

# **SOCIAL SECURITY POLICY BRIEFINGS**

## **Paper 8**

### **Social Security for All**

#### **Addressing inequities in access to health care for vulnerable groups in countries of Europe and Central Asia**

Xenia Scheil-Adlung and Catharina Kuhl

**Global Campaign on Social Security and Coverage for All**

**Social Security Department  
International Labour Office**

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## Abbreviations

CEE	Central and Eastern Europe
CIS	Commonwealth of Independent States
EC	European Commission
EU	European Union
IFAD	International Fund for Agricultural Development
ISSA	International Social Security Association
MDGs	Millennium Development Goals
NHS	national health service
NMS	new Member States
OECD	Organisation for Economic Co-operation and Development
SPF	social protection floor
SSA	Social Security Association (United States)
WHO	World Health Organization



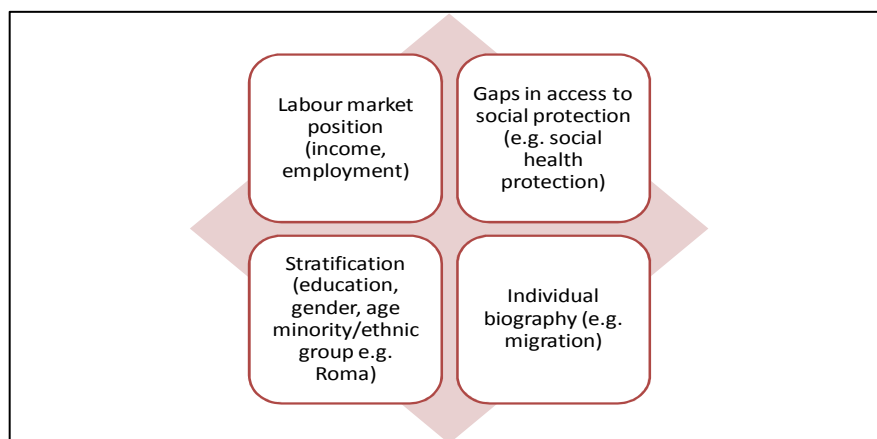
# 1. Introduction <sup>1</sup>

Europe as a whole is often perceived as a group of wealthy countries where inclusive social protection systems provide comprehensive protection for the most vulnerable, and health care at the highest standards is easily accessible to everyone. Because of this perception, the persisting gaps in social health protection coverage and inequities in access to health services experienced by vulnerable groups receive only little attention and are rarely adequately analyzed with regard to specific aspects such as gender, migration or issues related to ethnic groups.

As a result, in times of financial constraint policy discussions often circle around cutting back social protection expenditures without sufficiently investigating the impacts on those in need. Within the European Union, the austerity programmes of the euro debt crisis may serve as one of the most recent illustrations of such policies. A further example of inadequate attention to inequities in access to health care is the negligible amount of donor aid for health in Europe, which at merely US\$0.34 per capita is almost non-existent in many countries of Central and Eastern Europe (CEE) and the Commonwealth of Independent States (CIS) (OECD, 2011), despite the documented challenges of achieving the Millennium Development Goals (MDGs) by 2015 in many countries of the broader European region (UN, 2010a).

Against this background, this paper highlights issues that contribute to persisting inequalities in access to health care by vulnerable groups in the broader European region, including countries of the European Union (EU), CIS, CEE and selected countries of Central Asia. We focus on key determinants of vulnerability, primarily labour market impacts such as income and employment, and related gaps in access to social protection and to social health protection in particular. Moreover, we concentrate on the stratification of vulnerability, looking at specific population groups including women, the elderly, migrants and ethnic groups (mainly Roma), who are often disadvantaged in regard to determinants of vulnerability as focused on here (figure 1). Special attention is also given to rural and urban inequities.

**Figure 1. Key determinants of vulnerability**



Source: Authors.

<sup>1</sup> The authors would like to thank Ms Stefania Innocenti for her valuable support in finalizing this paper.

