



Access to healthcare in times of crisis



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European Foundation for the Improvement of Living and Working Conditions

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List of case studies in the report

Bulgaria	BG1
Greece	EL1, EL2, EL3, EL4, EL5
Hungary	HU1, HU2, HU3
Ireland	IE1, IE2, IE3
Latvia	LV1, LV2, LV3
Luxembourg	LU1, LU2, LU3
Portugal	PT1, PT2, PT3
Romania	RO1, RO2, RO3
Slovenia	SI1, SI2, SI3
Spain	ES1
Sweden	SE1, SE2, SE3

Executive summary

Introduction

In the wake of the crisis, many European governments have cut spending on healthcare services. However, in the face of rising unemployment and financial strain, there is an increased need for some healthcare services, while decreased disposable income has made access to healthcare more difficult for many households in the EU. In this context, policymakers and service providers are faced with the challenge of maintaining access to healthcare services.

This report explores which population groups have experienced reduced access to healthcare as a result of the crisis. It presents examples of measures taken by governments and service providers to maintain access for groups in vulnerable situations. The report is the final output of Eurofound's project on the impacts of the crisis on access to public healthcare services, and builds on an earlier working paper providing evidence from data analysis and a literature review. It draws on nine in-depth country studies, and on 31 case studies, carried out in 11 Member States.

Policy context

Along with effective prevention and social protection policies, access to high-quality healthcare services can reduce health inequalities, social exclusion and poverty, key objectives of the Europe 2020 strategy. At the same time, timely access to healthcare can prevent higher healthcare costs in the long run, increase productivity of the workforce and facilitate people's active participation in society, as emphasised in the European Commission's Social Investment Package. Furthermore, access to healthcare under the conditions established by the Member States is recognised as a fundamental right of the European Union.

Key findings

While the crisis has been a major factor influencing complex healthcare systems, there are significant differences between countries and between services in the impact the crisis has had on healthcare access. Nevertheless, even where a country's health services have hardly experienced any cuts (such as all services in Luxembourg, and nursing home healthcare in Latvia), it has still been possible to identify impacts of the crisis on access to healthcare.

Access to healthcare for groups in vulnerable situations

Difficulties in accessing healthcare have long been more common among certain population groups. In some cases, measures facilitating access for these groups have been cut. While there is great heterogeneity within these groups, they include people living in countries with poor overall access or in remote areas; those with low health literacy, poor education and low incomes; people with greater healthcare needs in general (such as people with disabilities, elderly people and people with chronic illnesses); or those who belong to a specific disadvantaged ethnic minority (such as Roma), as well as homeless people and migrants.

The crisis has resulted in the emergence of new groups that were not considered vulnerable previously due to increased unemployment, especially among young men, and increased household debt problems, particularly for young couples facing housing and job insecurity. People have found themselves in more vulnerable situations because of the crisis, particularly those who have experienced:

- reduced disposable income;
- loss of a job or benefit that came with insurance;
- the ‘twilight zone’ – being marginally beyond the threshold for which social support measures apply;
- new situations, to which the entitlement system has not adjusted or where the person is unaware of entitlements;
- need for a service for which coverage has been reduced, which has been particularly affected by cuts or which has experienced staff shortages;
- need for a service for which demand has increased significantly;
- closure of nearby healthcare providers;
- discrimination due to an increase in xenophobia.

Mitigating measures

Most service providers in the case studies reported a range of responses to sustain access during the crisis, including economising, seeking funds from other public sources, and leniency in enforcing copayments for people in need. Some governments have sustained or expanded coverage and exemptions from copayments for population groups affected by the crisis. Other strategies identified in the research include:

- accelerating trends of deinstitutionalisation, reducing hospital stays and keeping older people in the community, combined with development of an alternative care infrastructure;
- retaining and motivating staff, drawing on less costly workers, and work reorganisation;
- seeking new funding sources from alliances with local actors;
- ensuring basic services, such as scaled-down replacement services, when a service provider is closed; group sessions for patients with crisis-related mental health problems; self-help, medical helplines or e-healthcare for people in remote areas; basic information packages;
- scaling up screening and measures to prioritise most urgent needs and services.

Policy pointers

Policymakers and service providers need to be aware of the unexpected or indirect consequences of cuts and reduced disposable income on access to services. In some countries, demand for nursing home care has declined because the pensions of elderly relatives are an important source of household income (Hungary, Latvia). In some cases, people have moved from private to public healthcare creating increased demand (Greece, Ireland, Slovenia), while in others private hospitals have gained more clientele (Bulgaria, Romania, Sweden) partly as an indirect consequence of the crisis.

Simple cost-cutting solutions may incur higher costs in the longer term. It is important to be wary of increased use of emergency and inpatient care. In some countries, inpatient care has increased because family members cannot afford to keep patients at home (Bulgaria and Slovenia) or because of cuts in outpatient care (Ireland). In other cases, demand for emergency care has increased because it is cheaper to access, payments due from patients are less likely to be collected, there is no nearby

non-emergency care, or the facilities are open at more convenient hours (Bulgaria, Greece, Ireland and Sweden).

In addressing the challenge of maintaining access in the context of the crisis, policymakers and service providers may consider:

- integrating mitigating measures into cost-cutting policies, rather than reacting to problems after reforms are implemented;
- determining whether incremental responses to the new situation – creating a complex network of exemptions – may be worse than overhauling the system as a whole;
- recognising that investing in the working conditions of healthcare staff, apart from salaries, can be an effective option to tackle staff shortages;
- developing alternative care infrastructures when deinstitutionalisation and reduced reliance on inpatient care have been accelerated;
- making investments in the short run, for example, in ICT, self-help facilities, and home and ambulatory care, to free up resources in the longer term;
- recognising that while ‘leniency’ of service providers allows access for people in vulnerable situations free of charge, it risks unequal treatment and unreliability especially in times of crisis; but lessons can be drawn from locally identified needs for leniency;
- combining formal exemptions and entitlements with effective implementation;
- nurturing and communicating the importance of alliances with local stakeholders;
- reassessing all cost-saving measures implemented during the crisis once financial pressure is reduced.

Introduction

As a result of the economic and financial crisis, many EU governments have reduced funding for healthcare services as one approach to balancing their budgets. Patients have been required to pay larger shares of their healthcare costs themselves, and availability of healthcare services has been reduced (Mladovsky et al, 2012; Hou et al, 2013). Job losses and reduced income have made it harder for many to pay for healthcare. The crisis has also had an impact on health and increased the need for certain healthcare services, such as those dealing with anxiety and depression following job losses and financial problems (Karanikolos et al, 2013).

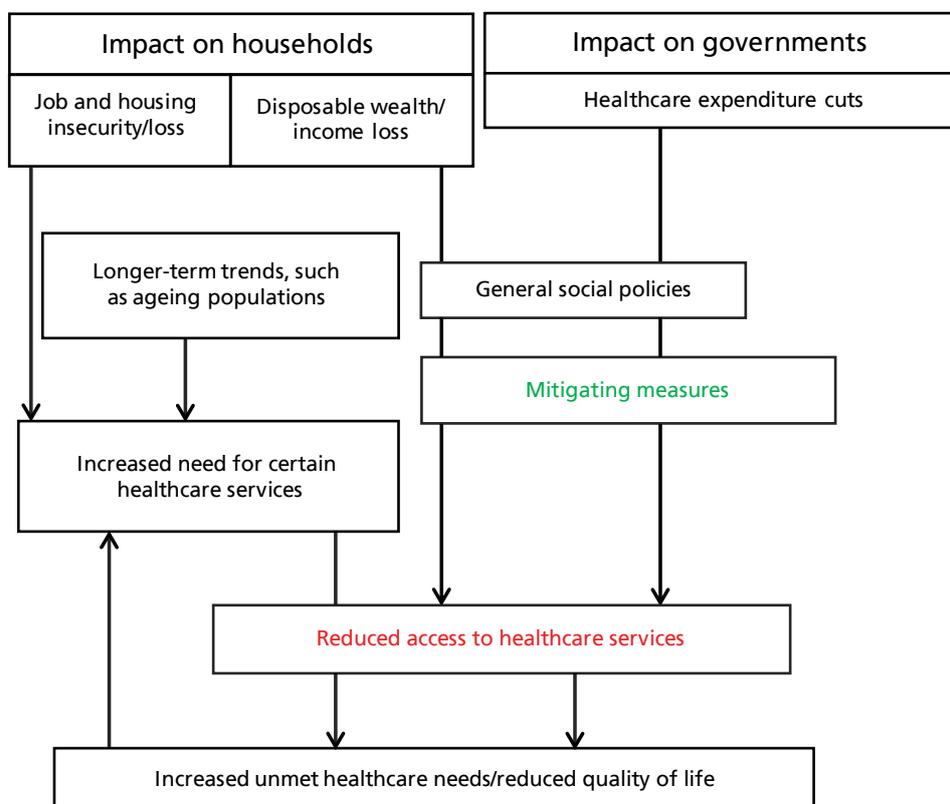
This report aims to identify population groups that have experienced reduced access as a consequence of the crisis, including 'hidden' groups that may not be identified easily by macro data. It further describes the steps governments and service providers have taken to maintain access to healthcare. The drive for more effective and efficient healthcare is not new, but this report will discuss its relationship to access to healthcare services in the context of the crisis. The added value lies mainly in up-to-date case studies of how healthcare providers have responded to the crisis, but evidence also comes from in-depth country studies, a literature review and data analysis. A background working paper for this project includes a discussion of the concept and various dimensions of access, an extensive literature review, and more in-depth analysis of data from the European Quality of Life Survey (EQLS) and European Union Statistics on Income and Living Conditions (EU-SILC) about the impacts of the crisis on various indicators of access for different population groups (Eurofound, 2013a).

The report focuses on healthcare, not on social care. The healthcare component of long-term care receives some attention. The study deals with healthcare services, rather than prevention or access to medicines, even though the link between prevention and demand for healthcare services will be discussed, and the importance of access to and savings in cost and use of medicines are acknowledged. It focuses on publicly funded care, not on private healthcare. The report looks at how the crisis has impacted on access to healthcare services for groups in vulnerable situations, rather than in general identifying groups in vulnerable situations which has been done in previous research (European Commission, 2008, 2009a; FRA, 2013; Doctors of the World, 2012, 2014).

First, the policy relevance of access to healthcare and the role of the European Union in this policy area will be discussed. After presenting the approach of this study, the report explores which population groups have particularly suffered from reduced access as a consequence of the crisis. It then discusses examples of measures taken by governments and service providers to mitigate the impacts of the crisis on access to healthcare. Lastly, the results are assessed, identifying policy pointers.

The economic and financial crisis, which started affecting Europe in autumn 2007, has impacted EU Member States at different stages, to different degrees and in different ways. During the crisis, governments in several Member States have received less income from tax and faced higher borrowing costs. In some countries where healthcare is financed predominantly by health insurance contributions from employees and employers, resources have also decreased because of reduced wages and falling employment rates. Furthermore, higher take-up of benefits, such as unemployment benefits, has increased public expenditure. In an attempt to balance their budgets, many EU governments cut public expenditure, including expenditure on healthcare services. A simplified framework of the negative impacts of the crisis on access to healthcare is presented in Figure 1.

Figure 1: Mitigating negative impacts of the crisis on access to healthcare services



Source: Adapted from Hou et al, 2013, p. 10

In particular, the framework highlights five important points.

- The crisis has not only had a negative impact on access to healthcare services because of budget cuts. Access to healthcare for households has also been reduced when disposable income has declined. This, for example, has made it harder to pay where a contribution towards healthcare costs is obligatory by means of copayments¹ or health insurance fees, or for transport to the healthcare provider.
- Job and home loss, or insecurity, have also been associated with worse health, in particular in the form of an increased need for mental healthcare. In the longer term, reduced access may also

¹ A copayment is a requirement for service users to pay part of the cost of services themselves, while the rest comes from public or social health insurance funds.

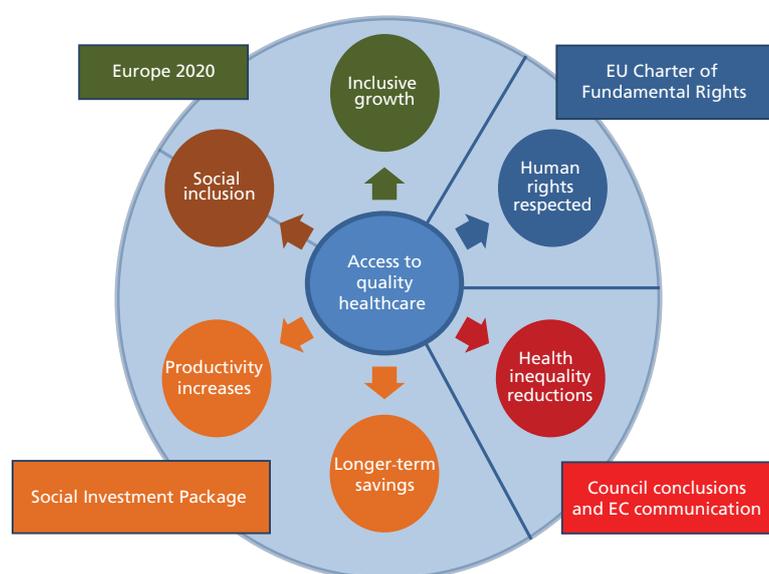
lead to unmet needs, with unaddressed health conditions possibly worsening, which in turn may increase demand for certain healthcare services.

- This report focuses on measures within the healthcare sector that mitigate the negative impacts of the crisis on access to healthcare services. Nevertheless, general social policies may also serve as a mitigating measure. Examples include income support for people with financial problems and improving employment options.
- An increased need for certain healthcare services has also come from longer-standing trends such as an increased prevalence of disability, ageing populations, new treatments and changing expectations.
- Whether an increased need for healthcare services translates into an increased demand depends on access.

EU policy context

Access to high-quality ‘services of general interest’ is an important aspect of social protection, contributing to ‘inclusive growth’, a main objective of the Europe 2020 strategy (European Commission, 2010). Healthcare is a key service of general interest. Effective prevention, access to healthcare and its quality are important factors in addressing health inequalities (European Commission, 2009b; Council of the European Union, 2010, 2011), social exclusion and poverty (European Commission, 2010). Healthcare helps to maintain a productive workforce and, by avoiding escalation of medical conditions, to reduce costs of care in the longer term (European Commission, 2013a; European Parliament, 2013; FRA, 2014). Furthermore, ‘access to good-quality healthcare’ was adopted as a ‘common value for EU healthcare systems’ by the Council of the European Union (Council of the European Union, 2006). ‘The right to benefit from medical treatment under the conditions established by national laws and practices’ was included in the 2000 Charter of Fundamental Rights of the European Union. This became legally binding with the entry into force of the Treaty of Lisbon, in December 2009. Figure 2 summarises these EU policy perspectives on access to healthcare.

Figure 2: EU policy perspective on access to healthcare



Source: Eurofound elaboration

The importance of healthcare is clearly recognised from the EU policy perspective, but actual policymaking is the responsibility of Member States. Nevertheless, the EU can support policymakers in the Member States (European Commission, 2014a) and has influence on healthcare. The EU has a particularly direct impact for example in Member States such as Cyprus, Greece, Hungary, Ireland, Latvia and Portugal, which received loans to help them weather the crisis on condition that they reformed their public spending regimes. In some cases, these conditions included detailed measures to reform healthcare systems (for example, Portugal). The various EU policy instruments in healthcare have been discussed in more detail in an earlier working paper (Eurofound, 2013a). The latest developments on two relatively recent policy instruments, the European Semester and the Joint Assessment Framework (JAF Health), are summarised below.

The European Semester covers a six-month cycle, starting with the Annual Growth Survey (AGS) and concluding with country-specific recommendations. The 2013 AGS called for assessing the performance of health systems against the twin aims of a more efficient use of public resources and better access to high-quality care. However, in practice the country-specific recommendations mostly focused on efficiency, reduction of pharmaceutical expenditure and a shift from hospital to outpatient care. The recommendations did call upon Spain to 'maintain', Bulgaria to 'ensure' and Romania to 'improve' access (Eurofound, 2013a). For Romania, the recommendation applies in particular to access for disadvantaged people and isolated communities. The 2014 AGS and recommendations continued the focus on sustainability of healthcare (EPHA, 2014). The European Parliament (2014) has called for indicators on access to healthcare to be reviewed on a regular basis.

A framework is being developed for the comparative analysis of health systems at EU level. This framework includes a list of indicators, to be used in the JAF Health exercise. JAF Health was developed by the Indicators Subgroup of the EU Social Protection Committee, by representatives of the national Ministries of Social Affairs, with the support of the Commission services. The framework includes indicators covering areas of health outcomes, access, quality, resources and non-healthcare determinants. The framework was approved by the Social Protection Committee in November 2013 for a pilot phase of one year (SPC, 2013).

2

Main approach and case study selection

This study draws upon evidence from various sources. The first stage of this project included data analysis and a literature review, presented in a working paper (Eurofound, 2013a); the second phase has involved nine detailed country studies and a total of 31 case studies. Both the working paper and this research report went through various rounds of feedback from experts. Two workshops were also held, one to discuss the country reports and the impacts of the crisis on access more generally, and a second to discuss a draft version of this research report, focusing on mitigating measures and groups in vulnerable situations. This approach allows for identification of some groups in vulnerable situations and of interesting examples of mitigating measures, but it does not allow for a comprehensive inventory of both.

Country studies

Evidence comes from research across the EU, but resources were concentrated on nine in-depth country studies: Greece, Hungary, Ireland, Latvia, Luxembourg, Portugal, Romania, Slovenia and Sweden. The country reports draw on up-to-date national literature, press, administrative databases, surveys, data from national complaint bodies, interviews with stakeholders and other sources the authors identified to provide as complete a picture as possible of the situation. The country reports were commissioned in two stages during 2013, but all contractors had until May 2014 to finalise the reports.

The nine countries were selected according to the following four criteria.

The crisis has had an impact on the country reflected in per capita gross domestic product (GDP) decline. In particular, there had been a negative average real GDP per capita growth between 2007 and the latest year for which figures were available. Even when there has been no decline over this longer period, the country may have had to cut public expenditure triggered by a decline for a shorter period. Therefore, a country also qualifies for selection if there had been a decline in GDP of 0.5% or more in at least two consecutive years. Only Poland does not fulfil either of these two conditions.

The country's healthcare sector has experienced a reduction of resources. The indicators used were the number of years of decline in per capita public expenditure on healthcare since 2007, and the extent of this decline (Eurofound, 2013a).

These first two criteria make it likely that the crisis has had an impact on access to healthcare in the selected country. Nevertheless, the study aims not only to describe this impact, but also to identify measures which have sought to maintain access. The ability of the healthcare sector to mitigate the impacts of the crisis depends on the existence of instruments that allow for the identification of groups in the most vulnerable situations, and the ability to target interventions towards them (Hou et al, 2013). Such instruments are most likely to be present in countries that have enough resources and strong welfare institutions. It thus makes sense to look not only at countries with low healthcare expenditure, but also to include countries where per capita expenditure is higher. Furthermore, as different measures may be applied depending on the level of resources available, the study is likely to benefit from some variety in health expenditure among the sample countries. So, as a third criterion, *Member States were divided into quartiles of per capita public expenditure on healthcare, and two countries in each quartile were selected which have experienced the largest cuts in expenditure on healthcare.*

Finally, as the focus of the study is on identifying effective mitigating measures, *there was special interest in any country where available survey data from EU-SILC and the EQLS did not show any decline in access between 2007 and 2011, despite expenditure cuts.*

At the time of selection, available data indicated where public expenditure decreased most: in the bottom expenditure quartile, in Latvia and Romania; in the second quartile, in Greece and Portugal; in the third quartile, in Ireland and Slovenia; and in the top quartile, in Luxembourg and Sweden (Eurofound, 2013a). Hungary was the only country that showed neither an average increase in the proportion of people reporting difficulties in accessing healthcare services on any of the dimensions asked in the EQLS, nor any increase in unmet needs in EU-SILC between 2007 and 2011.

The four selection criteria can be challenged and a different set of countries could have been chosen. Potential disadvantages of the selection criteria include the fact that a decrease in public expenditure does not necessarily imply budget cuts or an impact of the crisis, and average survey data may mask different impacts of the crisis on various population groups (Eurofound, 2013a). Nevertheless, the criteria were relatively objective and readily applicable.

A potential problem with identifying the impacts of the crisis is that these impacts may be delayed. However, case studies show a rather recent picture of the situation, in contrast to macro data, involving interviews at the service provider level and capturing real-time assessments of the impacts of measures on the ground.

Case studies

Case studies were carried out to illustrate the impacts of the crisis on both providers and service users. They are not intended to be representative, but rather to illustrate how in practice budget-balancing measures have affected specific public healthcare services and access to them. They also serve to present examples of how service providers have sought to maintain access. Different perspectives were sought by drawing on multiple interviews with stakeholders likely to have different points of view, and by priming interviewees to obtain a deeper understanding of the case. Where possible, interviewees' statements were contrasted with other data sources. As outlined in Table 1, most of the case studies are publicly funded healthcare providers – sometimes multiple service providers (for instance, see Box EL5 in the Annex) – and may involve services which are privately provided by non-governmental organisations (NGOs) or a commercial provider (Box EL2; LU1) as long as public funding was involved. One instance concerns a description of the implementation of a mitigating measure through the social security office (Box LU3).

Each country study aimed to include at least three case studies of healthcare service providers that had felt the effects of the crisis. In most cases this involved cuts, but sometimes could also concern increases or shifts in demand. Each country study includes at least two case studies describing a 'mitigating measure'. This could be a description of measures implemented by the service provider or by the government, with the case study giving an impression of their impacts at the local level. Case studies that did not concern a mitigating measure were selected to illustrate the effects of the crisis on access to healthcare services.

Five country studies (Greece, Hungary, Ireland, Latvia and Luxembourg), commissioned in July 2013, were expected to include three different types of healthcare services. Variation was sought in the types of public healthcare service providers included (see next page), to widen the scope of the findings.

The first concerned outpatient or ambulatory healthcare services for people with mental health problems. The request for this type of case study was prompted by the apparent rise in mental healthcare needs because of the crisis.

The second concerns healthcare services in a nursing home for elderly people, motivated by the increase in the number of older people in society, independent of the crisis. This expected increase in need may be particularly problematic to satisfy given that it coincides with an economic crisis. While the trend is towards keeping older people at home for longer, thus making outpatient care potentially more appropriate for a case study, it was considered that much research has already investigated outpatient services for older people. Nursing home healthcare may also have been subject to budget cuts because of its high expense. Therefore, nursing homes were included only where they contained a healthcare component.

