare in EU Member States and to analyse the redistributive impact of health coverage.

In addition, the EU has played an influential but less visible role in shaping national healthcare reforms, and thus coverage policy, through its socio-economic governance – notably the European Semester – and funding instruments.

Figure 2: Linkages between commitments on access to healthcare, the European Semester, and EU funding instruments



Source: adapted from [14]

UHC is monitored through the European Semester

Launched in 2011 to enhance the monitoring and coordination of economic and fiscal policies, the European Semester provides guidance to Member States at different stages of the policy process (**see Figure 2**). It assesses the situation and outlines the EU's economic and social priorities; evaluates national programmes and provides Country-Specific Recommendations (CSRs) for national reforms and budgets; and monitors their implementation. Healthcare has always been part of the Semester but, in the aftermath of the European sovereign debt crisis, the focus shifted heavily toward fiscal sustainability, with insufficient consideration for potential adverse effects on healthcare access and other social protection measures.[12] This imbalance contributed to increased inequalities and reduced access to healthcare for people in vulnerable situations.[13]

Access to healthcare gained traction in the second half of the 2010s, following the European Commission's decision to add the Social Scoreboard (in 2018) and the SDG indicator set (in 2020) to the European Semester to monitor progress towards implementation of the European Pillar of Social Rights (hereafter the "Pillar") and the SDGs. Framed as a tool to ensure fair employment and social outcomes, and to promote "upward social convergence" in the EU, the Pillar includes UHC through principle 16 on the right to timely access to affordable, preventive, and curative healthcare of good quality.

The Social Scoreboard* uses self-reported unmet need for medical care as a headline indicator to monitor implementation of principle 16, supported by two secondary indicators: public spending on healthcare as a share of gross domestic product, and out-of-pocket payments as a share of current spending on health. Unmet need is also part of the SDG indicator set used by Eurostat to monitor progress on SDG 3.8 on UHC.

The effectiveness of these monitoring tools is limited, however. First, because the Pillar and the SDG indicators are non-binding instruments, their impact

* Since its revision in 2021, the Social Scoreboard includes 17 headline indicators, which are used to monitor 18 of the 20 Pillar principles and to support analyses in key Semester documents, such as the Joint Employment Report. The secondary indicators aim to achieve broader coverage of the Pillar principles.

Table 1: CSRs addressing access to healthcare with a focus on affordability, 2020, 2022 and 2023

Country	Access to health care			Population coverage			User charges			Benefits package		
	2020	2022	2023	2020	2022	2023	2020	2022	2023	2020	2022	2023
Bulgaria	X											
Cyprus	X						X					
Estonia	X		X									
Finland	X											
Greece	X	X	X	X					X			
Hungary	X	X								X	X	
Latvia	X	X	X									
Lithuania	X		X									
Poland	X	X										
Portugal	X											
Romania	X											
Ireland	X									X		
Total	12	4	4	1	0	0	1	0	1	2	1	0

Source: Authors' own

may be limited in an area like access to healthcare, in which the EU has no direct power and there is no legislative initiative at European level. Second, the indicators used in the Social Scoreboard and the SDG indicator set do not provide a comprehensive understanding of healthcare affordability. Unmet need for healthcare is a useful but only partial measure of affordable access, since it does not capture the financial hardship caused by out-of-pocket payments. Similarly, the health spending indicators are only proxy measures of healthcare affordability, which is better captured by indicators of financial hardship, such as impoverishing and catastrophic health spending. Finally, the monitoring tools lack qualitative analysis of the different dimensions of coverage policy (population coverage, the benefits package and user charges) in Member States; this analysis helps to identify the types of changes Member States can make to improve affordable access to healthcare.

Country-Specific Recommendations target access to healthcare

CSRs define the areas in which Member States are monitored in the subsequent Semester cycle. The number of healthcare-related CSRs has increased since the Semester was launched, but it was only in 2020 that all Member States received a CSR on healthcare reforms. In response to the COVID-19 pandemic, the recommendation urged them to strengthen the resilience of their health systems, and investment in healthcare was facilitated by increased fiscal flexibility, enabling Member States to depart temporarily from EU budgetary requirements.

> "Unmet need for healthcare is a useful but only partial measure

The 2020 CSRs focused on access to healthcare in 12 countries (**see Table 1**). These access-related recommendations most often targeted service availability (e.g., workforce shortages) and focused on the affordability of services (user charges or the benefits package) in three countries. Attention to healthcare reforms did not last long, however. Healthcare-related CSRs dropped to eight in 2022, and six in 2023, with only four explicitly targeting access to healthcare (**see Table 1**). This drop may reflect the recovery from the pandemic, a renewed emphasis on macroeconomic and fiscal stability, and the Commission's decision to focus the CSRs on issues not already covered by funding instruments such as the Recovery and Resilience Facility.