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First, we present the main characteristics of social health protection systems in countries of the European region regarding financing, organization, and benefit arrangements. We then analyse remaining gaps in social health protection in terms of statutory coverage, financial protection and geographic availability of health services, and the impact of these on vulnerable groups as determinants of inequities in effective access to health care. This is followed by a discussion of the socioeconomic environment of vulnerable groups in Europe as underlying determinants of inequities in access to health care, to social protection in general and social health protection in particular. Finally, we suggest that inequities in access to health services for the most vulnerable groups can be best addressed by following the framework of the Social Protection Floor (SPF, see page 34).



## 2. Main characteristics of social health protection systems in the European region

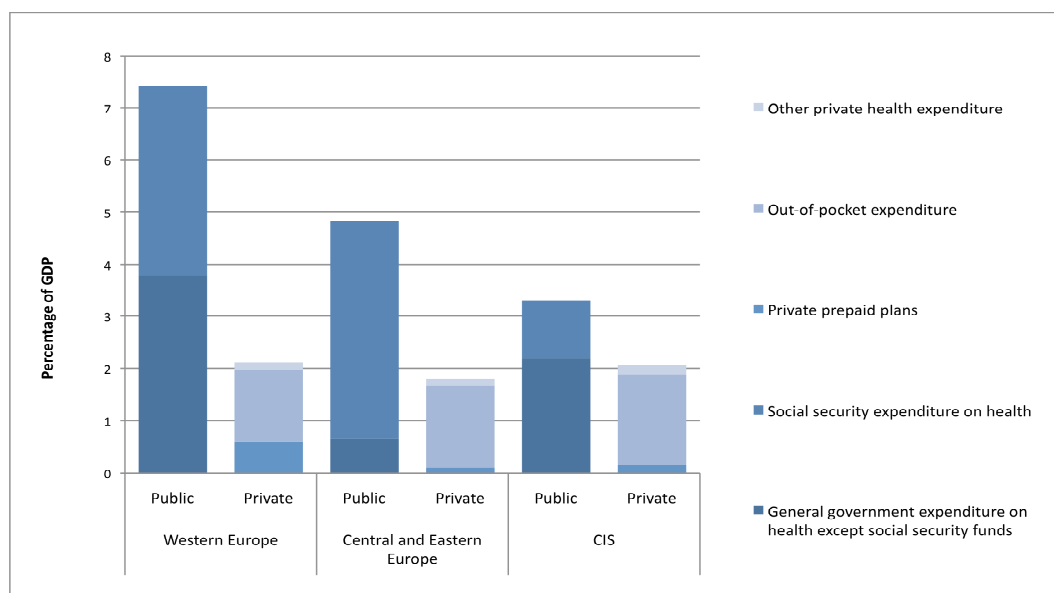
The provision of universal access to social health protection is an overarching goal stipulated by most countries in the European region. Although financing, organization and performance of social health protection differs widely between countries, key characteristics can be identified, which include the predominant use of:

- social or national health insurance funded by payroll taxes, often shared between employers and employees;
- national health services (NHS) funded by general government revenues or earmarked taxes; and
- out-of-pocket payments (OOP) requested from the sick at the point of service delivery, used to a varying extent.

Private insurance and employer-based schemes usually play a complementary role only, and community-based insurances are hardly ever found.

On the regional level, in 2008, **expenditure on social health protection** accounted for an average of about 70 per cent of total expenditure for health care in Europe (ILO, 2008a). Figure 2 displays health-care financing levels and sources of funds as a percentage of GDP in Western Europe, Central and Eastern Europe, and CIS countries: while in countries of Western Europe both public and social security expenditure play a major role, in CEE countries social security expenditure serves as the predominant source of funding, and in CIS countries public expenditure combined with disproportionately high out-of-pocket payments constitute the main source of funds.

**Figure 2. Total expenditure for social health protection, by sources of funds, 2006 (percentage of GDP)**



Source: ILO, 2010a.

An overview of financing and benefit arrangements for medical services, cash benefits and sick leave in health care, long-term care and maternity care in European social health protection systems is provided in table 1.