Lastly, contractors were asked to include outpatient healthcare services for people with disabilities. Again, this type of service was deemed especially interesting for the purposes of this study because an increase in the number of people with disabilities was observed, and this has coincided with the crisis (Eurofound, 2012b).

Naturally, country report authors were constrained by how easy or difficult it was to find services willing to cooperate. Four additional country studies were commissioned in December 2013 (Portugal, Romania, Slovenia and Sweden). They broadened the service providers covered, including at least one hospital and one primary healthcare service. The third case study was selected on the basis that the service provider was expected to have been particularly affected by the crisis.

In addition, Eurofound carried out two additional case studies. Contacts were secured for case studies in Bulgaria and Spain, bringing the total to 31 case studies in 11 Member States.

Table 1: Case studies

Box	Geographical area**	Type of healthcare provider
BG1: St George Hospital	Bulgaria, Plovdiv (urban)	University hospital
EL1: Vyronas-Kaisariani Mental Health Community Center	Greece, Athens (urban)	Community mental healthcare provider
EL2: Hellenic Society for Disabled Children	Greece, six centres: Agrinio, Athens, Chania, Ioannina, Thessaloniki, Volos	Rehabilitation services for children with physical disabilities
EL3: Kallimanopouleio Ecclesiastical Ministry Center (KEDIK)	Greece, Kalavrita region (rural)	Long-term nursing home care for elderly people
EL4: Social enterprises in the area of healthcare provision	Greece, Kos (rural)	Primary healthcare centre
EL5: Survey among rural and urban hospital emergency units	Greece (urban and rural)	Hospital emergency units
ES1: Maresme Health Consortium	Spain, Barcelona (urban)	Mental healthcare service
HU1: Awakenings Foundation	Hungary, Budapest (urban)	Community-based mental healthcare
HU2: Association of Physically Disabled Persons	Hungary, Budapest (urban)	Home care for people with disabilities
HU3: Platán Nursing Home	Hungary, Kecskemét (urban)	Nursing home care
IE1: Mental health service*	Ireland, urban area	Mental healthcare service
IE2: Connolly Hospital	Ireland, Blanchardstown on the outskirts of Dublin (urban)	Hospital
IE3: Acquired Brain Injury	Ireland, national	Community care for people with disabilities
LU1: Luxembourg city psychotherapy service* and Réseau Psy	Luxembourg, Luxembourg city (urban) and national	Two mental healthcare providers

Box	Geographical area**	Type of healthcare provider
LU2: E-health: Heart failure project, electronic health records and the health portal	Luxembourg, national	E-healthcare projects
LU3: Third-party payer system: two social offices	Luxembourg, Bettembourg (rural) and Luxembourg city (urban)	Two social offices in charge of granting exemptions to out-of-pocket healthcare costs
LV1: Stella Maris	Latvia, Riga	Nursing home
LV2: Vidzemes Slimnīca	Latvia, Valmiera (rural)	Outpatient care services for people with disabilities
LV3: Riga Centre of Psychiatry and Addiction Medicine	Latvia, Riga (urban)	Mental healthcare
PT1: Vila Nova de Gaia/Espinho Hospital	Portugal, two units in Vila Nova de Gaia and one in Espinho municipality (urban, rural)	Hospital
PT2: Hospital Centre Cova da Beira	Portugal, one unit in Covilhã and one in Fundão municipality (rural)	Hospital
PT3: USF Fernão Ferro Mais	Portugal, Seixal municipality on the outskirts of Lisbon (urban)	Primary healthcare centre
RO1: Tulcea County Hospital: telehealth in the Danube Delta area	Romania, Tulcea county (rural)	Ambulatory care by county hospital to patients at primary care facilities in remote areas
RO2: Oltenița Municipal Hospital	Romania, Oltenița (urban, rural)	Secondary hospital
RO3: General practitioner (GP) in Fetești, Romania	Romania, Fetești/Ialomița county (rural)	Health mediators
SE1: Dorotea Primary Healthcare Clinic	Sweden, Dorotea (rural)	Primary healthcare provider
SE2: Skåne University Hospital	Sweden, Lund and Malmö (urban)	Large university hospital
SE3: Karolinska University Hospital	Sweden, Stockholm (urban)	Large university hospital
SI1: Secondary care hospital*	Slovenia, south (rural)	Secondary-level hospital
SI2: Community healthcare centre*	Slovenia (rural)	Primary healthcare centre
SI3: Healthcare centre*	Slovenia, Ljubljana (urban)	Primary healthcare centre

Notes: * anonymised; ** urban is loosely defined as mainly serving a densely populated area. A summary of all case studies can be found in the Annex to this report.

3

Impacts of the crisis: Access for groups in vulnerable situations

Establishing to what extent the crisis has impacted on access to healthcare services for specific population groups is fraught with difficulties. One of the main problems is the lack of data or information from healthcare providers or official bodies about the situation of specific groups. There is even less information about whether access has changed during the crisis.

This chapter discusses situations caused by the crisis that have resulted in reduced access to healthcare services. It follows the framework set out in Figure 1, focusing on the impacts of the crisis on access to healthcare services on the supply side (reduced availability and coverage of services) and at household level (reduced income and increased need). Next, the effects of the crisis on some specific population groups highlighted in the country studies are discussed.

Impacts on healthcare provision

Since 2007, almost all EU Member States have experienced reductions in public expenditure on healthcare. A few countries, mainly those with already high expenditure, are exceptions (Eurofound, 2013a). Decreased expenditure does not always mean that budgets were cut; it may, for example, also indicate reduced need. Nevertheless, the countries in this study have experienced decreased budgets. This is sometimes concentrated on a few types of services, or on investment in healthcare equipment and refurbishment, rather than on decreased operational expenditure or failure of allocation of additional resources to services that experienced increased demand during the crisis.

The timing of the crisis and of consequent reductions in public spending on healthcare has differed somewhat across Member States. For several of the countries examined, the crisis started to take hold in 2008 and cuts in healthcare budgets came into effect in 2009 (Ireland, Latvia and Slovenia) or had sometimes started even earlier as a continuation of pre-crisis cuts (Hungary). In some countries, they started later. For example, in Romania cuts started in mid-2009, but were concentrated mostly in mid-2010, and in Luxembourg they have emerged mostly since 2012. In Portugal, while a number of cost-saving measures were implemented earlier, most spending cuts have been undertaken since 2011 in line with the conditions of financial support given by the EU, the International Monetary Fund (IMF) and the European Central Bank (ECB). In some countries, cuts were concentrated mainly in one year (Latvia, 2009), while in others they have been spread over a number of years (Hungary).

Reduced availability of healthcare services

One indicator of reduced availability of healthcare services as a consequence of the crisis is that, after years of steady reduction, average waiting times for some surgical operations in Portugal, Spain, England and Ireland show a small increase (OECD, 2013). In Portugal, after a decrease between 2006 and 2010, waiting times for hip replacements and cataract surgery have increased since 2010 (OECD, 2014). Reduced availability also seems to explain some of the unmet needs due to waiting times or distance to healthcare providers (Rodrigues et al, 2013; Eurofound, 2013a). The following sections discuss how the crisis has caused reduced availability for some groups of people in the EU.

Closures

A group of people in most of the countries studied have experienced reduced availability because nearby service providers have closed due to the crisis. Some have been closed by explicit, top-down government decisions. Others have closed because reduced reimbursement of the services they provided and reduced income from patients made them unviable. Such closures were usually not exclusively a consequence of the crisis. However, the crisis added to a mix of reasons, including long-term trends in reorganising healthcare systems to close down small service providers with

relatively little demand, to merge facilities and to reduce inpatient beds. There have also been changes in competition offered by private for-profit providers, and a range of political motivations.

The crisis has played a role for example in the closure of some smaller public hospitals in specific – mostly rural – areas (Box BG1; HU2; RO1; RO2; SE1). For example, in Romania, 67 public hospitals (about 15% of the country's public hospitals) in rural areas were closed in April 2011. People living in these areas have become more vulnerable to poor healthcare access, especially those with limited mobility or who cannot afford transport costs.

Cut, capped and delayed budgets

People have experienced reduced availability because the service they need has faced budget cuts or caps, or delayed public financing. Budget cuts were sometimes introduced for services facing increased demand. In Ireland, funding decreased in particular for home care (including home help, nursing and physiotherapy), with hours of service provision down from 13 million in 2008 to 9 million in 2013, while the number of people receiving home care increased from 9,000 to 11,000. Similarly, in Hungary the budget for home healthcare was cut by 3.9% in 2009 and by 9.3% in 2010. This, combined with a 15% increase in the number of clients served between 2007 and 2012, and a 1%–2% increase in the number of home-care visits, resulted in a decrease in the number of visits per patient, down from 26 in 2007 to 23 in 2012. Another example includes mental healthcare budget cuts in the Netherlands, Slovenia and Sweden, even though demand for mental healthcare has generally increased during the crisis.

In some Member States, maximum budgets were established for healthcare providers (Belgium, Bulgaria, Latvia and Luxembourg), limiting reimbursements for services provided beyond the threshold. In Latvia, hospital budgets for inpatient care and outpatient specialist care have been capped since 2010. In practice, there is no clear evidence that such budget limits have led to access being denied (Box BG1), but it may have worsened the responsiveness of the health system, with patients being forwarded to other service providers, receiving scaled-down services or more intensive forms of care being restricted to the most urgent cases.

Besides budget cuts and caps, delays in receipts of public funds by healthcare providers have also been identified as an impact of the crisis that has threatened continued service delivery and thus access (Box BG1; PT3; SI2). For example, in two of the Greek case studies the health insurance fund delayed payments for between 10 and 14 months because of the crisis (Box EL2; EL3).

In Greece, according to Justo (2013), cancer patients face extended waiting times to access the appropriate therapies, in particular for more expensive treatments. The waiting time for a cancer operation might be six to eight months, and the waiting time for radiation therapy (if the linear accelerator is in use) is more than four to five months. According to data derived from the Greek Health Map (2013), waiting times for a visit to an outpatient oncology clinic have increased between 2010 and 2012, but the data are limited and are only available for a sample of hospitals.²

Experiencing reduced reachability

Even where the nearest healthcare service has remained open and its budget was not cut, people have experienced reduced accessibility due to decreased public investment in transport or reduced ability to pay for the service (Eurofound, 2013a; see also Box PT1; PT2; PT3). Reduced reachability includes less frequency of public transport, and increased cost for users of both public and private

² Data for 2013 are derived from the Greek Health Map, provided by the National School of Public Health and the Hellenic Center for Disease Control and Prevention.

transport. It also includes decreased ability of governments to maintain roads because of the crisis. In Bulgaria, for example, there were reports of decreased snow removal in winter making facilities particularly hard to reach.

Staff cuts and migration

People have also experienced reduced availability of services because of staff cuts and limits on hiring new staff. These issues have posed a problem for sustaining service delivery for many of the healthcare providers investigated in this study. For example, in Spain, between January 2012 (when vacancies were restricted by law to a 10% replacement rate) and January 2014, the proportion of public health employees declined by 5.6%, from 505,185 to 476,689 (El País, 2014a). People who have needed healthcare from these facilities have experienced longer waiting times for the specific services affected (such as orthopaedic and vascular surgeries in Slovenia), have needed to rely on scaled-down service provision or have turned to other providers. In Spain, for example, data covering 14 regions (59% of the population) suggest that average waiting times have increased from a low of 53 days in December 2010 to 67 days in December 2013 (mainly in gynaecology, ophthalmology and traumatology), a record high since first recorded in 2004 (El País, 2014b).

Cuts have occurred often in sectors where costs were high or where cuts were easily made. For example, in Ireland many home-care services are contracted out to staff with 'zero hour contracts', which means they are paid per hour of work. This has allowed easy cutbacks. The same holds true for partly publicly funded voluntary and community organisations which saw cuts of about 10% per year (Harvey, 2012). In the Swedish case studies, cuts focused on nurses with the lowest qualifications (Box SE3) and staff with temporary contracts (Box SE2). In other cases, retiring staff were not (Box EL1; RO2; SI3) or were only partially (Portugal) replaced and early retirement was promoted (Box ES1; LV3). Sometimes staff on maternity leave were not replaced (Box ES1).

While staff cuts were usually clearly related to the crisis (Eurofound, 2014), difficulties in recruiting staff are often partly explained by longer-term trends such as emigration of medical staff (Eurofound, 2013b) and the difficulties in staff recruitment in rural areas. This is especially a problem for smaller service providers who can offer only limited career prospects. Insufficient students being trained and ageing workforces play a role. For example, in Hungary 70.5% of general practitioners (GPs) are aged 50 or older. Nevertheless, the crisis has interacted with these trends, in particular through salary cuts, whether mandated by the government or introduced directly by the healthcare provider. Sometimes cuts did not affect monthly wages but targeted other forms of remuneration. For example, the Spanish region of Catalonia abolished performance bonuses for mental health staff.

Reduced resources for professional development and investment in quality care have also worsened working conditions. This has accelerated emigration among younger healthcare personnel. In one case study, the problems caused by emigration of specific staff were noted by the service provider (Box LV3), and another mentioned this in relation to nurses and anaesthetists, although this was not felt to be a major problem (Box BG1). The problem varies across specialities and across healthcare providers. For example, in Slovenia labour shortages are a problem particularly for orthopaedic and vascular surgeries in secondary hospitals, and for primary care doctors in certain regions (Slovenj Gradec, Maribor, Metlika and Kočevje).

Diminished awareness

Because of the crisis, some people have a diminished awareness of how to use the healthcare system and of the exemptions that could make access easier for them.

The crisis has triggered many reforms. After such change, it usually takes time before people become aware of the new rules. For people who have moved countries because of the crisis to take advantage of potential employment opportunities, the new country's healthcare systems may offer access to them but they may not find their way through the system.

Moreover, even in an unchanged system, for people who have not emigrated, the crisis may have triggered information problems by creating new personal circumstances. This is particularly true for those 'new to need' who have lost employment and may qualify for support, and who have new healthcare demands. For example, in the Netherlands, an estimated 10% of those eligible for the healthcare subsidy in 2006 had not taken advantage of it by 2008. In contrast, among those who were not eligible in 2006 but were entitled by 2008, 41% did not take advantage of the subsidy (Tempelman et al, 2011). Some migrants in Portugal assume insurance is linked to employment. While this assumption is false, when these migrants lose their job, they think they have lost insurance as well and are less inclined to try to access healthcare when needed (Box PT1).

In addition, reduced awareness has also been the result of decreased resources for information campaigns and materials (Box SI3). Cuts in the health budget for migrants' health mediators in Portugal reduced access (Box PT1), and this was a service specifically designed to improve access to traditionally disadvantaged groups.

Lack of awareness not only applies to patients, but also to healthcare service providers and payers. For example, in Germany, in the first three months of residence, EU migrants are entitled to reimbursement from their home insurer (if they have any) and doctors in Germany apply for reimbursement by registering the patient at a local health insurance company. In practice, however, patients report that clinics ask for pre-payment before starting treatment and some even refuse treatment without a German insurance card (Doctors of the World International Network, 2013). After three months of residence, EU citizens insured in their home country can register with a German public insurance company (GKV) and receive the same coverage that they receive in their home country. In practice, however, it is not easy to use this service. Insurance companies are not always familiar with the regulations; the companies need the patient's coverage information from the home country; and language and bureaucracy problems make it more difficult to receive this information. In Portugal, undocumented migrants are legally entitled to the same access to healthcare as everyone else, but healthcare providers are not always aware of this.

The legal discretion of the healthcare provider may play a role, as in the Netherlands where undocumented migrants depend on the provider's judgement that care is medically necessary, taking into account the type of assistance needed and the patient's period of residence in the country.

Reduced coverage for healthcare services

Some countries have reduced coverage for certain services and for some population groups. An overview of such measures is given by Mladovsky et al (2012). Such reductions may involve loss of insurance, loss of coverage for specific services or reduced financial coverage.

Loss of insurance coverage

Reduced insurance coverage among the population has not always resulted from government cuts. In particular, in countries with social health insurance systems, unemployment has led to a loss of insurance coverage for certain groups not entitled to free insurance under exemption rules. In countries where insurance coverage is triggered by receipt of certain social benefits, loss of these benefits has also left people uninsured (Box RO3). In several countries (for example, Greece and

Slovenia), people with debts to public authorities or health insurers have been left without insurance coverage. This is a problem that has escalated during the crisis, in particular among the self-employed with little work. It is hard to obtain consistent macro data on these issues, but examples emerged from the country studies.

In Greece, the clientele of a charity in Athens, the ‘Social Mission Infirmary’ (see Chapter 4 section on ‘Drawing on less costly workers’) which treats uninsured persons, illustrates access problems for the groups mentioned above. Among its patients, 86% have lost insurance during 2010–2012. Almost half of its patients (48%) are self-employed people who lost insurance due to tax or insurance debts, and 8% are uninsured and pregnant.

In Bulgaria, the number of uninsured has increased during the crisis mainly because of an increase in unemployment and reduced disposable income for insurance payments among those groups who are not entitled to free insurance. Public insurance is automatic for employees, but not for unemployed people, those inactive in the (formal) economy and self-employed individuals. These groups can buy public insurance. If uninsured people need healthcare, they can get it free of charge, but only through the emergency care departments, which may be far away. Numbers of uninsured are unavailable, but interviewees suggested they have increased from under one million (many of them from the Roma group) to nearly one and a half million; an observed increase in emergency care supports this assessment (Box BG1).

When a person becomes unemployed in Luxembourg, their health insurance package is automatically transferred from the employer to the National Employment Agency (ADEM). If an unemployed person is not entitled to unemployment benefits, she or he must contact the national health insurance fund and start the process of obtaining health insurance, where the premium is paid initially by the individual. This insurance covers anyone who does not qualify for any other form of health insurance (for example, employee-based, spousal or dependent co-insurance or as a result of unemployment or disability or as part of maternity benefits) and is resident in Luxembourg. The system requires that the person is registered with the social security system for three months before any medical expenses are reimbursed.

In Greece, people who are unemployed for more than two years and their dependants are particularly at risk of losing insurance, since coverage is reduced after 24 months (see Chapter 4 section on ‘Increasing exemptions and coverage’).

In Slovenia, there has been an increase in the number of self-employed people who have no access to insurance until they settle their debts with the national insurance fund – perhaps as many as 10,000 people (Planet Siol, 2013a). To be counted as an uninsured person in Slovenia, one needs to have no prior debts with the national health insurance fund and be eligible for free treatment. The majority in this group are newly unemployed. Unemployed people are entitled to insurance but should change their insurance payee status within an eight-day deadline, which many fail to do (see Chapter 4 section on ‘Extended and continued coverage of groups in vulnerable situations’).

Loss of coverage for healthcare services

Coverage for specific healthcare services has also been cut (Mladovsky et al, 2012). This has not always been done by simply removing services from the benefit package, but also in more complex ways. For example, in Bulgaria, the insurance fund moved from refunding a fixed amount per clinical pathway, to only refunding if basic procedures and materials were used. Patients now have to pay

the full amount if they wish to have a higher-quality procedure. Previously, they only paid the difference between the costs of both levels of treatment.

Coverage for certain services has been reduced by changes in regulation, but also by less lenient reimbursement decisions by health insurance providers. In Slovenia, for example, there are reports of health insurers refusing prescribed applications for spa rehabilitation that were previously accepted.

Increase in out-of-pocket payments

People who experience increased copayments, loss of entitlements to exemptions, increased informal payments or increased enforcement of copayments have been at risk of reduced access. In social health insurance systems, the same holds true for people who have experienced increased insurance fees or own-risk excess.

The share of healthcare costs which patients need to pay up front for treatments has increased in many countries, for several types of services. Sometimes increases have come from government regulations. Some examples are presented in Table 2. In other countries, such out-of-pocket payments are set by regional governments, with those hit hardest by the crisis under higher pressure to increase them (Sweden) than regions not so severely affected. On some occasions, providers themselves have decided to charge more for their services (Box HU1).

It is clear that informal payments have not disappeared during the crisis (EPHA, 2014). Increased waiting times (Box SI2) may provide more scope for favouring patients by, for example, allowing them to jump queues in exchange for under-the-table payments, goods or other favours.

The reduced coverage not only comes from new measures, but also from situations where already existing copayments have been more rigidly enforced. Where service providers have previously not always implemented the collection of copayments or non-coverage of services or population groups, the crisis has increased the need for them to do so. As a consequence, even with constant levels of copayments and coverage, access has reduced where these have been implemented more strictly (Box SI3). An example of such reductions in leniency emerges from the Portuguese country study, with regard to care for migrants. In general, service providers would have more incentives to enforce copayments when under higher budgetary pressure than usual during the crisis, but in at least one case staff cuts reduced the providers' capacity to collect these payments (Box IE1).

Table 2: Examples of measures where cost of access to healthcare increased

Country	Measure
Greece	2011: Copayments increased from €3 to €5 for outpatient hospital care and health centres. 2014: A €25 hospital admission fee was established and then revoked because of protests from healthcare professionals and the opposition party.
Ireland	In 2008, it cost €60 to access emergency care and €60 per day for hospital care, capped at 10 days per year (€600). By 2013, this was increased to €100 to access emergency care and €75 per day for hospital care, capped at 10 days per year (€750). These fees are waived for people with a medical card (40% of the population in 2013).
Italy	Beginning in October 2011, the national government sought implementation of a €10 copayment for visits to specialists, with exemptions for low-income earners, people with disabilities, elderly persons and patients with chronic health problems. Some regions applied these fixed copayments, while others made them dependent on gross family income or service tariffs, or have not implemented them (De Belvis et al, 2012; Fenech and Panfili, 2013; Gruppo Remolet di Agenas, 2013).
Latvia	Copayments were increased in 2009 from LVL 0.5 to LVL 1 (€0.71 to €1.42) for outpatient GP visits, from LVL 2 to LVL 5 (€2.84 to €7.11) for outpatient specialist and hospital visits, from LVL 0.5 to LVL 5 (€0.71 to €7.11) for outpatient surgery in hospital, and from LVL 5 to LVL 12 (€7.11 to €17.07) for a daily inpatient stay (starting from day two). The maximum patient contribution for a hospital stay increased from LVL 80 to LVL 250 (about €114 to €356), and per year from LVL 150 to LVL 400 (€213 to €569). For outpatient specialist and hospital visits, copayments were cut again in 2010, from LVL 5 to LVL 3 (€7.11 to €4.26) and daily inpatient care charges from LVL 12 to LVL 9.5 (€17.07 to €13.51).

Country	Measure
Portugal	From 2007 to 2013, copayments for both inpatient and outpatient care were raised, with the largest increase occurring in 2012. Exemptions for chronically ill patients were restricted to consultations/treatments for their specific condition.
Romania	Copayments for inpatient spells were introduced in March 2013, capped at RON 10 (€2.28) per admission.
Slovenia	Copayments have increased for ambulance transport, dental prostheses and some ophthalmological appliances (Mladovsky et al, 2012).