EU funding instruments support access-related healthcare reforms

Various funding instruments support national reforms and investments in health, including access to healthcare†. In 2021, the Commission introduced the Recovery and Resilience Facility (RRF) in response to the pandemic. This temporary funding instrument aims, among other things, to increase crisis preparedness and the response capacity of Member States, including by improving the accessibility and capacity of health and care systems. As a result, all national Recovery and Resilience plans contain healthcare measures, including reforms to improve access to healthcare. For instance, Hungary has planned measures to eliminate informal payments, while Ireland has focused on improving the accessibility of primary healthcare. These plans are monitored through various tools, including the Semester's Country Reports and a new RRF Scoreboard. In relation to "health, and economic, social and institutional resilience", the RRF Scoreboard monitors the yearly capacity of healthcare facilities, reflecting the maximum number of patients

† Technical support is also provided, as described by Mauer et al. in this publication.

that can be treated annually, and measures the number of individuals who use new and enhanced public digital services, products, and processes. A third monitoring tool, the methodology for reporting social expenditure, includes "health and long-term care" as one of four broad social categories used to classify Member States' RRF spending. These tools focus on healthcare capacity, digitalisation, and expenditure; however, they do not provide much information on affordable access to healthcare.

Under the EU Cohesion Policy 2021–2027, the European Social Fund Plus and the European Regional Development Fund support healthcare reforms in almost all Member States, including with a view to improving access. In relation to affordability for example, these reforms address concerns regarding population coverage in Czechia and Romania, and user charges in Latvia. The Recovery assistance for cohesion and the territories of Europe (ReactEU) completes these instruments by providing funds for cohesion and regional development. As the European Court of Auditors has noted, the systems used to monitor the Cohesion Policy and the RRF are not yet sufficiently harmonised, limiting the potential for international comparison.[15]

Proposals for more effective EU engagement: How can the EU improve its support for affordable access to healthcare?

EU and Member State commitments to UHC are encouraging, but limitations remain. Many national policies still create gaps in health coverage, increasing inequalities both within and between Member States. This undermines the implementation of principle 16 of the Pillar and of SDG 3.8 on UHC, as well as the Pillar's overall objective of promoting upward social convergence in the EU, leaving no one behind. In addition, EU action on healthcare reforms has been characterised by ambiguity and contradiction. Over the years, the European Semester has developed a stronger social dimension, paying greater attention to healthcare; fairness is also one of the four dimensions that now guide the EU's recovery. Nevertheless, the Semester continues to focus disproportionately on economic and fiscal priorities. Further action is needed to enhance the social dimension of the Semester and achieve the stated objective of the Commission's proposal for a reformed EU economic governance: strengthening public debt sustainability while promoting sustainable and inclusive growth through reforms and investment, including for the implementation of the Pillar.

We propose two complementary approaches to improving EU support to Member States. First, EU policy coordination and data collection should be strengthened, to make the Semester's analyses and recommendations on access to healthcare more consistent, transparent, and effective. Second, implementation of principle 16 of the Pillar must be explicitly recognised as a key priority for the EU agenda in the years to come. An important step in this direction would be the adoption of a specific initiative such as a Council recommendation on moving towards UHC. This could use the Council Recommendations on access to social protection and on childcare as examples. Its aim would not be convergence towards a single health system "model", but rather the introduction of context-specific measures needed to progress towards UHC. **Box 2** provides concrete examples of how both approaches could be further developed.

Box 2: Summary of proposals for more effective EU engagement

1. Strengthen EU policy coordination and data collection to make the Semester's analyses and recommendations on access to healthcare more consistent, transparent, and effective.

Examples of actions in this direction:

- Expand the quality and availability of data collected in a standardised way.
- Support the quantitative indicators of unmet need for healthcare with indicators of financial hardship caused by out-of-pocket payments (derived from analysis of household budget survey data) and analysis of the role of health coverage in reducing poverty.
- Require Member States to carry out household budget surveys more regularly and make the microdata easily available to researchers.
- Make more use of qualitative information on coverage policy in Member States, not only to interpret quantitative indicators but also to identify the specific policy changes needed to improve access to healthcare in each country.
- Use WHO/Europe's new monitoring tool, UHC watch, to inform CSRs in the European Semester as well as EU and national health system performance assessments.[16]

2. Explicitly recognise implementation of principle 16 of the Pillar as a key priority for the EU agenda in the years to come, by adopting a specific initiative such as a Council recommendation on moving towards UHC.

Examples of content and scope of a recommendation on UHC:

- Flag the key principles underpinning affordable access to healthcare.
- Identify a minimum share of EU and national resources needed to support progress towards UHC.
- Highlight examples of good practice and indicate reforms to be included in national health plans.
- Enable Member States to introduce the context-specific measures they need to progress towards UHC.
- Set a timeline for implementation.

Stronger EU support for affordable access to healthcare will provide Member States with a clearer policy framework, improve the coordination and effectiveness of EU instruments, and ensure a more efficient use of EU funds.

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