**Table 1. Financing mechanisms and benefit arrangements for social health protection in selected countries**

			Albania	Belarus	Germany	Norway	Romania	Ukraine
Health and long-term care	Financing mechanisms used	Social health insurance	✓	✓	✓		✓	✓
		NHS / tax financing		✓		✓		
		OOP (varying extent)	✓		✓		✓	✓
	Available benefits	Medical services	✓	✓	✓	✓	✓	✓
		Long-term care			✓	✓		
		Cash benefits	✓	✓	✓	✓	✓	✓
		Sick leave	✓	✓	✓	✓	✓	✓
Maternity	Main financing mechanism	Insurance	✓		✓	✓	✓	✓
		Tax financing			In Slovenia only			
		Employers			In the United Kingdom only			
	Available benefits	Medical benefits	✓	✓	✓	✓	✓	✓
		Cash benefits	✓	✓	✓	✓	✓	✓
		Maternal leave	✓	✓	✓	✓	✓	✓

Source: Authors, based on data from ILO, 2010a; SSA/ISSA, 2010.

All countries in the European region provide for both **medical benefits and cash benefits** to protect wages and salaries in case of sickness. Cash benefits – linked to the period of sickness to serve as income replacement in the form of paid sick leave – show large differences in terms of length and replacement rates and apply only to workers in the formal economy (Scheil-Adlung and Sandler, 2010). They vary from lump sums to up to 100 per cent replacement of income received prior to the sick leave.

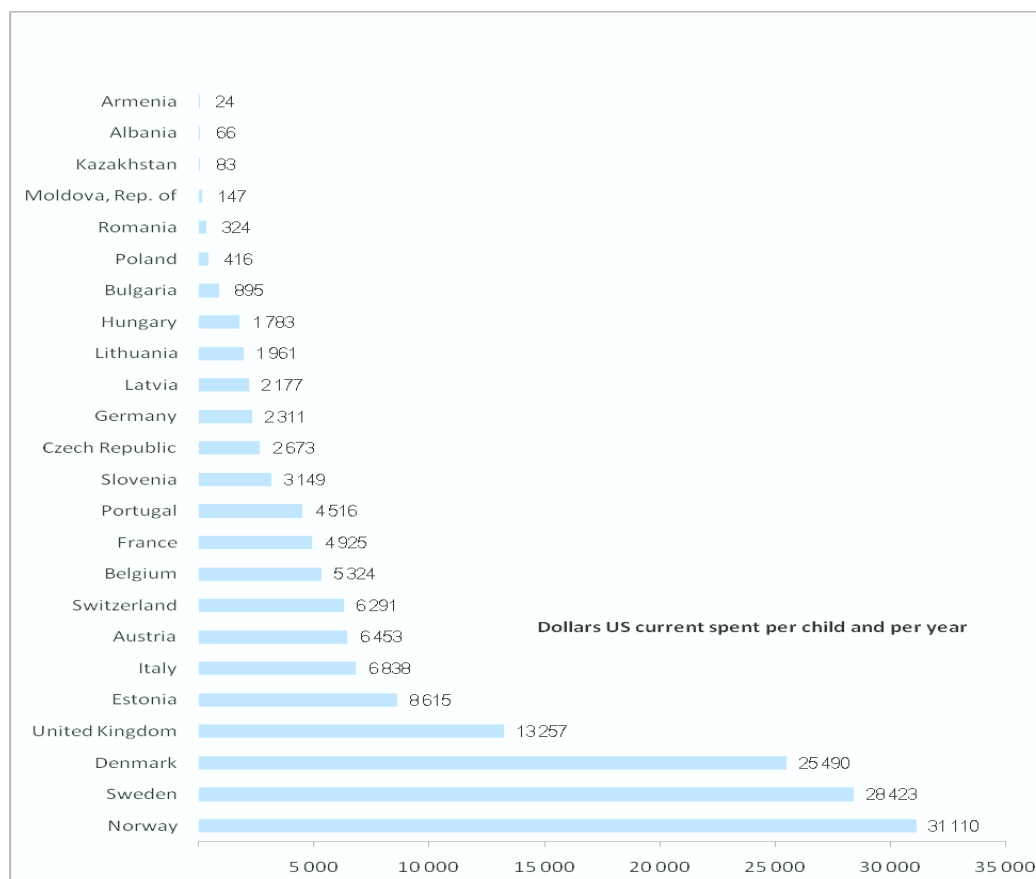
**Long-term care** includes a broad range of cash and in kind benefits for “persons who are dependent on help with basic activities of daily living, caused by chronic conditions of physical or mental disability” (EC, 2011a) such as home, community and institutional care. The scope of benefits varies greatly across European countries. Generally, long-term care benefits are provided either in cash (e.g. in Belgium), in kind (e.g. in France), or as a combination of both (e.g. in Germany, the Netherlands, and the United Kingdom). Despite the ageing population in European countries, long-term care benefits are provided in selected countries only – mostly in the EU region. In some European countries, separate long-term care schemes have been established, e.g. in France, Germany, the Netherlands, where a closer link to social assistance schemes can be observed (ILO, 2010a; SSA/ISSA, 2010). Frequently, the predominant health financing mechanism – insurance or tax-based system – is also used for the provision of long-term care.