Note: Euro currency conversions as at 28 July 2014.

Impacts on households

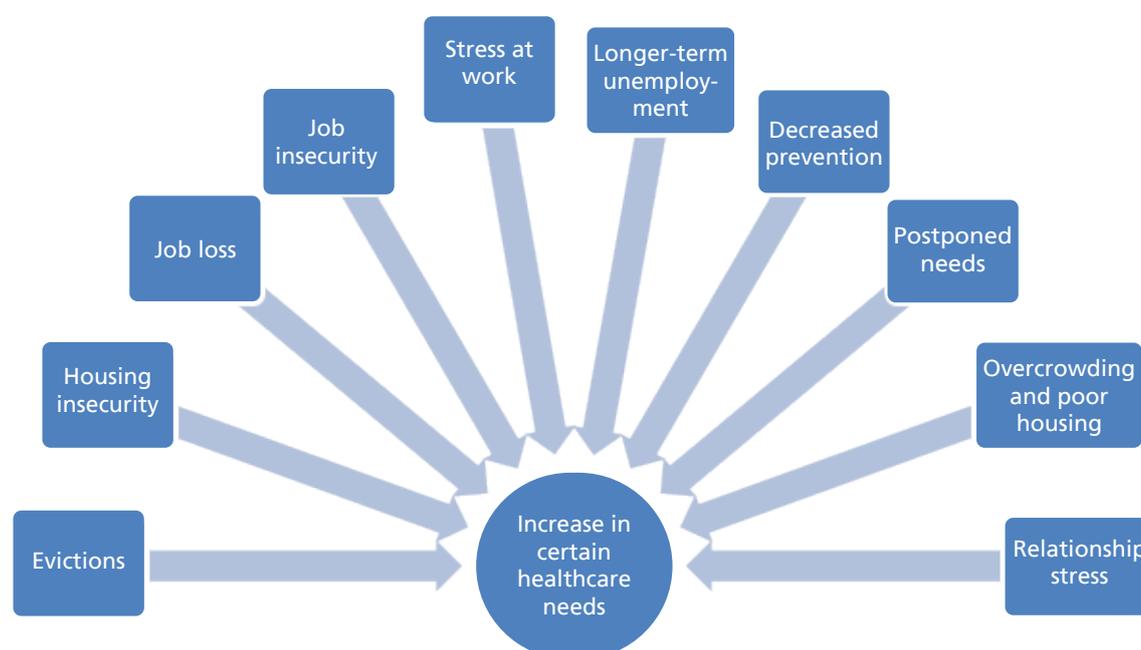
The impacts of the crisis on health and disposable income have been more immediate than the effect on healthcare provision. Nevertheless, the effects on disposable household income came with some time lag. For instance, in Portugal, market incomes decreased from late 2010, disposable household incomes in 2011 (European Commission, 2014b) and the bulk of increases in healthcare copayments in 2012. Delayed effects of the crisis on household incomes in the EU can be explained by the fact that unemployment benefits typically decrease with the duration of unemployment and living costs increase due to lagged public sector cuts. The increase in need also came with some time delay. People unemployed for more than a year were more likely to be at risk of poor mental health than the short-term unemployed (Eurofound, 2013a) and cuts in preventive measures may have an even greater delayed impact.

Increased need for some services

Reduced disposable income may have meant healthier lifestyles for some, with less smoking of tobacco and alcohol consumption. The crisis has also decreased the number of traffic accidents, births and pollution in certain areas. These factors led to a decreased need for some services. Nevertheless, the crisis has clearly resulted in an increased need for other services, and problems of access and policy challenges have been most pressing for them.

The crisis has had a negative effect on health particularly in the following ways (see also Figure 3).

- Job and housing insecurity or loss have led to mental health problems, including mood disorders, anxiety and alcohol-related problems. Major depression has been associated with mortgage repayment difficulties, evictions and unemployment (Gili et al, 2012; Avčín et al, 2011; Economou et al, 2012; Eurofound, 2013a; see also Box EL1; EL5; ES1; LU1).
- Physical health has also been affected for some by reduced finances and unhealthier eating habits as a result of separation (Rueger et al, 2011). Overcrowding and worsening housing conditions may also have led to worse physical health, for example respiratory diseases among children (Box PT3).
- The third mechanism differs in that it has been triggered by cuts in preventive healthcare rather than household-level problems. Preventive healthcare measures have been subject to particularly large cuts in some Member States (Morgan and Astolfi, 2014). While they have a lagged impact, which may not yet be fully felt, reduced prevention has been associated with an increase in communicable diseases such as HIV, tuberculosis and malaria in Greece, and in influenza and sexually transmitted diseases (Karanikolos et al, 2013).

Figure 3: Crisis-related increases in need for certain healthcare services

Source: Eurofound elaboration

People who experience increased need may not experience difficulties in accessing healthcare. Nevertheless, if services do not respond to increased demand, this causes problems. Furthermore, medical conditions associated with perceived stigma, such as communicable diseases and mental health conditions, are exactly those that have become more common during the crisis. Stigma has thus likely become a more frequent barrier to access during the crisis. In addition, the crisis has affected access for new groups of people due to over-indebtedness and unemployment. Among those groups who are 'new to need', some people have reported being embarrassed by their situation (Box SI3; Eurofound, 2011).

Reduced disposable income

Reduced access due to cost

The crisis has reduced the income of many households across the EU. Loss of employment, reduced salaries and fewer working hours have had a negative impact on household income, as have losses from investments. Households depending on monetary benefits have suffered further from cuts in these benefits (Box RO1), and public and private pensions have been reduced (as in Greece, Luxembourg and Portugal). Even when income has remained stable, many have experienced price increases of basic goods (for instance, energy costs in Bulgaria). Cuts in benefits in kind have caused household expenditure to rise, as people who previously received such benefits now have to pay for the services out of their own pockets. Groups which were hardly able to make ends meet before the crisis 'tipped over the edge'. Increased living costs and debt problems also contributed to a newly created poor, often in employment and without previous experience of poverty (IFRC, 2013; Eurofound, 2011). Even in the richest Member States, some people report great difficulties in making ends meet, and this group has increased during the crisis (Eurofound, 2012b).

For all these groups of people, it has become more difficult to make healthcare payments, whether formal or informal, when these apply. For example, a survey in the Netherlands found that the proportion of GPs reporting that several times a day they encounter patients who do not follow their advice (referral to specialists or further medical tests) because of costs increased from 9% in 2013 to 15% in 2014 (LHV, 2014). Transport costs to the nearest healthcare provider have also become a greater obstacle. For instance, in Latvia, access to first aid and primary healthcare services has been negatively affected during the crisis, particularly in rural areas with reduced incomes, increased unemployment and problems with public transport infrastructure (Baltic Institute of Social Sciences, 2012).

In countries with health insurance systems, it has become more difficult for some groups to make health insurance contributions. Increases in the number of uninsured, for example in Bulgaria and the Netherlands, can be partly explained by reduced disposable income (see earlier section on ‘Loss of insurance coverage’). In countries with reimbursement systems where patients pay healthcare providers up front and are reimbursed later, what matters is the ability to make the initial payments.

Reduced access to private healthcare

People experiencing reduced income have also had less access to private healthcare, defined here as including both Voluntary Health Insurance (VHI) and direct payments for private for-profit healthcare services. Although this study focuses on publicly funded services, this is relevant; these people, usually the ‘new poor’ or middle classes, may have experienced reduced access when moving to the public sector, such as longer waiting times to receive treatment or being unable to pay for examinations that are not covered by the public system. It may also have worsened access for other patients as higher demand for public care led to an increased workload for health services and longer waiting times for patients. It also has to be recognised that what is understood to be ‘private healthcare’ in various countries is often partly publicly funded, which brings it within the remit of this study.

‘Private healthcare’ means something very different across Member States. Sometimes it concerns VHI, often employer-provided as part of employee benefits (Ireland and Poland). Loss of employment leads immediately to loss of VHI if not replaced by insurance purchased personally. VHI facilitates access in several countries. Generally, tertiary or specialist care is received from public healthcare service providers in EU Member States, and VHI may, for example, entitle the patient to a hospital room shared with fewer people. VHI improves access in many Member States by decreasing waiting times for medical tests by using private services (Portugal, Slovenia and Spain) or for hospital treatment by using private wings in public hospitals (Ireland). In other countries, VHI mainly serves to reimburse copayments for public services (France and Slovenia). There are also countries where there are separate private, for-profit hospitals which receive the same state remuneration as public hospitals for clinical procedures from the national insurance fund, but they tend to charge patients more than public hospitals (Bulgaria and Romania). In some cases, patients using the services of these for-profit hospitals have no VHI and make payments directly to the healthcare provider.

In all countries, there are constantly flows in both directions, from public to private and vice versa, partly related to the crisis (see Figure 4). In several Member States, there is evidence of a shift in the direction of public funding and provision because people cannot afford private care anymore. This leads to greater demand for public services, a greater reliance on public funding and fewer resources for service providers.

Several case study service providers have noticed such a shift from private to public care (Box EL5; ES1; LU1; SI2). In Ireland, population coverage by private insurance decreased from 51% in 2008 to 45% in 2013 (HIA, 2013). In addition, over half a million people switched to cheaper private insurance packages with reduced coverage. In Slovenia, many people cannot afford private insurance for dental treatment anymore. This has led to increased demand for public dental services, and thus waiting lists. Simultaneously, some of these public providers who also offered private dental services have had reduced income from these private payers (Box SI2).

In Portugal, the largest private health insurer reported a 17% increase in policy cancellations in the first six months of 2012 (Vida Económica, 2012), although it also reported an increase in the take-up of new policies. Health insurance companies have also adjusted their products, with reduced coverage at lower prices and health cards entitling the holder to a fixed number of specialist visits. Overall in Portugal, the longer-standing upward trend in individual private health insurance was reversed in 2010, with a 2% decrease (about 20,000 people) in the number covered by private health insurance in 2012 compared to 2010 (ISP, 2010, 2013). In addition, Spain has seen a reduction in private health insurance coverage in recent years (OECD, 2014), and Cyprus and Greece have experienced a net flow from private to public insurance coverage (Eurofound, 2013a). In Greece, in 2014 the budget ceiling for providers was reduced by 50% compared to 2013, resulting in higher out-of-pocket payments for patients. This has contributed to decreased demand which, in combination with delayed reimbursements by the insurance fund, has triggered closure of six private clinics in March 2014, according to the Panhellenic Union of Private Clinics.

Figure 4: Crisis-related shifts in demand for public and private healthcare services



Source: Eurofound elaboration

This shift from private to public is not so clear everywhere in the EU, and is less pronounced particularly in countries where the long-term trend has been an increased role for private healthcare.

In Sweden since 2008, the number of private insurance policies has increased by 67%, with 573,000 people covered at the end of 2013. In Bulgaria, the number of private hospitals has increased during the crisis and there are now fewer public hospitals. Public hospitals can still be accessed free of charge, but they have started charging for treatment by doctors of choice and better rooms. The decreased price difference may have countered the flow away from the private sector by those who lost income. In Romania, the number of private hospitals increased from 10 in 2008 to 73 in 2013, and treatments reimbursed by the national insurance fund to private hospitals rose from 25,865 in 2008 to 110,816 in 2013 (DRG database, 2014).³ In both Bulgaria and Romania, many doctors working in public hospitals also work in private hospitals and redirect their patients from

³ The 'Diagnosis-related group (DRG)' national database is maintained by the National School of Public Health Management and Professional Development, Bucharest, available at <http://www.drg.ro>.

the public to the private hospital. Even in the countries where more people moved from private to public, some have moved from public to private because their income has improved, or because of lower price differences as a result of increased copayments for public services (see earlier section on ‘Increase in out-of-pocket payments’) and reduced-cost private insurance packages (Portugal and Italy; Fenech and Panfili, 2013), or because they perceive that the quality of public healthcare services has decreased.

Situation of specific groups in vulnerable situations

The following subsections describe the information available about groups in vulnerable situations gathered from the country reports and case studies.

Roma population

There are some data available for access to healthcare services by the Roma population, for example on discrimination by healthcare personnel experienced by self-identified Roma living in areas with concentrated immigrant or ethnic minority groups (FRA, 2009). While there are data on the barriers Roma face in accessing healthcare (such as discrimination by healthcare providers), they do not allow for comparison of the situation before and after the crisis. Data from a survey in Greece in 2011 show that for Roma people in rural areas the most frequent barriers to health services were long waiting times in hospitals, the attitude of health professionals and the high cost of healthcare and medicines (Galanis et al, 2012). Overall, obtaining reliable data disaggregated by ethnicity is challenging due to methodological difficulties, data protection issues and questions about the reliability of figures provided by advocacy groups (Eurofound, 2012b).

The link between Roma ethnicity, health status and access to healthcare services can in many cases be explained by low socioeconomic status (Masseria et al, 2010; Vokó et al, 2009). The Hungarian country report mentions that the health status of Roma people has worsened due to the decrease in regular social benefits. Roma are relatively often uninsured for public healthcare in Bulgaria and Romania. No clear evidence was found that the number of uninsured Roma had increased more than in other groups during the crisis. Nevertheless, in Romania, stricter implementation of entitlement criteria for minimum income, which guarantees health insurance, may have led to an increase in the number of uninsured, particularly among Roma (Box RO3). At the same time, interviewees suggested that access to primary care in Romania has improved for Roma due to longer-standing trends, such as increased possession of identity cards. The Romanian country report also makes it clear that rich Roma face fewer barriers to accessing healthcare compared to their poorer non-Roma fellow Romanians, and perhaps poverty may be a more important factor than ethnicity.

Given the scarcity of data, it is useful to analyse whether additional resources are in place to increase accessibility for Roma people, and how these have been affected by the crisis. In Ireland, the health budget allocated specifically to ‘Irish travellers’, a group of traditionally itinerant people in Ireland, has been cut by 40% since 2007. In Romania, there has been a national health mediation programme for Roma people for the last 10 years. Under the programme, health mediators are employed by local authorities and financed by the Ministry of Health. A recent report pointed out that there are still acute disparities in the coverage of Roma health mediators across the country: only three out of 42 counties had the recommended mediator-to-Roma ratio (Institute for Public Policy Romania, 2013). Although the Ministry of Health finances the health mediators, they are employed by the local authorities. There is no clear evidence that the service has been affected by the crisis, but it may have been affected by personnel-centred budgetary restrictions imposed on local authorities.

Migrants

Reduced access for migrants because of increased xenophobia due to the crisis has been observed in several Member States (Doctors of the World, 2012). Even if discrimination had remained constant, it would still have been new to people who had emigrated because of the effects of the crisis in their home countries.

The country reports and case studies show a diversified picture of the changes in access to healthcare for migrants. For instance, cultural and social barriers facing ethnic minorities and migrants are considered relatively low in Luxembourg and are not reported to have been exacerbated by the crisis as of yet. Spain was among the countries where undocumented migrants had among the best access in the EU (Karl-Trummer et al, 2010; FRA, 2011), but measures to ensure the sustainability of the National Health System have restricted healthcare for undocumented migrants since 2012. The Council of Europe European Committee of Social Rights expressed in its 2013 conclusions that 'this denial of access to healthcare for adult foreigners (aged over 18 years) present in the country irregularly is contrary to Article 11 of the Charter' (European Committee of Social Rights, 2014). The crisis has clearly made access to healthcare harder for undocumented migrants in a country where access has been among the best in the EU for this population group. Nevertheless, access still appears better in Spain than in many other Member States, with access to emergency care maintained, pregnant women and minors exempted. Moreover, there is variation in the regulations between regions in Spain, and in the level of implementation of these regulations among providers.

A greater number of migrants may have found themselves with undocumented status during the crisis due to unemployment or because they were unable to pay the necessary fees. In Portugal, however, migrants (whether undocumented or documented) have the same entitlement to healthcare as any other resident. Nevertheless, in practice, lack of awareness among administrative staff about the healthcare rights of migrants (especially undocumented ones) has been reported and staff in healthcare centres are often wary of granting access to migrants whose legal status is not absolutely clear, fearing that they will not pay the copayments or will give a false address. As a result, migrants tend to bypass primary care centres and go directly to hospitals where access seems easier and enforcement of copayments is less stringent, particularly in emergency situations. Difficulties arise when follow-up treatment or further examinations are required later. In these cases, migrants (particularly pregnant women) often drop out of treatment or miss follow-up consultations.

Before the crisis, the Portuguese High Commission for Immigration and Intercultural Dialogue (*Alto Comissariado para a Imigração e Diálogo Intercultural*) established a body of mediators to work with migrant communities. Resources for this programme were reduced as part of cost-cutting measures, and so migrants have found it increasingly difficult to access the healthcare services, for instance, at the Hospital Vila Nova de Gaia/Espinho (Box PT1), while hospital staff have lost an important facilitator in their contact with migrants. The hospital's 'Migrant-friendly hospital initiative' carried out a survey in 2010 of access to healthcare of the migrant population. It showed that, in general, migrants avoided contact with healthcare services and either resorted to self-medication (36.8% of the sample) or sought healthcare only in emergencies when hospitals, rather than primary care centres, were the preferred provider. With increased workload and decreased pay among the staff of many of the healthcare services investigated, some initiatives to enhance access for migrants have faced difficulty in securing the voluntary participation of staff (Box PT1).

According to a recent study on the access of migrants to healthcare services, conducted in 2012 in Greece, only 56.5% of participants had health insurance coverage, a relatively small proportion

compared to the native population (Galanis et al, 2013). Over half of the participants in the study (62.3%) said they had needs that were not met by healthcare services. The most important reasons for this given by respondents were long waiting times in hospitals, difficulties in communication with health professionals, high cost of healthcare and the health system's complexity; these findings were echoed by other studies. In a more recent study conducted in 2013, with a similar questionnaire and methodology, both the respective proportions have increased: 67.4% of participants reported no health insurance coverage and 82% of migrants reported unmet health needs (Kaitelidou et al, 2014).

Older people

On average, older people have greater healthcare needs than younger people. Any impact of the crisis on healthcare services may therefore have had a disproportionate impact on older people. Analysis of EU-SILC data shows that in the EU27 'enforced unmet needs', because of costs, waiting lists or distance, increased for those aged 65 and over (from 3.5% in 2006 to 4.7% in 2011), while it decreased for people aged between 16 and 64 (from 3.6% to 3.2%) (Rodrigues et al, 2013). There are large country differences, and the increase was most marked in Italy (from 5.7% to 7.3%) and Greece (from 9.4% to 13.2%).

Pensions became a more important source of income for households hit by unemployment, whether these had increased (Latvia) or decreased (Greece) during the crisis. Increased copayments for nursing homes (Latvia) and perceived decreased quality of nursing home care because of cuts may also have played a role, contributing to more elderly people living with their relatives instead of in a nursing home.

The reduction in pensions has made it harder for elderly people in Greece to access healthcare services. Increased copayments for medicines and the closure of certain local health structures have aggravated this situation (Kentikelenis et al, 2014). High unemployment has also been reported to have made people reliant on the pensions of their parents, further reducing the disposable income of the elderly and thus their ability to pay for healthcare. This has also been the case in Portugal, where some people have moved back to live with their parents because their pensions provide a steady form of income for the household.

In Latvia, the average monthly old age pension of a retired person has increased during the crisis, from LVL 141 in 2008 to LVL 178 in 2011 (from €200 to €253), while the average monthly salary of the working age population decreased during the same period (CSB, 2013). An interviewee in a Latvian nursing home case study pointed out that this gave families an economic incentive to keep frail elderly relatives at home rather than in a nursing home so that their pension could be an extra source of household income. In some cases, old people left nursing homes and returned home to support their relatives with their pensions. These developments could partly explain the decrease in the number of people on nursing home waiting lists and in the number of nursing home clients. This also seems to be the case in Hungary, where the number of clients in care homes decreased slightly in 2008 (down to 49,894 from 50,903 in 2007). While it is hard to assess the impact of these developments on access to healthcare by older people, it is clear that even when (real) pensions have not decreased, there has been an impact through intergenerational linkages.

Access has also been made increasingly difficult by cuts and changes to services that older people rely on more heavily. In Ireland, more elderly people are getting fewer hours of home care. One of the interviewees reported that it has become harder for all nursing home residents to access services since the onset of the crisis because of moratoriums on replacing staff who have left (interview

with the chief executive officer of Nursing Homes Ireland). Another potential indicator of access to nursing home care is the numbers waiting in an acute care hospital for a nursing home place. These people, known as ‘delayed discharges’ or ‘bed-blockers’, no longer need to be in an acute hospital, but cannot leave without a place in a nursing home or modifications being made to their home – and budgets for this type of service have also been cut. Despite persistent efforts to reduce the numbers of delayed discharges to free up much needed hospital beds, the numbers in Ireland remain high and increased during 2013.

People with chronic health conditions or disabilities

People with chronic health conditions or disabilities have relatively large healthcare needs, and many of them are elderly. The crisis has sometimes affected their ability to pay healthcare costs.

In Greece, according to the preliminary results of a study conducted by the Health Economics Department of the National School of Public Health (2013), about 60% of chronically ill patients reported difficulties in paying for treatment or being placed on extended waiting lists. Respondents on average reported to have reduced by 30% their visits to primary care services between 2011 and 2013, and by 20% their health expenditure. Out-of-pocket payments for primary health services had been reduced by more than 50% between 2011 and 2013.

Chronically ill and disabled people have also been affected by changes in copayment rules. In Portugal, the chronically ill are now only exempt from charges for healthcare services directly related to their condition. According to interviewees, this has created barriers for some groups of chronically ill patients because doctors are not always sure what qualifies as a directly related condition, particularly in cases of comorbidity. Interviewees also report that recent legal changes have restricted the provision of mobility aids (crutches and wheelchairs) to certain groups of patients and this may have created another barrier.

People with mental health problems

Mental health is of particular concern in the context of the crisis. Research into the links between increases in suicide and the crisis shows that in countries deeply affected by the recession, such as Greece and Ireland, suicide rose (by 17% and 13%, respectively), and in Latvia suicide increased by more than 17% between 2007 and 2008 (Stuckler et al, 2011).

A study investigating the impact of the current crisis on the mental health of the Greek population showed that there were increases in the prevalence rates of major depression between 2008 and 2011, with significant links to financial hardship. Individuals in financial distress displayed increased odds of suffering from major depression in 2011 (Economou et al, 2012). Between 2009 and 2011, there was also a substantial increase in the prevalence of suicidal ideation and reported suicide attempts in Greece (Economou et al, 2013).

In Portugal, an estimated 23% of people suffer from a mental health problem and only about one third of those with moderate mental health problems receive treatment (DGS, 2013). In Slovenia, a study of the depression and anxiety levels of public and private sector employees found higher levels among those who declared themselves affected by the crisis (Avčín et al, 2011).

According to the Latvian Centre for Disease Prevention and Control (SPKC), there was an increase in suicide during the crisis (Pulmanis et al, 2012). Analysis of the regional data points towards a potential causality between the unemployment and suicide rates, since regions with higher unemployment rates had higher suicide rates (2011 data; Pulmanis et al, 2012).

In some of the countries analysed in this study, the crisis has hindered the development of community-based mental health services. In Ireland, the mental health reform programme set out in 'A vision for change' (2006) has been affected by the crisis, with a delay in the increase and improvement of provision in the community. Analysis of budgets and staffing since the publication of the strategy show that, between 2008 and 2012, there was almost no increase in the transfer of either budget or staff from hospitals to the community. This resulted in the underprovision of community services and the overmedication and increased hospitalisation of people with mental health problems. Readmission rates also increased.

Public funding for mental health programmes in Greece has been cut by 20% in 2011 and by a further 55% in 2012 (Kentikelenis et al, 2014). Many intermediate structures such as community mental health centres (about 45) were set up already before the crisis. NGOs created 220 units (30% of all mental health units), which cover 50% of the places offered by the deinstitutionalisation programme. Public funding to these NGOs was roughly halved, leading many of them to default on their operational and payroll expenses for more than six months. To increase the probability of accessing public mental health clinics, some families have sought court orders stating that their relatives would commit suicide if they were not sent to a clinic.

Mental health service reform in Slovenia has been similarly impacted by the crisis. According to Svab and Svab (2013), Slovenia has failed to develop community psychiatry services, with insufficient funding in times of crisis being one of the reasons for the failure to expand the community-based approach. Other reasons highlighted by Saraceno et al (2007) are the lack of integration with primary care, the fragmentation of mental healthcare services, the limited training in community interventions and the centralisation of resources in major cities and institutions. Availability of outpatient mental health services remains limited, with long waiting times. Furthermore, variations in availability exist between regions in Slovenia, to the point that the availability of a psychiatrist is one of the factors found by Korosec et al (2013) to have a significant negative correlation with regional suicide rates. An interviewee at the Slovenian Society for the Psychological Treatment of Psychosis said that there might be more complaints about access to mental healthcare if not for the fact that 'people with serious mental illness do not complain a lot, due to the nature of their illness (they are not as assertive)'.

It has to be noted that the crisis is certainly not behind all the problems in the implementation of reforms in mental health. According to interviewees in Luxembourg, the crisis did not delay the implementation of its national mental health policy. Instead, delays were caused by the structure of the health system, the lack of coordination between the different departments, lack of expertise among GPs, and lack of awareness and acceptance of mental health problems in society.

Mitigating measures as a response to the crisis

The previous section described the negative impacts of the crisis on access to healthcare services. This section highlights examples of measures taken to reduce the impacts of the crisis and improve access for groups in vulnerable situations. These ‘mitigating measures’ have been initiated by various government spheres, by service providers and by civil society. The list presented here is by no means exhaustive, but it provides an extensive, illustrative picture across the EU, based on evidence from the broad range of contexts investigated in this study. The mitigating measures that have been identified are grouped under general headings, and advantages and disadvantages are discussed.

Extended and continued coverage of groups in vulnerable situations

During the crisis, several governments and service providers have sought to protect groups in vulnerable situations by reducing financial barriers to access healthcare. Sometimes the crisis has exposed a group that is growing rapidly or falling outside the system, and a new measure was implemented to facilitate access for this group. In other instances, there has been increased uptake of existing exemptions for groups in vulnerable situations, and they have been sustained or strengthened and become an important means of facilitating access for a larger proportion of the population. Sometimes exemptions were made formally at the service provider level, but also informally where the provider does not have formal competences in this area.

Supporting increased take-up of pre-crisis exemptions

Member States have various schemes in place to facilitate access to healthcare services for groups in vulnerable situations. The crisis has increased the number of people who are entitled to benefit from some of these schemes, relying on them for accessing healthcare. Sustaining these measures has to some extent mitigated the impacts of the crisis on access to healthcare services, at least for the groups covered by existing schemes.

- In Ireland, for instance, ‘medical cards’ cover primary and hospital care, free of charge for the user (some are ‘GP only cards’ introduced in 2005). People with incomes below a certain threshold are entitled to these cards, including many who are unemployed. In 2008, 1.4 million (30% of the population) had a medical card; 1.9 million (40% of the population) had a medical card in August 2013 (HSE, 2008, 2013).
- In Luxembourg, in 2011 (the first time data were recorded), €2.2 million in social assistance was distributed through social offices, with 13.6% dedicated to health. In 2012, the total amount distributed had increased by €0.1 million, and the proportion of that spent on healthcare had risen to 15.4% (Ministry of Family and Integration, 2012). In Luxembourg, since 2005, there has been a steady increase in the numbers covered by the General Medical Scheme. This increase reflects declining incomes and growing numbers of unemployed during this period.

Increasing exemptions and coverage

Several governments have made healthcare access for groups in vulnerable situations easier by removing copayments and expanding coverage (Mladovsky et al, 2012). Out-of-pocket payments for specific groups have been reduced or abolished.

- In Bulgaria, public insurance covers basic hospital care (free for users) and primary care for an out-of-pocket fee of 1% of the minimum income (just below BGN 4 or €2 in 2014). From 2014, retirees pay half the fee for primary care and the other half is publicly funded, particularly important for those who depend on the public pension only and receive no support from family members.

- Latvia introduced the Social Safety Net Strategy in October 2009. It exempted households with a monthly income below LVL 120 (€170) per head (reduced to LVL 90 or €128 in 2012) from copayments. Those with an income between LVL 120 and LVL 150 (between €170 and €213) became eligible for a 50% reduction of copayments. In 2010, under this scheme, copayments were covered for 23,400 inpatient stays, 42,200 day cases, 129,100 outpatients and 5,800 home-care patients (Mitenbergs et al, 2012).
- Luxembourg aimed to improve access for people finding it difficult to make ‘upfront’ payments, establishing a ‘third-party payer system’ from January 2013 (Box LU3). It was already under development before 2007, with the intention of targeting indebted households, those close to the poverty line and those facing higher housing costs.
- In Portugal, the income threshold for copayment exemptions for low-income families was raised, covering a larger group, with 2.8 million qualifying in 2013, up from 1.9 million in 2006.

Coverage has been extended to certain groups.

- In Austria, in September 2010, the *Bedarfsorientierte Mindestsicherung* granted health insurance, along with a financial benefit, to people who live in poverty.
- In Slovenia, on 1 January 2009, a measure came into force that entitles several groups in vulnerable situations to free supplementary health insurance, covering part of copayments (Buzeti et al, 2011).
- France, in July 2012, increased the income threshold below which people are entitled to a financial allowance to acquire complementary health insurance. It also facilitated access to state medical assistance (AME) for undocumented migrants.
- Within the existing measures in Greece up to June 2014, unemployed people are entitled to health insurance for up to two years of unemployment. Before the crisis (2006), the inactive and long-term unemployed were also covered if they lived on low benefits, via a so-called ‘Poverty Booklet’ giving them free access to treatment in public hospitals, to medical services and to medicines. The crisis has resulted in many people falling between these measures. In September 2013, Greece launched a ‘Health Voucher’ programme, targeting both the long-term unemployed who had lost insurance coverage and also their dependants. The vouchers are valid for four months and cannot be renewed, but provide for up to three visits to a GP or diagnostic centre, and up to seven visits for pregnancy care. Hospital care is not covered. In November 2013, a measure was implemented that gave self-employed who were in debt to the insurance fund (often the case for people who had owned a small business but went bankrupt) access to health insurance benefits if they were complying with a debt settlement process. Since late June 2014, all uninsured persons are formally entitled to access to medicines and hospital care, subject to medical need. Non-emergency cases involving uninsured persons have to gain the approval of a committee in case hospital care is needed. Emergency cases, of insured and uninsured persons, are entitled to access to the emergency departments of public hospitals. Under these new rules, access to medicines for uninsured persons is covered by Greece’s National Organization for Health Care Services Provision (EOPYY). The cost of these new provisions for the uninsured is covered by a separate budget line of the Ministry of Finance.
- In Ireland, in 2014 ‘GP only cards’ have been extended to all children under the age of six, an additional 240,000 children, allowing them free access to GPs.

- In Sweden, since 2008, people with long-standing pain problems fall under the ‘rehabilitation guarantee’. The guarantee has also, according to the National Board of Health and Welfare, increased skills development possibilities for county council healthcare staff. A progress report from 2012 by the Swedish National Board of Health and Welfare showed the measure had increased access to rehabilitation services. In Sweden, undocumented migrants and their children could only access emergency care that they were charged for afterwards. In July 2013, in a new law all undocumented children were guaranteed access to public healthcare free at the point of delivery. Adult undocumented migrants now have the same rights as asylum seekers: they can access healthcare ‘that cannot be postponed’, ante- and post-natal care, family planning, termination of pregnancy and dental care that cannot be postponed, provided that they pay a €6 fee for every visit to a doctor or dentist. Doctors have discretion in judging whether a condition cannot be postponed. In practice, however, many healthcare professionals are still unaware of these changes and migrants are sometimes asked to pay more than they should, or are denied access to care (Doctors of the World, 2014).

Reducing informal payments

Some of the mitigating measures which emerged in this research clearly have the potential to remove access difficulties caused by informal payments, although it is hard to measure their impact in this area. These measures are part of a longer-term trend aiming to curb informal payments (European Commission, 2013b).

In Latvia, informal payments were made a criminal offence in 2009, but few legal cases have emerged (Mitenbergs et al, 2012). Better anonymous reporting systems may help, such as a recently released transnational ‘app’ called Bribespot. Initiatives that promote e-health, with images sent to specialists some distance away, can also help to eliminate a layer of under-the-table payments (Box RO1). Sometimes incentives have been set to formalise informal payments, which is unlikely to directly improve access for users, but may contribute to the finances of the healthcare provider and its ability to maintain access. For example, salaries have been made dependent on a team’s financial performance (Box BG1).

Reduction of informal payments does not need to come from explicit measures, but can come from other developments related to the crisis. In some cases, there are signs of increased scrutiny and decreased public acceptance of implicit or explicit demands for such informal payments as a consequence of the crisis (Box SI2; European Commission, 2013b). Healthcare professionals may also be more reluctant to accept such payments in the context of the crisis.

Sustaining or expanding leniency

This research clearly indicates that facilitating access by granting exemptions to out-of-pocket payments is not only a question of official policy, but also of ad hoc leniency by service providers. Room for leniency by service providers has decreased on many occasions (see section in the previous chapter on ‘Reduced coverage for healthcare services’), while the need for it has increased. Still, this study shows that in practice leniency is an important factor in maintaining access during the crisis.

Healthcare providers frequently reported not enforcing, or postponing, payments for patients in vulnerable situations, regardless of their formal coverage (Box BG1; IE1; HU1; LU3; RO1). Service providers may absorb these costs by classifying them in a category for which reimbursement is possible. For example, Greek health professionals often do not receive the payment of €5 for the use of outpatient health services by unemployed people, but may nevertheless treat them. In the case

of Greek mental healthcare services, interviewees reported that professionals frequently waive fees without recording them in their accounts, considering that this is a kind of emergency aid and that professional ethics oblige them not to ignore groups in vulnerable situations. A similar situation was found in the case of a mental healthcare service provider in the Spanish region of Catalonia (Box ES1), where there were cases of undocumented migrants being given care despite the 2012 reform of the law that denied them treatment.

Sometimes leniency was more about administrative capacity than about giving access to those most in need. For example, in Ireland entitlement to medical cards giving older people access to public healthcare was removed from those with an income above a certain threshold. In practice, however, many people held on to their old cards and no system was put in place to check whether they were still entitled to free or subsidised care.

Pros and cons of exemptions

It is clear that extended and continued coverage has been key in maintaining and increasing access to healthcare services for groups in vulnerable situations. Nevertheless, with limited budgets, there is limited scope for such exemptions, and they should thus be carefully chosen. The risk is that through often incremental changes, groups that find themselves in vulnerable situations are not identified. For example, sustained reliance on exemptions based on an income threshold may miss new groups of over-indebted people at risk of reduced access to healthcare.

Furthermore, legal entitlements do not always ensure that they really reach the groups targeted. In Portugal, patients must request proof of their income from the tax system beforehand. They need to be aware that the exemption rule applies and that renewal is required, and they must have a valid home address. Proactive systems that find their way to people in vulnerable situations are important, rather than relying on people to find their way through the system. Sometimes concessions may need to be made to minimise administration (Box PT2). Effective information provision is important as well (Box PT3). Another example comes from Slovenia, where many newly unemployed were left without mandatory insurance, even if they were entitled to it. Ending up in a situation they were unfamiliar with, they failed to comply with the eight-day deadline to change their status. The number of uninsured thus rose to over 11,000 in 2011. Because the national health insurance fund proactively started contacting people who were without the mandatory insurance for 20 days or more, this figure was reduced to less than 3,000 by 2013 (Planet Siol, 2013b).

By adding new exemptions incrementally in response to the crisis, the system may become more complex and expensive to manage. People in vulnerable situations may be unaware of new exemptions in particular. After a new exemption is introduced, take-up needs to be closely monitored to be sure the measure is effective in practice. For example, the health vouchers in Greece were expected to cover 230,000 uninsured citizens during the 2013–2014 period. By mid-January 2014, only about 21,000 vouchers had been granted although there had been over 70,000 applications.

Leniency from service providers to patients, while problematic from various points of view, has clearly sustained access to healthcare for some people in the EU. While leniency may not be applied equally, it does at least allow selective exemptions when staff feel the exemption is justified. Besides facilitating discrimination, inequality in applying leniency can also remove the logic behind systems. For example, it can lead to increased use of expensive emergency care for non-urgent cases. In a survey conducted as part of this research among 20 hospitals in Greece, it also became clear that some people attended for emergency care outside of office hours, knowing that administrative staff

would be absent and copayments less likely to be enforced. In the case of Portugal, the perception that hospitals show greater leniency in waiving copayments than primary healthcare centres seems to have contributed to low-income groups bypassing primary care in favour of emergency services.

It can be hard for governments to establish which groups need to be supported in accessing healthcare services when setting rigid exemption criteria, especially in a situation where new groups of people in vulnerable situations are likely to emerge who are hard to define.

Governments could gather information from service providers to establish which groups of people are having difficulties accessing healthcare services. By stimulating transparency of leniency (service providers currently tend to hide it in their books), governments could use this information to convert these ad hoc exemptions into more systematic, well-targeted policies. This approach might also identify new groups in vulnerable situations.

Such systematic policies may be necessary, not only to avoid inequality in the application of leniency, but also to avoid reliance on informal mechanisms which may, ultimately, be abolished.

Reducing non-essential inpatient care

Steering people from inpatient facilities towards less expensive forms of care can free up resources and improve access. This can also benefit people with reduced access to hospitals if alternative forms of care are well developed. Three trends can be distinguished:

- reducing hospital stays by steering people towards outpatient care;
- deinstitutionalisation of people with disabilities or mental health problems;
- keeping older people longer in their own community.

They are longer-standing trends, but sometimes accelerated in the context of the crisis to mitigate its impacts. These trends are overlapping, but each comes from a somewhat different rationale. The last two have large non-healthcare components, but are also closely connected with healthcare. The focus here is on the healthcare aspects, but some comments will also be made about long-term care where the distinction between healthcare and non-healthcare is blurred.

Accelerating reduction of hospital stays

There has been a long-standing trend to cut costs by reducing the length of relatively expensive hospital stays. This trend has sometimes been accelerated by the crisis as a way to sustain service delivery and thus access.

Some hospitals shifted to outpatient or ambulatory care (Box LV2; PT2; SE3; RO2; Estonia: see HOPE, 2011), contributing to sustained service delivery. This shift was sometimes more because of immediate pressure on budgets and overcrowding (Box SE3) and sometimes a conscious strategy by the healthcare provider or the government (Box LV2; PT2).

In Latvia, the number of people receiving home care increased by more than 40% to 7,328 persons between 2009 and 2011 (Ministry of Welfare Latvia, 2011). This can be partly explained by active government action to stimulate home care, by including home care for the chronically ill in the benefit package from 1 January 2009 to reduce costs by diminishing demand for inpatient care. Initially, the eligibility for statutory home-care services was based on the list of medical diagnoses (including certain oncology and psychiatric diagnoses). From early January 2011, this list was

replaced by broader eligibility criteria: patients with a ‘chronic disease and functional disability’ and patients ‘discharged from hospital or day hospital after surgery’ were entitled to receive home-care services. From the end of June 2012, rehabilitation of patients after a stroke was added to the statutory home-care services, provided that the rehabilitation is initiated within six months of the stroke. In 2012, 1,081 stroke patients received rehabilitation services at home. In the first half of 2013, there were 848 stroke patients receiving rehabilitation services at home. In 2013, there were 67 providers of home rehabilitation services.

Accelerating deinstitutionalisation

Deinstitutionalisation of people with disabilities, who on average need healthcare more often, and of people with mental health problems is also a longer-standing trend. It is driven mainly by human rights arguments.

The case of Latvia can be highlighted as one where deinstitutionalisation was clearly accelerated as a mitigating measure, with cost-reduction playing an increasingly important role. In Latvia, although medical home care represents only a small fraction of outpatient care, during the crisis it became increasingly used as a substitute for inpatient care, including institutional care with large healthcare components. As mentioned, people with mental health problems (2009) and with disabilities (2011) became entitled to home care. The scope for home psychiatric care and care in day-care centres was also expanded. At the same time, financial incentives were introduced to shift patients from psychiatric hospitals to social care institutions, creating further potential for reducing the use of inpatient facilities (World Bank, 2010). This was a response to the financial crisis and the subsequent decrease in the available financial resources for healthcare, in particular for inpatient care. It was also consistent with the general strategy of shifting resources to outpatient settings and using them in a more cost-effective way. In Latvia, both the number of mental healthcare facilities and available beds fell between 2007 and 2011. The decrease in the number of beds over the last few years is in line with the ‘Basic principles on improvement of mental health for the population in 2009–2014’, prepared by the Ministry of Health in cooperation with the World Health Organization. The basic principles recommended that the number of psychiatric hospital beds should decrease by 3% per year in the 2009–2014 period and that care should be shifted to outpatient settings (Government of Latvia, 2008). The crisis was a factor behind the reduction in the number of beds in mental healthcare facilities, but it also caused the full implementation of the basic principles to be temporarily suspended between 2008 and 2010 (Government of Latvia, 2013).

In Sweden, between 1991 and 2011, the number of beds in mental healthcare facilities was cut as part of a longer-term deinstitutionalisation strategy. This development has continued with increasing speed in the wake of the crisis.

Accelerating care of older people in the community

Older people are more likely to have a mental health problem or disability, and are more often hospitalised, so the previous discussion particularly concerns them. Governments have actively sought to keep older people longer in the community, to improve their quality of life and so reduce public expenditure. During the crisis, some governments have accelerated this policy as a way to mitigate the impacts of the crisis. Here, the focus is on initiatives that reduced inpatient care.

In some cases, the initiative is taken at the more local, or healthcare provider, level. An example comes from Sweden (Box SE2), where the Skåne region in southern Sweden struggled to balance budgets by closing a hospital ward in Lund, mainly for elderly people with chronic diseases, and

transferring patients to a new, smaller ward in Malmö. Facing a shortage of beds, Skåne focused on increasing the number of home-care services instead of increasing the number of hospital beds. It also aimed to improve access for elderly people facing geographical barriers. More home-based healthcare has helped to relieve the pressure on hospitals and specifically on emergency wards.

Another example comes from Ireland, where a service provider has sought to reduce demand for inpatient care by cooperating with community care providers and another hospital to encourage more outpatient and community care for elderly people. This has allowed the elderly people to stay longer at home or in assisted living arrangements (Box IE2).

Pros and cons of accelerating trends of decreased inpatient care

Accelerating these three important trends can be judged as positive overall, both helping to maintain access to healthcare services and improving quality of life for patients and people with disabilities. Nevertheless, the effectiveness of these trends depends on whether alternative services are well developed, and one should be cautious about assuming that speeding up these trends has been entirely positive.

In the short run, deinstitutionalisation often needs investment to develop adequate alternative care services. Given the crisis, there are limited resources for such investment and cost-containing approaches may not only lead to lower-quality care, but also to higher costs in the long run. When healthcare needs are not met, the need for more prolonged and extensive care can escalate. Reducing hospital stays can free up resources to maintain access effectively only if home, ambulatory and outpatient care services are well developed.

Yet, for example, reduced availability of resources in the crisis has sometimes made it hard to purchase vehicles for healthcare service providers to improve home care (Box PT3). Furthermore, simply cutting the number of beds does not necessarily reduce costs (Box LV2), in particular if the infrastructure around the beds is not adjusted. Similarly, the acceleration of deinstitutionalisation has the potential to be a mitigating measure when community care is well developed. Where this has not been done, deinstitutionalisation has led to situations such as in a case in Greece where, following closure of several wards in public psychiatric hospitals (such as the Dafni Psychiatric Hospital in Attica), residents were transferred to inpatient facilities at short-stay clinics.

Decreased demand for nursing home care, as observed in Greece, Hungary and Latvia, does not necessarily imply that options for home care were successfully adopted. Interviewees reported that elderly people, many with chronic diseases, were kept at home with their families or had relatives move in with them, partly because their pensions proved an important contribution to household income (Box EL3; HU3; Latvia; see section in the previous chapter on the ‘Situation of specific groups in vulnerable situations’).

Solutions for retaining and motivating workforces

Retaining, attracting and increasing productivity of staff

Some service providers see staff shortages as the most immediate threat to healthcare access in the context of the crisis. Different solutions have been sought, including facilitating housing and flexible contracts with medical personnel working in two or more locations (Box RO2; SI1); providing work clothing; stimulating professional development; offering financial incentives for healthcare staff; and funding medical training under the condition that the staff member should remain at the healthcare facility for some time (Box BG1; EL3). Facilitating bottom-up voluntary initiatives (Box PT2) and

providing transparent information about the financial situation of the healthcare service to staff (Box SI3) can also contribute to staff motivation.

Increasing output of staff has also contributed to maintaining access. Some interviewees reported that this often meant increased workload. Sometimes increased work was required instead of salary cuts (Box SI1; SI2), while in other cases salaries were cut and staff had to do work done by former colleagues who had not been replaced (Box ES1; PT1) and/or cover increased demand (Box RO2).