**Maternity protection** is organized in close relationship to sickness schemes, and in all countries comprises maternal leave, cash benefits and medical benefits. In all countries maternity protection is provided through social or national health insurance, except in the Netherlands, Slovenia and the United Kingdom, where it is provided by unemployment insurance, the State, and employers respectively (ibid.).

The expenditure for maternity protection – and particularly for maternity leave – per infant and per year relates to the income levels of women giving birth and varies widely across

the European region. It can be as low as US\$24 (Armenia) or as high as US\$31,109 (Norway) (figure 3).

**Figure 3. Expenditure per newborn and per year, 2007/2009**



Source: Authors, based on data from ILO, 2010a.



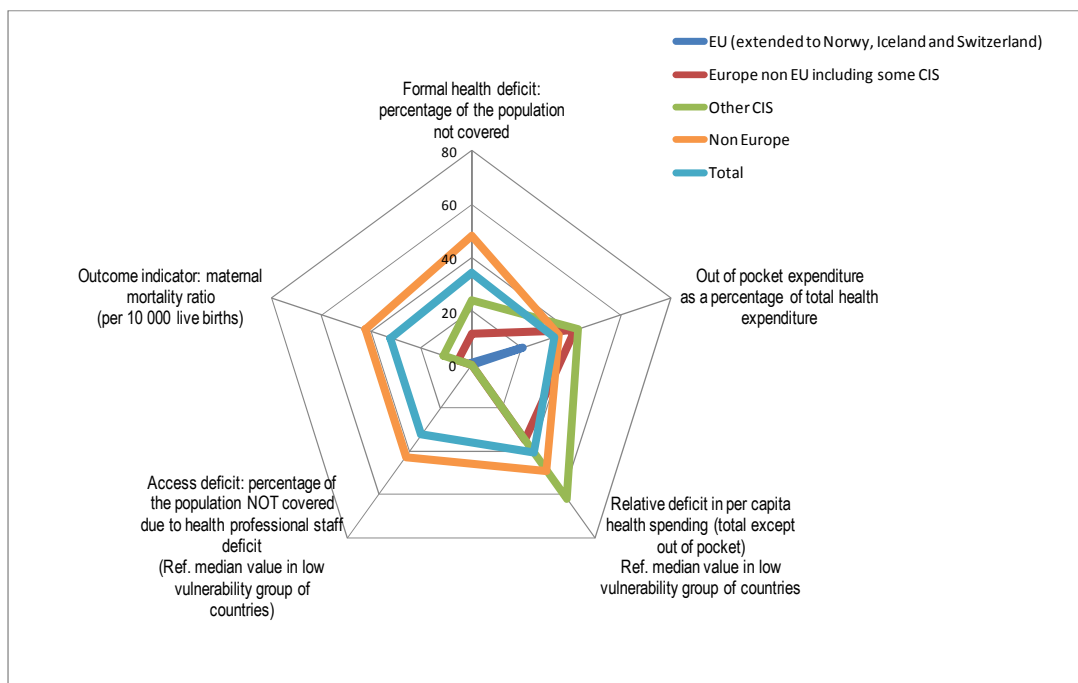
### 3. Determinants of inequities in access to health care due to gaps in social health protection

Despite the fact that the overall objective of providing universal coverage ranks high on the agenda of countries in the European region and is stipulated in most national legislations, substantial inequalities in accessing health services persist for vulnerable groups.