In some cases, increased output involved work reorganisation such as assigning a few hours to ambulatory care for inpatient staff (Box RO2). A text-messaging (SMS) system reminding people of appointments and making clear they should cancel if they could not attend was designed to cut wasted staff and treatment time (Box IE1). Some e-health initiatives also allowed doctors to make effective use of the time between face-to-face consultations and breaks (see p. 39 and Box PT1).

Drawing on less costly workers

With restrictions on hiring new staff presenting a key obstacle to maintaining access, several service providers have started to depend more on less costly labour.

One of the case study service providers has increased reliance on trainee doctors (Box RO2). A public employment scheme, providing low-paid jobs to unemployed people, was drawn upon for non-medical support tasks by another service provider (Box LV1). Temporary contracts were also used by some of the case study service providers who were trying to maintain access amid cuts (Box RO2).

This research does not focus on volunteering and charity services. Nevertheless, they have played an important role in maintaining access during the crisis. Some service providers made up for a loss of personnel by relying more on volunteers (Box ES1; HU1). Organisations such as Doctors of the World and the Red Cross have long facilitated access to healthcare, for example through their clinics, and demand for their services has increased in many locations in Europe during the crisis (Doctors of the World, 2012; IFRC, 2013).

The crisis has also triggered new initiatives. For example, in December 2011 the Metropolitan Community Clinic was founded at Elliniko in Athens to provide care to poor, uninsured and unemployed people. The clinic is one of 40 community clinics that operate across Greece, providing mostly primary health services and medication free of charge to people not able or not eligible to use the public services. Also, since February 2012, 300 doctors in the Social Mission Infirmery in Athens, established by the Church of Greece and the Greek Medical Association, have provided healthcare for uninsured people.

In Luxembourg, the European Anti Poverty Network Lëtzebuerg regularly covers the cost of basic insurance (€107 per month since October 2013) for those who do not have an address. Another example illustrates a trend of drawing on the retired workforce (Eurofound, 2012a). This has happened in Slovenia, where pro-bono outpatient clinics are run mainly by retired medical staff on a voluntary basis (Box SI2); in France, where there is a similar initiative run by the Hospital Federation; and in the UK, where some healthcare services encourage their employees to stay on after they reach the pensionable age to maintain staff levels in light of moratoriums on hiring new staff.

Pros and cons of workforce measures

In retaining and motivating the workforce, it is important to recognise that not only salary counts, especially when staff understand that cuts are made as a result of the crisis. Opportunities for

professional development, sound incentives and a good work atmosphere are also important. While these are hard to sustain in the context of cuts, they may be easier to improve than salaries. Other measures aiming to retain and recruit healthcare staff include management interventions to improve the work environment, family-friendly policies, flexible hours, continued professional development and improvement of physical environment (including equipment).

Increased workload has probably led to decreased quality of services, for example in time spent per patient. It also raises the risk of stress among healthcare workers (Box PT3). Whether increased reliance on volunteers, trainees and less costly lower-skilled workers leads to concerns about quality depends on how carefully work processes and division of work are planned. With increased workload and wage cuts, adherence of staff to volunteer-based initiatives may decrease (Box PT1).

Economising on operating costs and processes

Economising on cost

Faced with reductions in budgets, service providers have sought to economise in various ways, trying to minimise the impacts of decreases in access to, and quality of, healthcare. Healthcare providers have economised on utility bills and, for inpatient care, on food for patients (Box LV1; LV2; Spain). Additional services not required by minimum national standards have also been scrapped, such as psychiatrist and physiotherapist services for residents in a Latvian nursing home (Box LV1). For some healthcare providers, research activities were reduced to cut costs (Box EL1; SE1). In addition to economising within their own budget framework, some service providers have also actively reduced costs for patients by efficient reuse of used yet functional equipment (Box PT2).

Increasing efficiency of processes

Healthcare providers have also provided staff with incentives to economise, but also to increase their productivity. Examples include making staff income dependent on the financial performance of their departments (Box BG1), and getting them involved in reorganisation by creating teams to rethink processes (Box SE3).

Incentivising access

Governments have also incentivised healthcare services to improve access. Allocation of subsidies to service providers has been made dependent on effectiveness in terms of access to healthcare, which is measured by monitoring certain indicators. In Portugal (Box PT3) and Sweden (Box SE2), implementation of such indicators has coincided with the crisis. Two examples from Sweden are the 'healthcare guarantee' (*Vårdgaranti*) introduced in 2005, which prioritises 'first time' patients by guaranteeing them access within 90 days (Box SE3), and the 'Queuing billion' (*Kömiljarden*), a subsidy system created in 2009 to decrease waiting times. In Portugal, access-related targets are agreed between primary care providers and the Ministry of Health; for example, in case study PT3, one of the targets for 2012 was to 'provide 85% of pregnant women with a GP consultation within the first three months of pregnancy'.

Pros and cons of economising measures

Mitigating measures to cut costs and make processes more efficient have allowed several of the service providers in this study to sustain services, or at least to avoid more drastic reductions in accessibility. The crisis has encouraged healthcare providers to find beneficial efficiency gains by making better use of resources. Nevertheless, when this search for cost-efficiency goes beyond a

certain threshold, it is evident that compromises are made on quality. This may not apply to the core service delivery, but may affect the overall quality of facilities.

Short-term thinking can lead to higher costs in the long term, particularly when economising takes place from day to day without a macro-level strategy. Nevertheless, initiatives identified in the case studies that increased efficiency often came from service providers, which may be best placed to select appropriate measures, but may lack the time and oversight to develop such strategies.

Financial incentives to provide good access have potential. Nevertheless, in practice, it is hard to design and implement sound incentive systems and to avoid adverse effects or unintended consequences. The two Swedish measures mentioned above have been effective in achieving their specific objectives, but in the context of reduced resources and increased dependence on income on reaching these goals, they have risked crowding out patients who return with potentially more urgent conditions. Indeed, Sweden's National Board of Health and Welfare released a report to follow up the 'healthcare guarantee' between 2009 and 2011, and criticised the fact that the reform has not produced favourable outcomes for people with chronic diseases and co-occurring illness, with its focus on first-time patients.

Seeking new funding

Obtaining funds from other sources

With public budgets and reimbursements being cut, healthcare providers have sought to increase income from other sources. Some have successfully increased income by getting involved in research projects (Box EL2; LV3). Others have looked towards charity funding and assistance (Box EL2). EU funds have been important for training and some investments (Box BG1; EL2; HU1). In Hungary, about €1.4 billion went into infrastructural investment in healthcare in the 2007–2013 funding period. Twenty outpatient units (internal medicine, surgery, obstetrics and gynaecology, and paediatrics) were established between 2010 and 2012 in rural subregions which previously lacked capacity (Elek et al, 2013), county hospitals were refurbished and new hospital wings were constructed. Also, for example, a Swiss contribution of €100 million was spent to improve access to primary care in remote areas of Hungary.

Funds have also come from patients. Providers have replaced income from government subsidies with income from patient payments set by the government (Box LV1), or have introduced charges themselves (Box HU1). Some healthcare providers have started charging for catering (Box ES1), or offered services such as 'VIP rooms' or special meals (Box BG1) for patients who can and want to pay for them, allowing cross-subsidising of less profitable treatments and sustained service delivery for groups in more vulnerable situations. Overall, in Bulgaria, public hospitals started to charge patients for their choice of doctor, effectively formalising the informal payments that were already being paid.

Funding has also come from local businesses (Box HU3). A case study in Greece (Box EL4) illustrates the funding structure for a healthcare service based on a network of local partners. It shows some role for the government in its initial phase, but an important part was also played by funding from private providers aiming to take over fully in the longer term.

In some cases, governments sought to increase the tax base: Hungary introduced a public health tax in 2011 on food judged 'unhealthy', with high sugar or salt content, and part of this revenue was earmarked for healthcare.

Accessing other public funding and indebtedness

The impacts of the crisis on access have also been mitigated by shifting budgets. Transfers of budget from central government avoided cuts in expenditure which may have affected access (Box LU1). Local governments, especially when owning the healthcare facilities, have also stepped in with their budgets to supplement reduced funds from other government spheres (Box HU3; RO2; Latvia). Providers themselves also transferred funds between budget items, or reserves were used (Box SI3). There have also been accounts of accumulated debts (Box BG1; PT1; SI2; Latvia), and of moving expenditure to the next budget year.

Some governments have shown leniency towards healthcare providers who overspent their budgets. Sometimes this was done generally, such as in Ireland where a €360 million supplementary budget was provided in October 2012 to compensate for overspending, and in December 2013 another €119 million was added. On other occasions, such leniency was applied more selectively, at the individual requests of service providers or in response to the individual needs of patients (Box HU2; LV1; LV2; RO1; Bulgaria).

Pros and cons of new funding sources

Services that have had funding cut and have replaced this funding via other public funds or by incurring debts may be seen as relatively unaffected by the crisis. Nevertheless, they may be concerned about the sustainability of these new funding streams, sometimes incentivising them to explore additional funding sources (Box BG1; LU1). Furthermore, funding may not solve all access-related problems. For example, EU funds in Hungary have been used to improve healthcare infrastructure; while this improves access in terms of distance to services, it may do less to address lack of access due to staff shortages and cost of treatments.

Leniency of governments towards healthcare providers, similar to leniency of service providers towards users (see earlier section on 'Extended and continued coverage of groups in vulnerable situations'), carries similar advantages but also disadvantages of being inconsistently applied and based on political ties. Yet it allows for discretion and flexibility when more budget becomes available than foreseen.

In the case studies, successful replacement of funds has depended particularly on establishment of effective alliances with local governments, NGOs and businesses (Box HU3). Seeking new funding to maintain or improve access has the advantage that there is less need for economising and thus risking reduced quality. Seeking additional funding from patients who can pay more, or from local businesses that may want to negotiate priority treatment for their workers, may create inequality in the system. Nevertheless, this also allows for cross-subsidising access for people who may otherwise not get it, and this seems a common occurrence among various service providers examined (Box BG1; SI2).

Promoting less costly types of service provision

Several of the mitigating measures identified in the case and country studies are related to improving access by focusing on relatively affordable ways of service provision, on providing at least some basic level of services, on accelerating longer-standing trends in shifts from specialist to primary care, or on increasing the use of information and communication technologies (ICT) for more affordable types of service provision.

Keeping basic services accessible

Some cuts in services have been accompanied by the establishment of an alternative, scaled-down service to address immediate needs or to facilitate accessibility of at least some basic services, often focusing on emergencies (Box RO1; SE1; see later section on ‘Keeping emergency care accessible’). Such ‘replacement services’ were sometimes implemented as conscious strategies by governments or service providers. In other cases, they were created only after learning from the consequences of closure (Box IE1), sometimes induced by public pressure (Box SE1).

When demand has increased (Box EL1; EL2), basic services have been established or maintained to ensure timely access regardless of lack of resources. An example includes basic group sessions for people with psychological problems, which were set up in an area in Slovenia particularly affected by the crisis (Box SI3), and by a mental healthcare provider in Greece and Spain (Box EL1; ES1).

Some people in need of healthcare have faced increased inability to pay for transport and, if needed, overnight stays in the area of the closest healthcare provider. Furthermore, some hospitals have closed, particularly in remote areas. To facilitate access for patients in such areas, small and sometimes mobile medical units can help (Box SE1; SI1). An example from Latvia includes the ‘feldsher points’ (doctors’ assistants or clinical officers located mostly in rural areas) which already existed before the crisis, but have since been strengthened to maintain access to basic services. In Bulgaria, in some areas where hospitals closed, additional doctors’ surgeries were opened at emergency medical help centres.

In some cases, the basic services consisted of information provision. For example, a healthcare provider in Portugal noted a shift in the type of demand with changed causes of healthcare needs due to the crisis (Box PT3). It responded by developing tailored basic information services, partly dealing with the underlying non-healthcare needs of this increased demand, to improve support for these patients and to increase efficient time use of medical staff.

Placing emphasis on primary care

Directing patients to primary care, rather than more expensive specialist care (and use of emergency care for non-emergency needs), has been a long-standing effort, mainly motivated by the pursuit of increased efficiency of the healthcare system and reduced expenditure on specialist care (Saltman et al, 2006; European Commission and Economic Policy Committee, 2010). The results from this study show that this trend was sometimes accelerated in the context of the crisis to maintain access.

Some measures focused on incentives for patients. For example, in Latvia, copayments for specialist care were increased, but not for primary care. In Portugal, copayments for both primary and emergency care increased, but in absolute terms increased more for emergency care, aiming to encourage use of primary care over emergency care. In both countries, these measures followed recommendations of the IMF/World Bank/EU troika.

Minimum access measures for groups in vulnerable situations have focused on guaranteeing access to primary care. The health vouchers in Greece and ‘GP only cards’ in Ireland discussed previously are other examples (see earlier section on ‘Extended and continued coverage of groups in vulnerable situations’). In Sweden, a cost limitation was implemented for primary care, with future visits in the same year being free of charge after SEK 900 (€98). Mitigating measures aimed at directing patients towards primary care rather than more expensive forms of care sometimes went beyond financial incentives. One service provider recognised that it was hard to change the habit of people going to emergency care rather than to primary care, and sought to do it by increasing primary care opening

hours (Box SE2). It also located the primary care unit close to the emergency care unit to increase the confidence of patients in the quality of primary care.

Other measures focused on service providers. In Romania, the total value of commissioned services has been cut for hospitals, but less so for primary care. In Latvia, primary care saw relatively small reductions while hospital and secondary ambulatory care services experienced the largest cuts. This was part of an explicit strategy to increase use of outpatient surgery and other alternatives to hospital stays while protecting primary healthcare services (Hou et al, 2013). Capacity was also strengthened, for example by funding made available in 2010 for an additional nurse at primary healthcare service providers in Latvia.

Moving towards ICT-based services

ICT has also served to lessen the impacts of the crisis. The potentials of ICT such as telehealth, remote monitoring and telecare, for example in keeping older people longer in the community and providing healthcare at home, are well known (Carretero, 2014). Here, examples are highlighted where ICT played a role in minimising the impacts of the crisis on access to healthcare services.

Basic information phone lines were established or stepped up, and awareness of their availability was raised after the closure of a hospital in a remote area in Sweden (Box SE1). The Latvian Social Safety Net Strategy also included the development of a family doctor advisory telephone service. Web portals or email systems have facilitated access for people in remote areas by sending digital images of the patient's condition from primary care providers to specialists in hospitals, allowing for remote diagnosis (Box PT1; RO1). In some countries with smaller healthcare budgets, short-term savings were made and few new investments were needed (Box PT1), or external funding was available (Box RO1). In some countries with larger healthcare systems, certain national strategies have been stepped up (Box ES1; LU2).

ICT has also been used to maintain or improve access by informing users. Confronted with increased numbers of people who typically have more difficulty finding their way to healthcare services and who have low awareness of their entitlements (migrants or those new to need), some providers developed improved information services. The University of Athens is developing a website aimed at migrants, mapping available health services (public and run by NGOs) and social insurance funds in Greece, and describing the healthcare access rights for each category of migrants (legally resident migrants, undocumented migrants, refugees and asylum seekers). It gives details of the relevant cost-sharing fees and lists symptoms of the most frequent or dangerous infectious diseases. The website also gives advice on prevention, treatment and occupational health.

Pros and cons of less costly service provision

Scaled-up basic service provision has played a role in mitigating the impacts of the crisis, in particular by maintaining basic services when other services were closed, facilitating access for people living in remote areas with decreased affordability to reach a service provider located further away and to reduce pressure on healthcare providers. The effectiveness of these measures hinges on whether the basic care is appropriate, on the follow-up and on effective referral when patients need further care.

In some cases, the basic service may be the best possible option given the budget constraints. Nevertheless, if people in areas affected by closure of services need to rely on local services from a GP, this can be problematic for people with more specialist needs. Problems can be lessened when pre-empting increased reliance on basic GP services, for example because of a hospital closure, by increasing capacity of these basic services (Latvia) or by establishing an emergency ward. Otherwise,

increased reliance on basic services may be a problem, in particular when these services are poorly equipped, such as GPs in Romania with 80% of them having no emergency kit (WHO, 2011).

In other cases, budgetary pressures may have encouraged service providers to redesign their services in ways that guarantee delivery of timely basic services which may be more effective than the original. Examples may include group sessions for people with mental health problems stemming from the effects of the crisis, showing them that they are not alone, and effective and comprehensive information provision. When the basic service provision concerns information provision, this can remove pressure from healthcare services and free up resources for improved access. When information provision more effectively guides people to healthcare services, it increases demand in the short run, while potentially reducing demand in the longer term by avoiding the escalation of medical conditions.

Increasing prioritisation

Governments and service providers have sometimes aimed to lessen the impacts of the crisis by focusing resources on what they see as the most urgent services, patients and groups in vulnerable situations.

Scaled-up screening and more selective service delivery

Several service providers examined in the case studies faced with budget constraints have become more selective in providing services. Costly services have been delivered to those people identified to be in greatest need (Box ES1; LV2), and increased demand for services has been counteracted by stepped-up, early screening (Box EL1; PT1). In some cases, government policies motivated such triage. In Latvia, capped budgets for service providers were accompanied by more resources for attendance of certain prioritised groups (for example, children and pregnant women). Furthermore, proactive screening took place by an additional nurse at primary healthcare providers under the Social Safety Net Strategy, whose tasks include identifying needy patients registered with the GP.

Responding to increased specific urgent needs

The crisis has brought changing demands for healthcare services. Access is particularly at risk when demand increases or the type of demand changes, and healthcare services are poorly prepared. Some examples emerged of prioritisation of certain services, increasing funding even during the crisis. In Sweden, in the Skåne region, an increased prevalence of mental illness was observed, especially among young people. In response to that, about SEK 100 million (€10.9 million) has been invested in new measures, including telephone helplines and increased contact with doctors for this patient group.

Keeping emergency care accessible

In several countries, regardless of increased difficulties in accessing healthcare services, emergency care is provided free of charge for the user, and if a person is uninsured they can purchase social health insurance when the need arises, without incurring any penalty. In countries where this has been sustained during the crisis (Bulgaria, Slovenia and Spain), it has proved to be an important entry point to services for groups in vulnerable situations. This has also been the case when emergency care was not free, but copayments have not been enforced for patients in need (see earlier section on ‘Sustaining or expanding leniency’).

Maintaining access to emergency care has also served to maintain access to healthcare to some extent where hospitals have been closed. For example, in a Swedish rural area the closure of a clinic was eventually accompanied by provision of an additional ambulance and better access information (Box SE1). In a Romanian county, two hospitals were closed, but one was replaced by a basic emergency care unit (Box RO1). In Latvia, capped budgets for service providers were accompanied by more resources for emergency care.

Pros and cons of prioritisation

Prioritisation has the potential to effectively mitigate the worst impacts of the crisis on healthcare access, in particular if combined with scaled-up screening, basic service delivery for patients with apparently less urgent needs, and a focus of resources on patients with the most urgent needs. Nevertheless, it will inevitably reduce access for less urgent cases if basic service delivery is not scaled up enough. This strategy of increased prioritisation also risks ignoring less urgent cases, potentially leading to escalating conditions, or missing some urgent cases if screening processes are insufficient.

Lastly, keeping emergency care accessible in theory only for truly urgent cases may lead to it being used as an entry point to regular care by uninsured people. Resources may be better allocated if these people had better access to cheaper and more appropriate forms of care.

5

Discussion of main issues

Impacts of the crisis

Limited budgets and difficulties in accessing healthcare services are not new; they should not be too easily attributed entirely to the crisis, and are unlikely to ever disappear altogether. The crisis has been one influence on hugely complex systems, interacting with, and sometimes dominated by, other major drivers of change in healthcare. Furthermore, when a country's healthcare funding was cut, this sometimes left certain services untouched, even in countries affected strongly by the crisis. This report has focused on service providers which were impacted by the crisis, and in describing the consequences on health it has also focused on the negative impacts, as these were judged most relevant from a policy perspective.

It is evident from the results of this study that many people have experienced difficulties accessing healthcare services as a consequence of the crisis. This is even the case in countries whose healthcare systems have been largely spared from the effects of the crisis, and where survey data do not show clearly worsening access on average. People have been affected by the crisis at the healthcare-provision level, in terms of reduced coverage or availability, in certain areas of the country. Many have also been affected by impacts at household level in terms of increased need for healthcare services and reduced resources for accessing services.

The causes of problems with capacity differ across countries. For example, increasing waiting times for hospital services are a key problem in Slovenia and Sweden. Acceleration of staff shortages (in particular nurses and anaesthetists) is among the core problems in Bulgaria, Hungary and Romania. Decreased pace of investment in healthcare infrastructure is a key issue in particular in the countries that have had low public expenditure in healthcare long before the crisis, such as Bulgaria and Romania. Decreased healthcare facilities in some remote rural areas apply to all these countries.

It is hard to pinpoint specific population groups that have suffered most from reduced access to healthcare services as a result of the crisis. There are groups that have had access problems for a long time and the crisis has usually not improved that situation. Young people, and men in particular, in countries most affected by the crisis were most likely to become unemployed during the downturn. They can arguably be singled out as a group that has suffered both in terms of healthcare need and access to services. Still, this leads to the danger of overlooking women and older people impacted by the crisis who sometimes have particularly pressing healthcare needs.

An advantage of identifying groups on the basis of individual characteristics, such as demographics, ethnicity or sexual orientation, is that these groups are easy to define. Inevitably, however, this also implies generalising about groups that are in fact rather heterogeneous, and potentially missing those in the most vulnerable situations. This research, rather than focusing on individual characteristics, identifies people according to the situations they are in. Policies could be designed accordingly. Examples include groups who have experienced the following crisis-induced vulnerable situations that affect their access to healthcare.

- **Reduced disposable income:** There is a group of people who have experienced cost-related problems in accessing healthcare services, because the crisis has led to reduced income (from work or benefits), increased living costs or debt problems, including debts to local governments or sickness funds.
- **Loss of insurance:** This group includes people who lost employment in countries where the unemployed are not automatically insured, or lost benefits such as minimum income where this comes with insurance.

- **The ‘twilight zone’:** In several countries, copayment exemptions and free insurance coverage are available for several vulnerable situations, such as being retired, unemployed and earning an income below a certain threshold. Nevertheless, the crisis has created additional groups of people who fall outside the criteria for those exemptions, such as people who are self-employed but have very little work due to the crisis, people who experienced income reductions but are just above the threshold that entitles them to exemptions, or people who lost their jobs just before retirement in countries where retirees qualify for entitlements but the unemployed do not.
- **New situations:** This includes people who experience situations which are not (yet) accommodated for by healthcare protection policies. In most Member States, income-dependent exemptions exist to facilitate access for people on low incomes, but they do not take into account debt problems. This was a problem before the crisis but has been exacerbated by it. This group also includes people experiencing situations they are unfamiliar with, such as being ‘new to need’ or having moved to another EU country in search of employment, and who are unaware about their entitlements.
- **Reduced coverage:** This concerns people who lost coverage.
- **Need for services particularly affected by cuts:** Regardless of coverage, if the service needed by certain people has experienced particular cuts, they are at risk of reduced access.
- **Being part of an increased-need patient group:** People in need of a service for which demand has increased because of the crisis (in particular, mental healthcare and services which have experienced an influx from previous private healthcare users) are at risk of reduced access, especially where funding for such services has not increased.
- **Closure of nearby healthcare providers:** Where closure takes place in areas far away from alternatives, and where insufficient scaled-down ‘replacement services’ are established, access has declined. This study has identified areas with reduced access, in particular where smaller hospitals in rural areas have closed.
- **Decentralised financing of healthcare in geographical areas affected by the crisis:** People living in geographical areas that have been particularly affected by the crisis experience increased need for healthcare services. Public healthcare services face more financial problems where there is an increased need for healthcare in combination with decreased tax revenue for these decentralised geographical areas. In decentralised settings, national government structures are less likely to compensate. This should not be seen in isolation of a more complex picture, where long-term deficits were accumulating before the crisis but have come to the surface only more recently.
- **Staff shortages:** Among the poorest Member States in this study – those with the lowest GDP, lowest expenditure on healthcare and lowest salaries among healthcare staff (mostly those that have joined the EU since 2004) – the consequences of some longer-term trends, such as ageing (Bulgaria and Romania) and migrating healthcare workers, have been aggravated by the crisis. This problem affects deprived rural areas with small hospitals more than wealthier urban areas with large hospitals.
- **Discrimination:** There have been groups which have relatively often experienced discrimination in access to healthcare as in other areas of civic life. There are no signs that this situation has improved during the crisis. Some of these groups have increased in size as a consequence of the

crisis, such as homeless people and migrants, and there are reports that discrimination of certain ethnic groups has increased since the onset of the crisis.

The impacts of the crisis on access to healthcare services does not only come from the impact on households in terms of need and disposable income, and on healthcare services in terms of reduced resources. It also comes from reduced funds for social assistance and from reduced investment in other public services such as transport. It is important for policymakers to take a broad perspective.

There are trends in demand observed at the national level, where the crisis has had an impact such as decreased demand for nursing home services (Greece, Hungary and Latvia). Nevertheless, these national trends do not necessarily imply that every healthcare service provider in the country has experienced this; for example, care services in some nursing homes in Latvia experienced increased demand (Box LV1). It is important to keep this heterogeneity in mind when designing policies, and when being confronted with national average data.

The crisis has increased reliance on emergency care in some countries (Romania; see also Box BG1; EL5; LU1; SE2) because of the lower cost barriers to access. This has several risks. First, it is a relatively expensive type of care which may compromise financing of healthcare and thus access to other types of care. Secondly, because the threshold for accessing emergency care may be higher, because of distance or because people feel they should wait for a real emergency, some may postpone attending until health conditions escalate. Finally, when people access emergency care for non-emergency needs, the care they receive may not be the specialised care required.

It is important to look out for, and be sensitive to, unforeseen consequences of the interaction of the crisis with policies. These include changes in behaviour by populations impacted by the crisis. One example is elderly people staying with relatives or even leaving nursing homes if relatives need their pensions (Greece, Hungary and Latvia). In other countries, there are reports of people being kept longer in hospital, because relatives cannot afford to have them at home or because they have come from remote areas and have transport issues (Bulgaria; Box RO1; SI1; SI2).

In several Member States, the crisis has increased demand for public services partly because of a move from private to public, as people cannot afford private services anymore. However, even in countries where macro data at the national level suggest a move from private to public services, the dynamics are complex. Households have shifted both ways; even in countries most affected by the crisis, some people have moved from public to private services because of decreased price differences, perceived decreased quality of public provision, increases in income for some households, or increased pressure by doctors in public hospitals to have patients treated in the private clinics where they have second jobs. Again, these developments are not caused exclusively by the crisis and are interconnected with longer-term trends.

It is hard to assess how the crisis has affected under-the-table payments. In any case, such payments clearly make access more difficult for people whose income was reduced during the crisis. Because such payments are difficult to observe, it is also hard to identify the groups most affected by this. They may thus create groups in vulnerable situations that are unnoticed by policymakers.

Lastly, it should be reiterated that this research focuses on healthcare services. Cuts have also targeted preventive healthcare and healthcare administration. This has also impacted dependence on, and the capacity of, the healthcare system. The findings in this report should be interpreted within that broader context.

Mitigating measures

Some pre-crisis measures to enhance access for groups in vulnerable situations have been discontinued as a consequence of the crisis, but new measures have also been established by governments and service providers. Several of the ‘mitigating measures’ identified in this research concern processes that had already begun but in some cases gained urgency because of the crisis. This includes accelerating deinstitutionalisation in Latvia and e-health policies in Luxembourg. It is hard to gauge the precise impact of the crisis on these processes, but it is clear that the crisis has been used as an additional argument to step up efforts.

Smart reforms

When a government implements a cut, it can foresee to some extent the consequences for access to healthcare services. Anticipating them, governments should integrate mitigating measures in the reform itself to ensure access for groups in vulnerable situations, rather than relying on ad hoc measures in response to escalation, or leaving the issue unaddressed. Simultaneous implementation is likely to avoid escalation of medical conditions, loss of trust in government, additional cost associated with (re)establishment of ‘replacement services’ at a later stage, and overlooking certain groups. It should be acknowledged that rational policymaking is not always feasible, not least because impacts may not be clear at first sight. Trial and error can lead to reestablishment of specific services as mitigating measures (Box IE1; LV1; SE1). Available resources may fluctuate and politics play a role. Regardless, it is important to be aware that temporary lapses in services may leave long-term scars.

Access problems do not always come from explicit cuts in services, but may instead be the result of the impacts of the crisis at the household level. This makes it harder to foresee required measures and more likely that problems are responded to only when they emerge, if they are identified. For example, elderly people may remain longer at home because families need their pension income. If this trend is unrecognised and the decrease in demand for nursing home care is just taken as a welcome given, there are risks for quality of healthcare for elderly people that they may have easier access to from a nursing home. Properly designed mitigating measures, concentrated on improving community and home healthcare services, can both accelerate the decrease in demand for nursing home services and improve quality of life for elderly people and their relatives. In general, it is important to look beyond the numbers and keep an eye open for unexpected impacts and use them for smart policy design.

Reduction of inpatient care has great potential to lessen the impacts of the crisis, but only if supporting community care structures are well developed. Paradoxically, countries which have not seen decreases in demand for inpatient care may be in a better position to see the types of need for scaling up community care because the needs are more visible. Reducing reliance on inpatient and emergency care by encouraging patients to use primary and non-emergency care services has the potential to free up resources to improve access. However, at the micro level, service providers reported that decreased numbers of inpatient beds did not always result in immediate savings. Structures need to be rethought if such reforms are to free up resources for improving access. Again, investment, for example in home care, may be needed in the short run to free up resources in the longer term.

Several of the mitigating measures have an ICT element. Examples include increased emphasis on information lines and websites providing basic healthcare consultations and information to facilitate access; secured information systems to allow distant consultations by specialists for patients in remote areas; SMS systems to decrease non-show among patients and cut waiting times; and technologies which discourage informal payments. It is important not to overlook the potential of these relatively new ways of improving access to healthcare, and investment in the short run may free up resources in the longer term.

Setting the right incentives

Just like households, healthcare service providers react to financial incentives. Also in the context of decreased funds and – sometimes – increased demand, this research confirms that their response is greatly dependent on incentive structures. In Bulgaria, hospitals have incentives not to cut patient stays below the mandated minimum because they would then not qualify for reimbursement (Mavrov et al, 2013). They would also not develop outpatient care options as these were not reimbursed. In Latvia, service providers reacted swiftly by increasing outpatient and home-care services when these were encouraged by contractual arrangements.

Several of the mitigating measures actually reduce access to certain types of healthcare for some people, even if they aim to improve access to healthcare overall. Examples include the shifts to home, outpatient and day care, while simultaneously limiting access to inpatient care. Another example is stimulating primary care at the cost of specialist care. Access to healthcare should not be seen as a goal as such, but as a means to an end. So, if these reductions of access to certain types of healthcare lead to better health outcomes in more sustainable systems, that should be reflected in the indicators on which policy is based.

There has been a general trend in healthcare systems to make budgets of health service providers dependent on performance. The indicators used differ among Member States. The crisis has impacted on these systems, and in particular has increased the importance of receiving such payments for healthcare providers, thus placing growing pressure on them to meet the set objectives. While there are advantages to this, there are also risks when healthcare services experience decreased flexibility while in some localities it may make sense to compromise on one of the indicators. As discussed earlier (see Chapter 4 section ‘Economising on operating costs and processes’), there is increased need due to the crisis to focus narrowly on such financial initiatives, with potential downsides.

Risky mitigation

Most of the healthcare providers investigated in this study have relied on a mix of mitigating strategies rather than on a single one. Within one country, one provider has sometimes decided to implement different measures than another provider of the same type of healthcare service. As each healthcare service provider faces a different local context and a different organisational culture, it is logical that effective mixes of responses to the crisis differ. On the one hand, such flexibility can be facilitated and steered towards locally optimal choices. On the other hand, the cases displayed much ‘firefighting’, with service providers struggling to continue providing access while implementing day-to-day savings. While decentralised implementation of cuts can lead to creative responses fit for local contexts, the service provider cannot always be expected to come up with carefully designed long-term strategies, in particular when cuts are sudden and uncertainty remains.

It is important to be aware of the fact that initiatives have been taken in an environment where cost played a stronger role in the balance of decision-making; therefore, when more resources become available, risks may need to be reevaluated. Examples may include e-health with some risk of decreased data protection; rapid shifts from inpatient to outpatient care with some risk of patients not getting the care they need; and extreme forms of screening and prioritising with some risk of missing urgent cases. New bottom-up approaches may also have emerged, seeking regulation or quality control.

Alliances

Several of the mitigating measures of various types have come about by creating alliances. Such alliances have been formed within organisations, between staff and management, but in particular also with external stakeholders, including local governments, NGOs, other healthcare service providers and businesses. Such alliances have often been nurtured by need amid the crisis, but the results may be sustainable. They may not only have proved useful to lessen the impacts of the crisis on access to healthcare services to some extent, but may also contribute to improved future service delivery. For example, stronger links with NGOs may allow better identification of groups with unmet medical needs. It must be noted though that integration of services and inter-agency cooperation can also be hampered by the increase in workload because of the impacts of the crisis.

Pressure from various population groups, facilitated through organisations like NGOs, patient groups or service providers, can be effective in helping to improve access for these groups, and in identifying groups which have suffered most in terms of reduced access (Box HU2; SE1). For example, problems caused by the crisis stimulated several cancer patient groups to unite forces in Greece in 2012 under a 'Cancer Patient Rights Advocacy Committee', acting as a watchdog on measures introduced to curtail healthcare benefits. Such bottom-up initiatives can facilitate development of well-designed mitigating measures. Nevertheless, it is important not to overlook access problems among groups that lack a strong lobby infrastructure and that are not confident enough to voice their needs.

Alliances between public healthcare and other public sectors are also important. It should be recognised that broader social assistance, such as unemployment benefit extensions, public employment for those who do not receive unemployment benefits and effective minimum income schemes, can lessen the effects of the crisis on healthcare as well. People who are protected by such measures have better access to healthcare services. Investment in other services, such as public transport, is also key to maintaining access. It is important not to limit perspectives to the healthcare sector when seeking to mitigate the impacts of the crisis on access to healthcare.

Some of the increase in demand for public healthcare services has also come from non-healthcare needs, with alternative service providers probably being in better positions to provide support. Examples include primary care services that are faced with people contacting them about their deprivation and living standards, and mental healthcare services coping with anxiety crises due to job loss or debt problems. Where mental health problems are linked to unemployment, it can be questioned whether these patients would benefit more from investment in healthcare or from investment in employment inclusion. This is a legitimate consideration, but in the short run investment in mental healthcare may be needed so as not to lose sight of this group and as a precondition for their integration in the labour market. However, here it is also important to create alliances between the different sectors at the policy level, and also at the service provider level, between employment offices and mental healthcare providers. Similarly, for people with mental

health needs due to household debt problems, debt advisory services or effective policies to solve debt problems may be key to providing a long-term solution. For those living in deprivation, effective benefit systems and clear information about entitlements as well as simple application procedures may be more effective than a short-term healthcare response. Healthcare services may have to cope with decreased funding for these alternative services, but where possible prompt referral is all the more important for efficient use of services.

The crisis has reduced access to healthcare for many people across the EU. On the one hand, this is caused by reduced availability of healthcare services and reduced coverage. On the other hand, reduced access results from households' increased need for certain services and reduced disposable income. However, there are large differences among Member States. The broad range of policy pointers set out below is grounded in the results presented in this report. While some may apply more to certain contexts than to others, they serve to inspire policymakers.

- Many changes in the healthcare sector can be ascribed to developments other than the crisis. It is thus all the more important to think of the long term when implementing reforms, rather than thinking narrowly of the crisis context. It is also important not to attribute everything to the crisis, in order not to lose credibility. Recognising the real underlying reasons allows for appropriate solutions.
- This study has shown that the crisis has often had a strong immediate impact. Solutions may relatively often need to be short-term, being aware that longer-term scars may be left because of the crisis.
- Explicit reforms and cuts can be easily described, but implicit consequences of the crisis also have an impact. For example, it is important to be aware of the consequences of tougher enforcement of copayments by service providers, but also that enforcement may sometimes be an alternative to other measures such as increasing copayments.
- It is important to be aware that the impacts of the crisis do not only come from cuts in healthcare expenditure. Examples include reduced demand for nursing home healthcare services because elderly people remain in the community, contributing their pensions to the household income of their unemployed relatives, and the reduced affordability of transport services for people in remote areas using providers further away.
- Policymakers should consider countering the increased demand for relatively expensive emergency care and inpatient care among some service users, paying attention to:
 - increased reliance on emergency care by people for whom this provides a cheap and accessible entry point to the healthcare system, because copayments are low or relatively rarely enforced;
 - increases in inpatient care because of cuts in home care, requests from households to keep elderly people longer in the hospital because they cannot afford having them at home, limited transport options to return from the hospital to home, ill-thought-out financial incentives for hospitals, and lack of space in nursing homes.
- Well-thought-out investments in the short term, for example in ICT, self-help facilities and home and ambulatory care, may be needed to free up resources in the longer term while improving access and quality of care.
- People have moved from private to public healthcare, but also vice versa. It is important to be aware of the dynamics, and not only look at the net figures but also take opposite shifts into account when anticipating the impact of reforms.
- Cuts by service providers have often been incremental, focusing on easy targets such as discontinuation of temporary employment contracts or ICT. Policymakers should be aware of the impact on the general rationale of the healthcare system, for example reversing initiated trends that in the longer term would save resources.

- Governments have increased copayments, but have also implemented new exemptions from copayments or insurance coverage, or met increased demand for existing ones. It may be better to further overhaul and simplify such systems rather than incrementally adding more exemptions. It is important to avoid lock-in of old policies, inappropriate for the new circumstances.
- It remains important to focus policies on the numerous demographic groups which are relatively often in vulnerable situations. Nevertheless, the crisis has added new groups which have not been seen as vulnerable in the past: young people and men, who have been more likely to lose employment, and young families who have become over-indebted. This strengthens the importance of focusing on situations that are flexible enough to allow for unpredictable future needs.
- At the same time, policymakers should be careful not to overreact to new vulnerabilities due to the crisis, ignoring those who have been in vulnerable situations for a long time and whose access has further deteriorated as measures facilitating access have been cut during the crisis.
- Policymakers should be aware of the multiple potential causes of decreased access to healthcare. Care should be taken not to narrowly focus on financial barriers alone, but also to recognise, for instance, that poor knowledge of the healthcare system has become a greater obstacle to access to healthcare for some.

This research found several examples of measures taken by service providers and governments seeking to maintain access amid budget cuts. These examples inform the following policy pointers for service providers and policymakers.

- Integrate mitigating measures into cost-cutting policies, rather than react to problems in access that may be observed after reforms are implemented.
- Provide sound incentives for service providers, such as stimulating them not to keep patients in the hospital longer than needed, and to develop ambulatory and outpatient options where appropriate.
- Provide sound incentives for households, such as steering them towards less expensive forms of appropriate care.
- Invest in working conditions beyond salaries alone, increasing output and retaining staff.
- Ensure that deinstitutionalisation and reduced inpatient care are accompanied by investments in home care and outpatient care.
- Service providers have sometimes been lenient, treating patients who cannot pay. Governments have sometimes been lenient as well, funding healthcare providers who overspent budgets. Such leniency has maintained access for some people in vulnerable situations, but at the risk of creating inequity and low long-term reliability especially with decreased budgets. Policymakers can learn from such bottom-up identification of groups in vulnerable situations, designing more systematic policies to guarantee access.
- Formal exemptions and entitlements are not enough. It is important to ensure that they really lead to access through effective implementation and awareness raising.
- Several of the mitigating measures have reduced quality of care, and advantages and disadvantages need to be carefully assessed.

- Nurturing and communicating the importance of alliances with local stakeholders, including healthcare staff, is essential.
- Measures put in place out of financial pressure and without weighing up potential risks should be reassessed when financial pressure is reduced.

This report focuses on healthcare services, but prevention, access to medicines and social protection measures should not be overlooked. Preventive measures can mitigate the impacts of the crisis by reducing the need for healthcare services. It is of concern that cuts have also targeted these areas. Some benefits have come from reducing the cost and unnecessary use of medicines and encouraging the use of generics, but there are also reports of reduced access to essential medicines. Social protection measures such as improving housing conditions, improving employment options or guaranteeing a minimum income can reduce health inequalities and improve access to healthcare.

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Annex: Case studies

Box BG1 – St George University Hospital, Bulgaria

The St George University Hospital currently has 1,287 beds and 75,257 patients, up from 66,930 patients in 2007. It is located in the city of Plovdiv and serves the surrounding areas in the south of Bulgaria. The hospital has 35 clinics in two locations in the city. Its funding comes mostly from reimbursement of clinical pathways by the national insurance fund. Reimbursements are only received if patients stay the specified number of nights, a minimum of one night even for cataract or endoscopy examinations. Therefore, the hospital has no incentive to provide day care, and if a patient leaves early the hospital is not refunded.

As a result of the crisis, the hospital's maximum reimbursement from the national insurance fund was capped in late 2010 and early 2011. In late 2013, part of the reimbursements came with some delay. Some clinical pathways are relatively well reimbursed, while others are cross-subsidised. Emerging private hospitals have focused on these profitable pathways. This has created a challenge for public hospital finances. Because of competition with a new dialysis centre in Plovdiv, the hospital's own centre was refurbished and patients returned. However, smaller hospitals in the area are expected to close.

During the crisis, the hospital has had to deal with an increasing number of uninsured patients. Reasons for patients having no insurance vary. Some do not discover until they need treatment that their employer does not pay the required contributions and are not aware that they can check this themselves, or that they are involved in undeclared work. Some people choose not to pay for insurance and some simply cannot afford it. Roma people have traditionally been overrepresented among the uninsured.

Unemployment is largely responsible for the increase in the number of uninsured. Uninsured people are entitled to free emergency care and can then be admitted to hospital for long-term care. As a result, demand for emergency care at the hospital increased from 28,490 hospitalised patients in 2007 to 31,714 in 2013, but the hospital gets a fixed amount of funding for emergency care. When admitted, patients are encouraged to take up insurance immediately. If patients cannot pay insurance, there is a fund to support them. While no earlier data are available, in 2013 the hospital treated 1,107 uninsured patients, and 309 applications were made to the agency for social support of which 270 were approved. For the remaining patients, it proved difficult and expensive to enforce payment and the hospital had to cover their treatment costs.

During the crisis, almost all hospitals in Bulgaria started charging for special services and a patient's wish to choose their medical team. St George also offers VIP rooms, single rooms and a choice of meals for an additional payment. Regardless of these measures, its debts have increased because it continues to offer access for all patients.

As a response to the high turnover of staff, the hospital is committed to yearly pay increases of 10% for doctors' basic salary. It has also started offering bonuses to individual clinics, depending on their financial performance. Professional development has been identified as a factor that is as important as financial incentives for staff retention. Extra training was provided, with those trained passing on knowledge through a mentoring system.

Other incentive schemes have included giving staff new work clothing. Interviewees argued that this was more important than it might seem at first sight because it shows that the hospital's management cares about its workers. The hospital funds medical studies on the condition that these students work at the hospital after completing training for a specified period. These measures have decreased turnover, but there still is a shortage of some specialities. However, only for nurses and anaesthetists is this likely to be connected to migration to other countries due to the crisis.

Box EL1 – Vyronas-Kaisariani Mental Health Community Center, Greece

The communal mental health centre at Vyronas-Kaisariani, Greece, provides clinical services and rehabilitation, along with education and research. The following changes have taken place as a result of the crisis:

- salaries have been cut by about 30%;
- two retiring health visitors and three recovery-unit trainers have not been replaced;
- there is less income from research projects;
- increased demand for services – between 2006 and 2012, the number of first visits increased from 295 to 322 and the number of individual sessions from 5,910 to 8,392;
- since 2009, there has been an increase in particular in the number of students and middle-aged men among the patients;
- there was one recurring case each week in 2006, while in 2012 there was an average of seven due to the inability of patients to continue psychotherapy in private centres;
- the inability of nearby hospitals to treat mental health patients has also led to an increase in patients at the centre.

Reasons beyond the crisis also played a role in the changes, such as reduced stigma surrounding mental health issues due to education and increased public awareness about the centre. Before the crisis, patients could be seen immediately at the centre, but waiting times have gradually increased from one week in late 2010 to 75 days in late 2013. This is mostly due to the non-replacement of staff, but also increasing numbers of patients.

A triage system already in place before the crisis was formalised in 2010. A social worker, apprentice psychologist and health visitor assess the severity of each case and all cases are discussed in two weekly meetings. The service has also stepped up its home-care unit since 2009, being reinforced and refocused from simple information provision to functioning as an emergency and crisis assessment unit. In particular, it tries to keep patients in the community and help them to reintegrate by, for example, helping them obtain health insurance.

The centre has also established close cooperation with the non-profit organisation Doctors of the World (*Médecins du Monde*) to provide dental coverage to the uninsured, with doctors and pharmacies in the area, with local centres for the elderly and with private hairdressing schools. In addition, the centre has set up group sessions to respond to increased demand, with four groups for problems such as unemployment, drug addiction and relationship difficulties. The number of groups is being increased to reduce the workload of the centre's staff. Participating patients must not have major psychopathology. In 2013, one of the groups was free of charge because four of the 10 participating patients were unemployed or senior citizens with small pensions. For other groups, patients paid €10 per month.