Although all countries in the region provide some form of medical and cash benefit for sickness and maternity, gaps in **statutory coverage** and specific eligibility criteria, as well as **limited scope of benefits**, may lead to inequalities of access. This may be due to the actual exclusion of specific population groups, or to the exclusion of particular health needs of population groups. Legal gaps and inadequate scope of benefits lead to out-of-pocket expenditure for health care that is not covered under social health protection schemes, and result in **gaps in financial protection**, which in turn can impact on access to health care for those unable to pay. Exclusion may also occur through an inadequate provision of care in some geographical areas, e.g. due to insufficient allocation of funds, health workforce, or quality of care. These issues undermine the aim of providing universal social health protection to all, defined as *effective access* to financially, physically, and geographically available quality health services (ILO, 2008a).

The overall performance of social health protection systems differ with regard to the accessibility of health care between countries, regions, and for vulnerable populations groups. Figure 4 provides a snapshot of inequities in effective access to health services in the broader European region.

Figure 4. Inequities in effective access to social health protection in the European region



Source: ILO, 2010a. Calculations based on WHOSIS 2006 data, available at <http://www.who.int/whosis/>.

The four main country groups distinguish between the extended European Union, non-EU European countries including some CIS countries (Albania, Armenia, Azerbaijan, Belarus, Georgia, Republic of Moldova, Russian Federation, Serbia and Ukraine), other CIS (Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan) and non-European Central Asian

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countries. The following set of indicators is used as a proxy for effective access to health care:

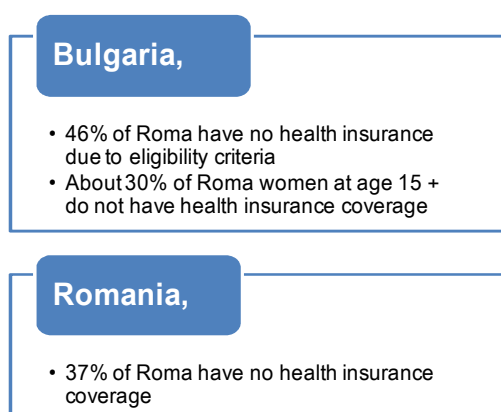
- statutory / formal coverage deficit as a percentage of the population not covered;
- out-of-pocket payments as a percentage of total expenditure;
- the relative deficit in per capita spending compared to the median spending of countries that have relatively low levels of poverty and informal economy (ILO, 2010a) such as the CEE countries;
- the deficit of professional health staff compared to the median spending of countries that have relatively low levels of poverty and informal economy;
- maternal mortality outcomes.

Figure 4 shows large inequities in access to health care across the European region, whereby the countries of Central Asia show higher than average deficits regarding all indicators. While within the extended European Union we find universal statutory coverage, other countries of the region have deficits of up to 50 per cent of total population coverage. Out-of-pocket payments as a percentage of total expenditure – a key indicator for inequities due to financial barriers – play an important role in all countries, with variations ranging from some 20 to 50 per cent of total health expenditure. The relative deficit in per capita health spending reaches 60 per cent in non-EU countries, and the health workforce deficit more than 40 per cent compared to the median value of countries with low poverty rates. As expected, these inequities result in significant differences in maternal mortality.

### 3.1. Gaps in statutory coverage

Formal rules defined as eligibility criteria can lead to inequalities in access to health services. This concerns particularly the exclusion of groups that do not or only partly participate in the formal labour market. Eligibility criteria for social health protection and maternity protection often include formal employment contracts based on full-time work or residency, and thus frequently exclude, for instance, women employed in part-time or other working arrangements, including the informal sector. Women in general, ethnic women such as Roma, and migrant populations who often face difficulties in accessing the labour market, are therefore particularly disadvantaged.

**Figure 5. Key facts on statutory coverage of the Roma population**



Sources: Authors, data from various sources including EDIS, 2009; European Roma Rights Center, 2006; Krumova and Ilieva, 2008; Milcher, 2006.

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Recent studies have revealed that **Roma households** in general face multiple barriers in access to health care. These can be attributed to difficulties in meeting eligibility criteria for the inclusion in social health protection mechanisms related to employment and legal status, as well as incomplete documents (European Roma Rights Center, 2006). The percentage of Roma without health insurance due to not meeting these criteria thus amounts to 37 per cent in Romania and 46 per cent in Bulgaria (ibid.), resulting in health care expenditures having to be paid out-of-pocket.