Box EL2 – Hellenic Society for Disabled Children (ELEPAP), Greece

ELEPAP has six centres across Greece, with a range of services for children with physical disabilities and developmental difficulties. On a daily basis, over 1,000 children benefit from therapeutic, counselling and educational programmes. Since disabled people generally have higher healthcare demands, healthcare services are important to them. Specialists such as orthopaedic consultants, neurologists, paediatricians, psychiatrists, ophthalmologists and dentists are among the organisation's employees. Salaries have been cut slightly, and staff reduction has been modest, from 220 in 2009 to 210 in 2014. Of its annual budget (€7 million), about half comes from the social security scheme (€2–2.5 million) and the Ministry of Health (€1–1.5 million), while the rest comes from charity. During the crisis, payments from the social security scheme were delayed. Revenue from property investments has decreased. Government funding of investments has decreased.

The number of services provided has not decreased during the crisis, but rather expanded. The organisation has sought additional funding from EU research projects, entered into partnership with other local initiatives such as social pharmacies and sought other private funding sources. In 2008, it established a charity programme to encourage private donors to 'adopt a child', with the child remaining anonymous to the donor except for some basic information.

Box EL3 – Kallimanopouleio Ecclesiastical Ministry Center (KEDIK), Greece

KEDIK is a day-care and long-term nursing centre with 72 beds for people facing chronic diseases. In the rural area where it is located (Kalavrita, Western Greece), patients are mostly bedridden and chronically ill elderly people. Of 35 staff, 11 are nurses, two are general doctors, one a neurologist and one a physiotherapist. Before 2010, occupancy was always near 100%, with waiting lists. During the crisis, the rate has varied from 62 to 67 beds at the most. The number of patients has been reduced, but reduction of staff is not an option because the service would lose its institutional registration. Salaries were reduced by 5% in 2010 and 10% in 2011 for all staff, and by a further 25% (2012) for staff who earn above €1,020 a month.

Box EL4 – Social enterprises in the area of healthcare provision, Greece

In 2006, the municipality of Irakleidon on the island of Kos granted one of its buildings to the Ministry of Health to create a local health centre. The ministry would equip the building and hire the necessary personnel. The health centre was to be incorporated into the National Health System. However, there was a stipulation in the agreement that if the health centre did not start operations within three years, the building would return to the municipality. Due to lack of funding, the ministry has not put the health centre into operation, and the local population has no access to a primary healthcare structure. Kos is an international holiday destination with a tourist infrastructure of 110,000 beds, but tourists receive primary healthcare services through informal and/or illegal health centres, often operating out of hotels.

To remedy the situation, the municipality proposes to establish a social enterprise, whose board will be made up of individuals and institutions from the local community. It should be noted that under Greek law, the board members of social enterprises are not paid; 35% of the enterprise's earnings go to the employees, 60% are reinvested in the enterprise and the remaining 5% is used to increase the capital of the enterprise. The centre will be run in cooperation with the municipality. The municipality will fund the centre until the social enterprise can run it without external funding. A similar process has been tried on other islands such as Santorini.

Box EL5 – Survey among rural and urban hospital emergency units, Greece

A total of 19 hospital emergency units (9 rural and 10 urban) have provided data to better understand the impact of the crisis on access to healthcare services. During the crisis, the number of patients going to the emergency units of these hospitals had grown considerably, particularly in urban areas: 95% of the 10 urban hospitals had seen increases of between 10% and 35%, while 30% of rural hospitals had seen increases of 5% to 15%. The majority of respondents identified similar new groups of patients coming to emergency units: people with anxiety problems, depression and stressful situations (reported by 98% of respondents), uninsured young people (75% of respondents) and retired people with small pensions (68% of respondents).

This increase was triggered by patients being unable to afford private doctors and because some private doctors do not have agreements with the national health insurance. In addition, some patients prefer to avoid the long delays of inpatient hospital services. Most urban (90%) and rural (75%) hospitals said that the increase in patients was more evident during the afternoon and night. This is because many emergency units only have administrative staff on duty during the morning, and once they are gone no fees can be collected (€5 for each admission). This has also caused overuse of ambulances, which are free for the patient even if with hindsight it appears that the case was not urgent.

To cope with this increased demand on the emergency services, hospitals participating in this survey have implemented triage systems, intensive education and professionalisation of staff, online medical exams, increased involvement of support from volunteer organisations, savings in the administration of materials and control of expenses.

Box ES1 – Maresme Health Consortium, Spain

In Catalonia, cuts in the mental health budget, which began in 2010 with a decrease of 3%, came after a marked growth in the allocated budget between 2006 and 2010. This had a strong impact on staff, in particular on training provision and performance-related bonuses. Some staff moved into part-time work or took early retirement, but dismissals were not widespread. The crisis also impacted development of new infrastructures (such as additional hospital beds) already planned and budgeted for. Before the crisis, treatment of mental health disorders had been strengthened in primary healthcare centres through, for example, the creation of training groups in psychology for nurses, leaving specialised services receiving fewer referrals free to deal with more severe disorders. This trend has continued despite the crisis, although now there is more emphasis on issues such as the rationalisation of pharmaceutical drug use. Other reforms, such as the more widespread use of ICT – for instance, the use of webcams to communicate with patients and the sharing of patients' databases across institutions – were already in train but implementation was stepped up due to the crisis.

The Maresme Consortium in Barcelona provides mental health services for a population of about 400,000 people living in the Maresme area, a coastal area in the province of Barcelona. The area has high rates of immigration. As with other health services in Catalonia, it is a public enterprise subsidised by the public government on a capitation basis. Cuts in funding were first felt at the end of 2010, when there was no yearly budget increase of between 2% and 3%. In 2011, the budget decreased by about 10%. Staff were not laid off, but there was no cover for staff who went on leave.

During the period 2012–2014, six posts for psychologists or psychiatrists were lost, largely as previous incumbents retired and were not replaced. These posts constitute 15% of the total workforce in the mental health team at the hospital in Mataró.

It should be noted that, during this period, there was an increase in the demand for services. This was linked to the saturation of social services. People with problems as a result of the economic situation started to contact primary care centres and emergency health services. Interviewees reported that during this period there was no increase in suicides in Catalonia, although there was an increase in suicide attempts. There has been a significant increase in demand for child and adolescent mental health services. This is in part due to an improvement in early detection of mental health problems in schools, but also due to the fact that families can no longer afford to go to private providers for certain services, such as treatment for disorders such as anorexia and bulimia, and that there have also been more cases of family break-up.

To mitigate the increased demand for services, patients with severe mental health disorders such as bipolar disorder (about 25% of all patients) are prioritised, and there is a continuous monitoring of their condition to avoid the need to readmit them. Another mitigating measure is the more widespread use of group therapies rather than individual psychotherapy sessions. The hospital includes psychology students training at the hospital in these sessions to help with taking minutes or arranging them. ICT is also increasingly used to maintain contact with service users. ICT has the advantage that it is well received by young people. The hospital uses software that is being trialled and is therefore free.

Box HUI1 – Awakenings Foundation, Hungary

The Awakenings Foundation provides community-based mental healthcare services, covering Budapest and its suburban regions. It is linked to the Semmelweis University. The number of patients in community-based psychiatric care increased from 98 in 2009 to 250 in 2012. Interviewees said this increase mainly came from improved awareness of the services among its target populations. The social health insurance revenues were cut in two subsequent years: between 2008 and 2009 by more than 15%, and between 2009 and 2010 by almost 26%.

This first wave of cuts was offset by successful applications to the central government for the public financing of community social care, and to the National Health Insurance Fund for financing of chronic outpatient care for addiction disorders. The second wave of cuts reduced funding for chronic outpatient care for addiction disorders by around 9%. Furthermore, funding of community social care was cut by 64% between 2011 and 2012.

There were fewer successful applications for research project funding after the crisis, an important additional source of income, despite revenues from EU-funded training programmes in 2013. To sustain service provision, staff took temporary salary cuts of 20%. Two employees resigned and their posts were covered by increased involvement of volunteers (currently over 10 psychologists and psychiatrists, several of them students or medical residents). In the autumn of 2012, copayments were introduced: HUF 5,000 (€16.20) for the first consultation, individual or family therapy, HUF 2,000 (€6.48) for taking blood, an injection or medical examination, and HUF 3,000 (€9.72) for infusion treatment. Patients with financial difficulties can postpone payment, and payments are sometimes waived.

Box HU2 – Association of Physically Disabled Persons (MBE), Hungary

Along with other non-healthcare services, MBE is a social health insurance-contracted provider of home nursing healthcare and therapeutic home care (carried out mainly by physiotherapists and speech therapists). Its principal target group are physically disabled people. With the help of various projects and sponsors, in 2010 MBE established an outpatient specialist care programme, including services such as physiotherapy with non-portable equipment, such as special mattresses and large biopton lamps. The initiative was discontinued for a number of reasons: because clients preferred home care, because of transport problems and because some felt such services were stigmatising.

Out-of-pocket payments for home healthcare in Hungary increased from HUF 3,000 (€9.72) in 2007 to HUF 3,380 (€10.95) in 2011. MBE experienced two waves of funding cuts: 40% between May 2009 and April 2010, when the number of visits reimbursed by the national insurance fund fell from 286 to 176. Between May 2010 and April 2012, the monthly number of reimbursed visits doubled again. In May 2012, reimbursed visits were cut by 36%; however, unlike the first austerity cuts which lasted for two years, the number of reimbursed visits was on the rise again after six months. MBE channelled the complaints of disappointed service users to decision-makers, and the numbers of reimbursed visits was recalculated. After a slight (4%) decrease in May 2013, the number of visits paid for by the national insurance fund reached its highest for the analysed period in October 2013. According to the interviewees, compensation for the loss of revenues in the first austerity period came partly from the redistribution of visits of smaller providers at the end of 2011. This meant that some small providers of home healthcare had to close down. Overall, there has been a decrease in the number of visits per patient rather than in the number of patients visited at home.

Box HU3 – Platán Nursing Home, Hungary

Nursing home care in Bács-Kiskun, a southern region of Hungary, is provided by the Platán Nursing Home (120 places) in its capital city of Kecskemét. Daily medical check-ups are provided to its residents, and it has a smaller unit (25 places) on the outskirts of the city. The Platán Nursing Home employs 34 nurses and a nursing assistant, and four medical doctors on a part-time basis, two of whom are GPs responsible for daily check-ups. The average waiting time is half a year. Revenues come from central government transfers, local government financing, donations and user charges. Homes that provide permanent placement are allowed to charge residents up to 80% of their personal income (usually pensions), and the Platán Nursing Home applies this maximum. Most frequent diagnoses are dementia (48 residents), Parkinson's disease, diabetes, musculoskeletal diseases and hypertension, or combinations of these.

There was a cut in central government expenditure in nursing home care in 2006–2007, before the crisis, and the crisis then aggravated the situation prompting more cuts in 2008 and 2009. Local governments stepped in to compensate for the cuts to some extent, and helped locate external resources through cooperation with NGOs and religious communities, and EU Structural Funds for infrastructure development. Such combinations of funding also made it possible to solve emerging problems, such as, in 2012, lack of transport to take residents to external medical services where nursing homes could not provide this.

A longer-standing trend is the difficulty of staff retention, since many nurses have emigrated. During the crisis, demand for nursing home care in Hungary has increased less than expected, given the ageing population.

In 2008, there was even a decrease, from 50,903 to 49,894 elderly clients in nursing homes. Some of the elderly have stayed with relatives, contributing to their household income, and some even left nursing homes to help relatives increase their income. In this particular nursing home, occupancy remained close to full capacity and there were still waiting lists.

Box IE1 – Mental health service, Ireland

This publicly funded mental health service provider is one of 123 community-based adult mental health services in Ireland and serves an urban area of over 185,000 people. Staffing decreased from 132 full-time equivalents in December 2008 to 118 in December 2012. Attendees of the outpatient clinic increased from 3,585 in 2008 to 4,509 in 2010. Patients without medical cards are supposed to be charged €75 per visit/day (capped at €750). According to the service manager, this has not been implemented since 2008 because the person who administered this charge took a retirement package in 2008 and was not replaced. If it had been collected in 2012, it could have raised €100,000. However, even before 2008, people billed for their hospital stay frequently did not pay. A short-notice 'crisis intervention service' was also curtailed in the summer of 2013, but has since been reinstated with reduced capacity. It was considered an important aspect of outpatient care for people with mental health problems, preventing worsening conditions. The service introduced a text-messaging system to bring down the number of 'do not attends', reducing them from 14% to 9%.

Box IE2 – Connolly Hospital, Ireland

Connolly Hospital in Blanchardstown, Dublin, is a major teaching hospital providing a range of medical inpatient, day-care and outpatient services to a growing catchment population. Its staff was cut from 1,152 in 2009 to 962 in 2013, and its budget from €104 million to €86 million. Demand also increased: inpatient discharges rose from 9,832 in 2009 to 12,036 in 2013; day cases from 8,382 to 11,401; and emergency department admissions from 7,953 to 10,537. Average length of stay shortened from 7.1 to 5.3 days.

Many of the emergency attendances and readmissions were older people from nursing homes. A steering group from the hospital, local health office and senior clinicians developed a service to support older people through the process of early discharge back to their nursing home and to provide onsite visits to nursing homes by GPs, with referrals to specialists.

In 2010, resources were invested to improve care for elderly people and to decrease demand for emergency and inpatient services in the hospital. Phone and email triage is a key component of this strategy, as is training of emergency department staff, nurses and GPs. The team that developed the service says that emergency attendances and hospital admissions of the nursing home cohort reduced by 24% and 37%, respectively, before and after the project.

Box IE3 – Acquired Brain Injury (ABI), Ireland

ABI works with people across Ireland who have acquired brain injury to enable them to live at home with access to rehabilitation and other specialised healthcare services. Between 2008 and 2011, ABI's budget was cut by 10%, to €11.1 million. ABI has 260 staff, with 'case managers' who facilitate discharges from nursing homes and hospitals and prevent readmissions. Because of reduced funding from local government, ABI has cut one case manager post even though it faces increased demand for its services.

Box LU1 - Luxembourg city psychotherapy service and Réseau Psy

Overall, in Luxembourg, hospitalisation increased markedly between 2002 and 2009 because of misuse of alcohol (up by 11%) and for reasons of severe stress (up by 65%). While no yearly data are available, it is suggested that part of this increase comes from 'burnout' exacerbated during the crisis by increased job instability, job loss and failed job applications. This case study looks at two mental healthcare services.

Réseau Psy, a public provider of mental healthcare services, was faced with a cut in government subventions by 5% in 2009, but it compensated for this budget cut with financing from the health insurance fund for 'sheltered living services'. The service does not believe this is sustainable and is looking for other sources of income. The service is reimbursed, but patients who struggle to make the initial payment must go first to a primary healthcare provider to receive an appropriate diagnosis and initial treatment.

The psychotherapy facility in Luxembourg city is a private provider of mental healthcare services, whose services are partly reimbursed from public funds. Before 2007, patients who were struggling to pay were paradoxically more common than in the years after. Interviewees at the facility suggested that many of these patients now seek help from emergency, non-specialised hospital or primary care services which can be reimbursed to a higher level or are free of charge. The clients now attending the service have more severe problems such as obsessive-compulsive disorder, phobias, severe anxiety and depression. Since the crisis, the dropout rate of clients who cannot afford to continue treatment has been around 15%.

Box LU2 – E-health services, Luxembourg

The e-health action plan for Luxembourg was adopted in 2006 as part of a European Commission initiative. Interviewees reported that the plan was speeded up due to the crisis, as it responded to the potential negative impact of the crisis on access. It was motivated by an increased need for quality services and collection of data rather than by cost-effectiveness. It is a challenge to motivate doctors to participate as they are usually only reimbursed for patient visits.

Box LU3 – Third-party payer system in two social offices, Luxembourg

Since January 2013, people with low incomes can apply to the social security system to cover the out-of-pocket costs of their healthcare. The scheme is known as the 'Third-party payer system' (TPPS). Eligible people can go to one of 30 regional social offices to receive a certificate, usually valid for three months, which can be presented to any doctor or dentist and instructs them to claim the full cost of the treatment not from the patient, but directly from the National Health Fund. Alternatively, applications can be sent directly to the social office following delivery of one-off care to a patient without a TPPS certificate, so that the healthcare provider can reclaim the money directly. Anybody who legally resides in Luxembourg can apply for the TPPS. Nevertheless, applicants must have health insurance and regularly reside in Luxembourg, including those who generally stay in a homeless shelter. Social offices are free to set criteria or leave judgement to social assistants. Qualifying applications tend to be for more expensive, regular and long-term treatment, such as cancer care or treatment for depression, and not for travel cost to a doctor's office or the need for a non-urgent single healthcare visit. In practice, healthcare providers sometimes absorb the costs of treatment for people who cannot pay, but this differs between providers and data are unavailable.

National data on the number of people who benefit from the TPPS are as yet unavailable. Case studies in two of the 30 social offices were conducted to get an impression of its impact.

The social office in Bettembourg is responsible for a population of 19,268 in the south of Luxembourg. Between 1 January 2013, when the TPPS was implemented, and January 2014, it received 45 'original' successful applications for the TPPS, refused nine applications and dealt with 15 applications of further need from previous beneficiaries. Most applicants are single-parent families and single-person households. Typically, they are in financial difficulties due to unemployment, bankruptcy or separation, and belong to the lower socioeconomic classes. Treatments are mostly higher-cost, such as dental care, and particularly for children. Social assistants are free to assign the benefit where they see fit. Initially, it was unclear whether applications had to be made individually or per household, and some households did not understand that the TPPS covers only primary care fees.

The Luxembourg City office, serving the largest urban population (90,000) of all the 30 offices, had just under 400 TPPS applications in 2013. There is no information on repeated applications or refusals. Most were elderly people, pregnant women and people with mental health conditions. Most common applicants were those with frequent healthcare costs. A single monthly appointment with a doctor does not qualify for the TPPS. The office uses benchmarks to guide social assistants in assigning the benefit; for example, if income is below €400 per month, the assistants are advised to take a close look at the situation.

Box LV1 – Stella Maris, Latvia

Copayments from clients and municipality funding are the main sources of revenue of nursing homes in Latvia. The number of people in nursing homes in Latvia decreased from over 5,700 in 2007–2008 to just over 5,300 in 2010, before going up again. The number of people on waiting lists dropped between 2007 and 2009 by about 300, to remain relatively stable between 50 and 100 afterwards. As a response to decreased demand, nursing homes reduced staff and salaries, and some closed in 2011. Interviewees suggest the decrease in demand can be explained by relatives choosing to keep the elderly at home so that families could benefit from pensions, which have increased from LVL 141 (€200) a month in 2008 to LVL 178 (€253) in 2011, while copayments increased from 85% to 90% of pensions in 2009.

Stella Maris is a nursing home owned by the municipality of Riga. In 2007, it had 101 long-term and six short-term clients. Financing by the municipality fell by 40% in 2008 and 19% in 2010, with its share in total financing decreasing from 75% (2008) to 55% (2011). The rise in copayment rates prescribed by the government resulted in a 31% increase in this type of income in 2009, with its share increasing from 25% (2008) to 45% (2011). The nursing home did not suffer from the decreased demand noted in Latvia overall, but the planned number of clients was not met and waiting times decreased. Furthermore, the increase in receipt of out-of-pocket payments did not offset the decrease in income from the municipality. To balance its budget, it converted short-term beds into long-term beds, economised on catering and cut psychiatrist and physiotherapist services (reinstated in 2012). Salaries and staff benefits, such as private healthcare insurance, were cut. Stella Maris further made use of a government programme to give unemployed people temporary jobs in exchange for LVL 100 (€142) a month, hiring 25 temporary staff to carry out tasks such as maintenance and kitchen work, but also helping permanent staff to take care of clients.

Box LV2 – Vidzemes Slimnīca, Latvia

Vidzemes Slimnīca is an inpatient and outpatient healthcare provider, owned by Valmiera municipality. Besides a facility in that municipality, it has facilities in two other cities. In 2008, it had 332 inpatient beds and 763 employees. In 2011, this was down to 222 beds and 631 employees. The share of public funding dropped from 78% in 2008 to 68%–69% in 2009–2011, and income from copayments increased from 8% to 14%–15%, consistent with the trend in Latvia overall of state-mandated decreased global budgets for hospitals.

To be able to offer the required services with decreased budgets, expenditure was reduced. Salaries were cut by 18% in 2009 and 17% in 2010. Catering costs declined by 47% in 2009 because of a reduction in cost per hospitalisation and a reduction in hospitalisations. Utility expenses were reduced by 23% in 2009. Savings were also made in ICT and office supplies. The number of beds was reduced, but this did not lead to immediate expenditure reductions because the facilities remained the same. The number of inpatient admissions fell by 18% in 2009 (to below the contracted amount) and outpatient visits stayed stable (above the contracted amount) but increased in 2010 by 17%, a reflection of government policy. There was no penalty for delivering fewer services than contracted, and only in 2010 did the government stop covering expenses above the contracted amount. Home care dropped initially, probably because GPs started to provide home care to supplement their incomes and took some business away, but increased by 19% in 2012. This was partly due to the inclusion of homecare services in public contracts. Interviewees said that hospitalisation was restricted to more serious cases. A slight increase in the mortality rate and a sustained reduction in readmissions in 2009 support this assertion.

Box LV3 – Riga Centre of Psychiatry and Addiction Medicine (RCPAM), Latvia

The RCPAM is a state-owned provider of outpatient and inpatient mental healthcare services in Riga. In 2007, the RCPAM had 735 beds and 1,274 employees. In 2011, the centre reduced the number of beds to 555 and employees to 906, responding to the number of hospitalisations contracted by the government. A drop in beds would probably have occurred without the crisis as part of the psychiatric care reforms initiated in 2004, but it was accelerated. The share of government funding for the centre decreased from 88% in 2008 to 82% in 2011, with drops in financing of 22% in 2009 and 25% in 2010. Receipts from copayments increased from 8% in 2008 to 12% in 2010. Other income from training students, clinical trials and rents increased from 1% in 2008 to 5% in 2011. Inpatient admissions fell by 15% in 2009 and 5% in 2010. The numbers of drug and alcohol abuse patients decreased and this was ascribed to increased copayments. Numbers of psychiatric patients (in particular outpatients), who are not subject to copayments, increased. Combined inpatient and outpatient visits increased, and interviewees said all patients who turned to the service for mental care received it, with no waiting time for acute patients, and up to two weeks for other inpatient care.

Several doctors and support staff left to work abroad, and many above the retirement age stopped working partly because, in 2009, their pensions would have been reduced to 70% of the full amount if they had remained in employment. In 2008, salaries made up 59% of expenses, and in 2011 they amounted to 52%. In 2009, the reduction was mostly due to a decrease in the number of staff, but in 2010 savings also came from salary cuts of 16%. Catering costs declined by 14% in 2009 due to the decrease in hospitalisations.

The service found it hard to cut utility expenses or expenses for food per hospitalisation, but reduced other expenses (ICT, laundry, office supplies and disposal of medical waste) by 17% in 2009 and 33% in 2010.

It also implemented a strict approvals procedure for new spending. There was an increase in day hospital services intended for psychiatric care, but this was limited by bed space in the day-care section which is required to be separate from the inpatient section.

Box PT1 – Vila Nova de Gaia/Espinho Hospital, Portugal

Hospital Vila Nova de Gaia/Espinho had a capacity of 550 beds in 2012, up from 539 in 2008, the earliest year for which these data are available since the hospital's foundation from a 2007 merger. It had 466,839 consultations in 2012, up from 350,436 in 2007. Emergency episodes dropped from 200,241 in 2007 to 169,139 in 2012, following a national trend. The hospital had 3,198 staff members in 2012, up from 2,949 in 2007. Cost-containing measures affecting human resources were implemented mainly after 2011. Despite budgetary constraints, the hospital sought to prioritise hiring doctors and nurses, contributing to a loss of €3.8 million in 2012 compared to positive results in previous years. Despite the overall increase in staff, some specialities have seen a decrease in staff, in particular the dermatology department (currently seven specialists). Action was taken to maintain patient access to this department. Another project was introduced to deal with increased difficulties in reaching, communicating and treating migrant patients, particularly those of Ukrainian descent, as a result of budgetary cuts made in the national health mediator programme.

The TRIAD project – Rapid Screening in Dermatology through Telemedicine – uses digital cameras in local primary care centres to take pictures of conditions sent through a dedicated secure email by GPs to contact specialists in hospitals who screen and prioritise patients, avoiding hospital visits for benign cases and cutting waiting times for urgent ones. It also cuts labour absenteeism and travel costs for the patient. In the first 12 months of operation (June 2009 to May 2010), 188 patients used TRIAD; 14% were said to have avoided going to hospital as a result of the initiative. GPs also welcomed the opportunity of a quick second opinion, although some raised concerns that TRIAD could increase their workload, compared to just referring the patient to the hospital.

A 'Migrant Friendly' initiative of the hospital has no dedicated funding and is staffed through time volunteered by nurses and administrative staff. It is supported by an NGO made up of hospital patients and staff and by local migrant NGOs. It provides training to staff, mainly nurses and administrative staff (doctors are less willing to participate). It provides information to migrant communities in multiple languages, and is currently trying to find hospital staff who speak the languages of migrants. Reduced wages and longer working hours have made it more difficult to attract voluntary participation. Mediators were once employed to work with migrant communities, but their posts were abolished as part of government cuts. Improvement in information technology registries made healthcare access difficult for undocumented migrants, despite being covered by the Portuguese system, because they lack the required identification number and cannot provide proof of income. This means they do not qualify for copayment exemptions and are therefore more likely to enter the system through hospital emergency departments where copayments are less likely to be enforced.

Overburdened staff are not always aware of migrants' rights and not always able to invest time in communicating across language barriers. It should be noted that interviewed hospital staff reported a reduction in the number of migrants accessing inpatient care, particularly those due to work-related accidents. This may suggest reduced access, but also a decrease in employment.

Box PT2 – Hospital Centre Cova da Beira, Portugal

The hospital covers four rural municipalities where about 30% of the population are aged over 65. Since 2009, there has been a steady shift from inpatient and emergency care towards outpatient care. The number of staff decreased from 1,315 in 2008 (earliest available figures) to 1,255 in 2012; consultations went up from 121,962 in 2007 to 163,755 in 2012; and emergency episodes dropped from 114,683 in 2007 to 77,831 in 2012. Interviewees said the main difficulty in access experienced by patients is related to transport costs, with limited public transport options and lower reimbursement. In particular, older people were often unaware that they would need to resubmit proof of eligibility for exemptions. With decreased resources, access to devices that might allow people to leave hospital earlier, such as crutches, wheelchairs and adjustable beds, was reduced.

In February 2013, a scheme (BAPA) for renting used, sterilised technical aids was set up. For a deposit and monthly payments (for example, €0.50 for crutches, €4 for a wheelchair, €6 for an adjustable bed), equipment can be rented. There is no means-testing to allow for swift decision-making on the basis of urgent demand, and to minimise bureaucracy and administrative costs. However, doctors have to confirm need and the patient should live nearby to increase the likelihood that equipment will be returned. The equipment comes from patients who have returned items received from the more expensive public system (SAPA). In the first six months, 300 pieces of equipment were issued and 145 were returned. Simultaneously, demand for equipment through SAPA has decreased by a similar number, implying savings for the government and for patients. With information about the initiative spreading, more people are returning their equipment borrowed through SAPA, and interviewees report the initiative contributes to satisfaction among hospital staff.

Box PT3 – USF Fernão Ferro Mais, Portugal

There are over 350 primary care centres in Portugal. The USF Fernão Ferro Mais was the first to be created, as part of a national reform in 2007, by a group of healthcare professionals on the outskirts of Lisbon. There has been increased demand for respiratory healthcare services for children, and interviewees attribute this to increased overcrowding (families moving in with older parents) and worsening housing conditions (families moving into sheds previously used for holiday stays). Rising unemployment and increased migration among male family members has been related to increased demand for mental health consultations. Pregnancy consultations have decreased. With more people depending on public transport as a consequence of the crisis, accessibility has worsened with more limited connections of buses and trains.

Purchasing medical and non-medical consumables for the healthcare service has been centralised to the regional health administration. While this has the potential to save costs, it has led to increased time spent on ordering supplies and to temporary shortages.

With staff facing increased workload while wages have decreased, management have tried to prevent staff burnout by improving teamwork.

Although copayments for chronic patients can only be waived if treatment is related to the chronic condition, in practice it can be hard to assess whether the treatment needed relates specifically to the condition.

The USF reached many of the 'access to healthcare' objectives set for performance-related funding, such as conducting 150 domiciliary visits by nurses per 1,000 inhabitants. Objectives not reached were all related to preventive care, suggesting that people in the area may not always access care if there is no immediate need. Performance-based reimbursements by the Ministry of Health have been delayed and the USF had planned to purchase a car to increase domiciliary visits, but the moratoria on vehicle purchases by public bodies have prevented this.

Being confronted with problems that go beyond healthcare, the service set up a volunteer group to support socially isolated older people, liaised with the local community to facilitate exchange of second-hand goods and collaborated with the local parish and municipality to monitor social problems. To facilitate access to social support and make medical consultations more effective, the USF prepared a directory of information on available social support for patients.

Box RO1 – Tulcea County Hospital: Telemedicine in the Danube Delta area, Romania

Out of the 245,000 people in Tulcea County, in southeast Romania, 195,068 (79.6%) are insured and the rest are eligible only for the minimum package of services. Several villages have no GP, and there is a shortage of several specialities, in particular oncologists, endocrinologists, paediatricians, pulmonologists, urologists and diabetologists. The hiring restrictions and salary cuts during the crisis, but also freer movement within the EU, have made it more difficult to fill vacancies in the county. The number of outpatient specialists in the various hospitals in the county are down from 84 in 2010 to 78 in 2012. Inpatient care has seen a similar decline, mostly in emergency care.

The Tulcea County Hospital (TCH) has 700 beds and is the main provider of outpatient and inpatient specialised care in the largely rural county, located in the main town of around 90,000 inhabitants. Reaching the hospital takes several hours from many of the remote areas, with the need to stay overnight for specialist consultation. In 2011, two hospitals were closed in the county, increasing demand for treatment at the TCH. One basic emergency care unit was set up after the hospital closure in Sulina, a particularly remote area. During the tourist season (June–September), Sulina triples its 3,500 population. Major emergencies are usually sent to the TCH. The TCH was affected by budget cuts. The deficit in personnel was eased by hiring medical staff from the closed Sulina hospital, but the increase in wage costs (accentuated by court-ordered wage recalculations) swallowed the budget for materials and medicines which patients now have to pay for up front themselves.

The Ministry of Health initiated and coordinated a telemedicine project to improve access, facilitating communication between GPs in remote areas and specialists in the hospital through a dedicated web platform. The project began in April 2012, involving 10 GPs and the TCH. The GPs and other medical personnel involved in the project had five training sessions on basic use of computers and the medical and communication equipment used. Training and equipment were funded by an NGO raising corporate donations, but the ministry coordinated the project and medical personnel were reimbursed through the public system. In 2013, 93 patients benefited from the system, with 682 sessions and 350 medical data uploads.

Challenges included insufficient training to reduce fears among doctors of breaking the equipment; also, some doctors may be less inclined to use the system because it cuts out the possibility of supplementary income through under-the-table payments or referrals to the private clinics where they also work; there are doubts among specialists about the quality of GPs' scans; some local GPs may feel patronised by high-status specialists from the hospital; some GPs dislike being deprived of their option to refer patients to specialists with whom they usually work; and there is a feeling among some GPs that they may be 'bothering' the specialists with their requests for consultations.

Box RO2 – Oltenița Municipal Hospital, Romania

The hospital in Oltenița, a town of 25,000 inhabitants in the southeast of Romania, covers a wider rural area. It has 210 beds and an outpatient section. As in all public hospitals in Romania, the hospital faced staff restrictions from 2009 to 2012, with an allowance of one new member of staff for every seven vacancies. In 2012, this was changed to one new member of staff for each vacancy, but in practice the bureaucratic process for new staff applications made it hard to replace staff.

As for all public employees in Romania, salaries of staff were cut by 25% from 2010 to 2012. From 2012, the insurance fund contracted only 171 of the available 220 beds. Furthermore, one of the other two hospitals in the county (in Budești, a town of 5,500 people with a large Roma population) had to close in April 2011. While Budești lies between Bucharest and Oltenița, many patients turned to Oltenița because of lower transport costs.

The hospital regards hiring restrictions as a bigger challenge than salary reductions. Vacancies emerged mainly because of retiring staff, or involuntarily due to budget restrictions. Only a few nurses emigrated. The hospital reacted to hiring restrictions by attracting more trainee doctors, and by accelerating the practice of hiring doctors on a contract basis for ambulatory care. A downside of hiring doctors on a contract basis was that it caused some waiting times, as contracted doctors were there only a few days a week. Furthermore, inpatient doctors were allocated ambulatory hours. Occasional support for investment came from local businesses and the Ministry of Health, and in particular from a good working relationship with local government which became the hospital owner in 2010.

There has been some increase in primary care usage in the county, and the hospital has shifted some inpatient care to day care. Overall, ambulatory care has remained constant, but inpatient care has decreased. The hospital and the local government are developing an emergency care centre because central government funds its staff and this will take some pressure off the hospital. Apartments for doctors are already being built by the local government.

Box RO3 – GP in Fetești, Romania

Fetești is a town of about 25,000 inhabitants in southeast Romania, including several predominantly Roma communities on the outskirts of the town that are quasi-rural in terms of infrastructure. 'F.D.' has been a GP in Fetești since 2011. He has about 1,300 patients registered, of whom about 500 are Roma. None of his patients are employed, very few are pensioners, about a third are children and are insured by law, and another third are recipients of the minimum income guarantee (MIG), which comes with health insurance coverage. The remainder are not insured and qualify only for the basic benefits package.

To reduce costs, in 2010, the central government enforced more strictly the existing eligibility rules for the MIG. As a consequence, beneficiaries in Fetești decreased from 550 (2009) to 336 (2010). An example of a person who lost entitlement is 'M.I.', who is 70 years old and lives with his wife (61) in a one-room clay house. In 2010, his application for the MIG was rejected as the area of land on which his house stands is more than 1,000 square metres. Another family has a separate house on the same land, but it is registered in M.I.'s name. Property transactions in the neighbourhood are often informal, to avoid transaction taxes or because they consider informal agreement between the two parties sufficient, so there is a mismatch between the real ownership and the official records. Setting the record straight through the courts is costly.

In 2011, new conditions were introduced for the MIG, stating that those who owed property taxes were no longer eligible. As a consequence, 37 of F.D.'s patients lost eligibility. The total dropped from 328 in 2011 to 282 in 2012. 'C.L.' lives in Dudești in a household of three people (two adults and a child in school). They have a debt of RON 1,000 (€228) in property taxes to the local government. Because of this, the family lost income support in 2012. Currently, the household has some income from occasional, unregistered work done by C.L. He is supposed to visit the cardiologist and take medication regularly. Since losing access to the MIG, the family have not been able to afford his medical care. When he is not feeling well, they go to the emergency ward where he receives treatment.

Fetești authorities have tolerated uncertain property status in some cases, such as when former owners die and the transfer of land has been postponed by their heirs. They have also considered rescheduling debts, but so far no particular action has been taken. The GP said he had not demanded copayments from patients he knows cannot afford them.

Health mediators have also played a role in mitigating the impacts of the crisis. In Fetești, the mediator covered only one community of the three, slightly wealthier than the others and less populous. A second mediator covering the largest community resigned in 2013 and no replacement was hired. In addition, the community work has been affected because local travel costs are no longer reimbursed by local authorities and mediators and community nurses have to cover their own costs. Given their relatively low salaries, this is an important disincentive to reach the Roma neighbourhoods which are most distant from the town centre. Examples have been reported of effective mediators in Ialomița county where Fetești is located. However, there are also reports of less effective locally appointed health mediators.

Box SE1 – Dorotea Primary Healthcare Clinic, Sweden

Until the end of 2011, the Dorotea Clinic was a 'mini-hospital', with an emergency ward with four sick beds, a lab, paramedical services and radiology. It was staffed 24/7, and covered a sparsely populated area larger in size than Luxembourg. In 2008 and 2011, the clinic showed exceptionally large deficits due to decreased income from tax, of SEK 296 million (€32.3 million) in 2008, and SEK 186 million (€20.3 million) in 2011.

In 2011, the Västerbotten County Council's management presented a savings package of SEK 150 million (€16.4 million), intended to stave off expected drops in income from taxation in 2012 and 2013 and to help balance the council's budget.

As a result, the emergency ward and four sick beds at the Dorotea Healthcare Clinic were closed. For many inhabitants of the area, this increased the ambulance journey by half an hour to the closest small emergency clinic in the village Åsele, 47 kilometres away. The clinic also closed during weekends and at night.

The clinic filed a complaint against the county council to the National Board for Health and Welfare (NBHW). Simultaneously, people started a sit-in protest at the entrance of the clinic from January 2012. The council had to present a report on how the safety of patients had changed and been affected by the closure of the emergency ward and primary care in Dorotea. While the NBHW was satisfied with the results, a group of citizens collected signatures demanding a referendum that the authorities were obliged to hold on 8 January 2013 at the cost of about SEK 15 million (€1.6 million). The results made the council responsible for reinstating the emergency sick beds. This was done at a nursing home in Bergvattengården, in collaboration with the municipality, to maintain access to emergency sick beds for the people of Dorotea municipality. The council is also looking into the possibility of providing access to primary healthcare by paying the municipality to hire a 24/7 primary care nurse. Consultation by phone and internet is already possible. The sit-in at the clinic continues, but popular support for it declined with some patients and medical staff feeling watched.

Box SE2 – Skåne University Hospital, Sweden

The financial crisis struck the Swedish Skåne region in 2008 when the decreasing tax base, in combination with increasing costs, led to budget cuts and staff reductions in hospitals for which it was responsible. Two hospitals were merged to become the Skåne University Hospital which, after several years of deficits because of increasing staff costs, focused on increasing productivity. The hospital includes one division in Lund and one in Malmö, covering about 1.7 million people with a budget of SEK 10 billion (€1.1 billion).

After recording a deficit of SEK 274 million (€30 million) in 2011, the region decided that Skåne University Hospital had to save SEK 450 million (€49 million) in its 2012 budget. Life science work at the hospital has been cut. The focus shifted towards cutting costs and improving accessibility and patient safety, mostly due to the 'Queuing billion' (*Kömiljarden*) subsidy system. In August 2012, an employment freeze was imposed, and savings were made mostly by not renewing temporary contracts. The number of beds in the emergency wards in Lund and Malmö were reduced. At both divisions, two wards were closed and 40 beds were removed. The closed ward in Lund had mainly treated elderly people with chronic diseases who will now be treated at the new geriatric ward in Malmö opened in February 2012. The nine new beds, compared to 17 beds in the closed ward, was estimated to be much less than needed to host patients currently kept in surgical wards. To meet the demand, the Skåne region focused on increasing lower-cost home-care services instead of increasing the number of beds.

In a reaction to criticism by the Swedish Work Environment Authority, the hospital reallocated resources towards the emergency ward and advised hospital staff to take additional shifts. The measures decreased waiting times in the emergency department and increased patient flow to other wards. An evaluation in March 2013 concluded that despite an increasing number of requests for treatment, waiting times and average treatment time decreased in Malmö by 28% and in Lund by 33%.

Some of the measures, especially having GPs on the emergency ward, were not as effective. Skåne University Hospital has further tried to solve the problem of increased demand for emergency care by locating public primary healthcare clinics within the grounds of the hospital to make patients feel that they are receiving hospital-standard care. Longer opening times further aim to direct the patients to the primary health clinics.

Box SE3 – Karolinska University Hospital, Sweden

Karolinska University Hospital is the largest hospital in Sweden, based in Stockholm. It had accumulated debts and experienced an increased number of patients. The impact of the crisis on future funding made reforms urgent. In 2009, a range of cost-cutting measures was implemented. Most doctors and nurses were retained, but the number of assistant nurses was reduced. Doctors and nurses took over tasks previously done by those assistants, and the union reported that this also resulted in increased workload for the remaining assistant nurses and delays in the healthcare process. Patients were supported less during recovery from surgery and meals were not always prepared and served on time. Nurses and doctors in the hospital also reported that, due to cost pressure and overcrowding, patients were sometimes dismissed too early from the hospital, particularly elderly patients with multiple conditions.

The financial situation improved, and employees were trained at various levels about the long-term economic consequences of their actions. In late 2010, the focus shifted towards access. For example, reallocation of tasks by ‘improvement groups’ – employees with the task of improving patient flow processes – cut waiting times in the orthopaedic clinic and paediatrics department. The monitoring of waiting times is based on the statutory health guarantee, which only regulates the patient’s first contact with the healthcare provider. The hospital does not report statistics for a second visit. Lead times have been reduced, but also surgery processes can be performed in other places by Karolinska doctors or subcontractors. In addition, the hospital has been able to pass on to other establishments any patients not considered part of the mission of a university hospital.

Box SI1 – Secondary care hospital, Slovenia

A secondary care hospital, covering 132,000 people in the south of Slovenia, provides specialist services, ambulatory care and dialysis, gynaecological and primary care services. Public funding, through the Health Insurance Institute (HII), has been cut by 15% over the past three years, although the amount of care provided has not decreased. Payments from the HII have also been delayed, and the hospital makes up the shortfall with loans from the Treasury. There is a shortage of certain staff, which the management tries to fill with external contractors. Waiting lists have increased for MRI scans, rheumatologist consultations and orthopaedic services for patients who cannot afford to avoid the queues by making additional payments. Patients’ families often insist the hospital’s relatives must stay in hospital because they cannot afford to care for them. This is particularly the case for terminally ill patients, and many relatives find it difficult to combine care with work. To cut waiting lists, doctors are required to screen a minimum of four patients per month at the hospital’s outpatient clinic. A psychiatrist was hired in 2011 to avoid the need for patients to travel to Ljubljana. A small satellite dialysis centre is being established in a remote area. The hospital has also required doctors to work more hours for the same salary.

Box SI2 – Community healthcare centre, Slovenia

The community healthcare centre has 1,405 employees and was established by Ljubljana municipality. It provides a wide range of healthcare services, including outpatient nursing, mental health, dental care and gynaecological services. The budget has been reduced by 10% because of lower reimbursement rates from the national insurance fund, and no new staff appointments are allowed. The number of examinations carried out by its for-profit dental services, which provided a source of income, has dropped. Increasing complaints are made about the bad condition of materials, poor information and waiting times, in particular for public dental care. Patients, especially those moving from private to public healthcare, have become less tolerant of practices such as no prior information about cost and no receipts being issued for dental services. There are more patients with psychological problems. There is an ambulatory pro-bono service for people without insurance and demand for this has increased during the crisis.

Box SI3 – Healthcare centre, Slovenia

The healthcare centre provides a wide range of services, such as dental, paediatric, psychiatric and basic emergency care. It serves a mixed urban and rural area with over 70,000 inhabitants. The area was among the first impacted by the crisis, and business closures and a collapse in the value of real estate led to unemployment, debt problems and evictions. The centre had to find government-mandated cuts of 2.5% from its budget in 2009 while the number of patients increased. The centre responded to cuts by drawing on its reserves.

The management held regular meetings to keep staff informed about the financial situation of the centre and about requirements by the government. Community healthcare centres previously employed social workers to help people find their way through the healthcare system. In 2013, their numbers were reduced as part of budgetary measures, but numbers were maintained in the centre examined for this case study and in two other centres in Slovenia. The centre became stricter in checking insurance coverage of patients than it had been before.

The type of services demanded has changed, particularly since 2010–2011, with more demands for psychological and physical healthcare from people experiencing problems making ends meet and bullying in the workplace. Newly created poverty has been accompanied by feelings of shame and guilt, resulting in problems such as increased alcohol intake and dysfunctional partnerships and parenting. Patients in poverty not only find it difficult to get to the doctor for follow-up treatments but also to comply with the doctor's recommendations.

Patients with alcohol dependence from lower socioeconomic brackets and those affected by poverty are included in an outpatient 'group alcohol treatment programme' in the centre, due either to lack of this kind of service where patients live or their inability to pay any kind of fee. The level of treatment offered has been lowered, focusing more on immediate harm reduction. Until 2010, more comprehensive programmes included psychological treatment and a focus on the quality of life of the patient.

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In the wake of the economic and financial crisis, many European governments have cut spending on healthcare services. At the same time, unemployment, financial strain and reduced prevention have increased the need for certain healthcare services, while falling disposable income has made access to healthcare more difficult for many EU households. This report identifies the groups most likely to face barriers to healthcare as a consequence of the crisis, including a number of new groups that have been generally overlooked by policymakers. It suggests a range of policy pointers, including the need to consider mitigating measures in tandem with policy reform, and suggests policymakers and service providers might consider reviewing crisis responses once financial pressures on EU Member States begin to ease.