Roma women, whose participation in the formal labour market is typically much lower than that of Roma men, and who receive lower income, are especially vulnerable in terms of lacking social health protection: almost one-third of Roma women over the age of 15 are not covered by any social health protection mechanism (Krumova and Ilieva, 2008).

Given the high poverty rates among the Roma population, which disproportionately affect women, gaps in statutory coverage result in high health-related out-of-pocket expenditures especially with regard to maternal health, and create substantial financial barriers in access to health care.

Many **migrant populations** also face problems related to their legal status. In the United Kingdom, for example, it is estimated that 47 per cent of all migrants are not covered by standard employment-based social health protection (Avato, Koettl and Sabates-Wheeler, 2009).

Even in countries with universal statutory coverage, the remaining gaps lead to significant financial barriers in access to health services. Hardly anywhere can health care be obtained without financial implications for the vulnerable.

### **3.2. Limitations in the scope of benefits**

Gaps leading to inequities in access to health services are found in all countries of the European region, including in EU countries that have reached almost universal coverage, such as Belgium, France, Germany, Luxembourg and the United Kingdom. Such gaps may occur because of a limited scope of benefits. In Belgium, Denmark, Greece, Iceland and Portugal, for example, dental care is often excluded from benefit packages (OECD, 2009). In many European countries, roughly two-thirds of total expenditure on dental care is paid from private sources (OECD, 2010). The exclusion of such benefits results in high out-of-pocket payments and hinders effective access to care.

Long-term care benefits, which differ widely between countries in the broader European region, serve as a further example of limitations in the scope of benefits. Even in those countries where long-term care benefits are provided, they often fail to sufficiently cover required services and the related high expenditures. Deficits in the scope of benefits may therefore result in high out-of-pocket payments and inequalities in access to adequate long-term care, especially for the elderly, who suffer from higher poverty rates, and for elderly women, who are disproportionately affected by poverty.

Limitations in the scope of benefits also have more far-reaching consequences. To contain the related costs, a large proportion of long-term care is delivered by family members or through informal working arrangements. This in turn has significant implications for social protection coverage and the income situation of caregivers (World Bank, 2010a).

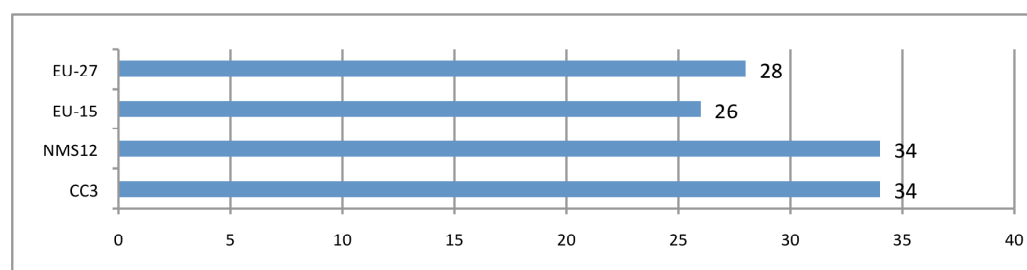
The situation is worsened by shortages in the health workforce. Ageing has strongly increased the demand for care and contributed to increased migration of often low-paid care workers, particularly from Eastern Europe and developing countries in Asia, to Western European countries where benefit packages do not include long-term care.

### 3.3. Gaps in financial protection

The gaps in statutory protection discussed above, as well as other aspects such as co-payments, for example, can result in high out-of-pocket (OOP) expenditures, even if statutory coverage is at 100 per cent. The lack of financial protection against OOP can substantially limit the ability to access care when in need.

The costs of accessing care vary widely between countries, and within the EU-27 have been reported as a reason for difficulties in accessing doctors' medical care by 28 per cent of respondents to the European Quality of Life Survey (see figure 6). In the EU-15, costs were reported to create barriers to access by 26 per cent of the respondents, and by over a third of respondents in the twelve New Member States (NMS) as well as the three candidate countries (CC3) Croatia, Macedonia and Turkey (European Foundation for the Improvement of Living and Working Conditions, 2009a).

Figure 6. Respondents reporting difficulties in accessing medical care due to the cost of seeing a doctor, by country groups, 2007 (percentages)



Source: Authors, based on data from European Foundation for the Improvement of Living and Working Conditions, 2009a.

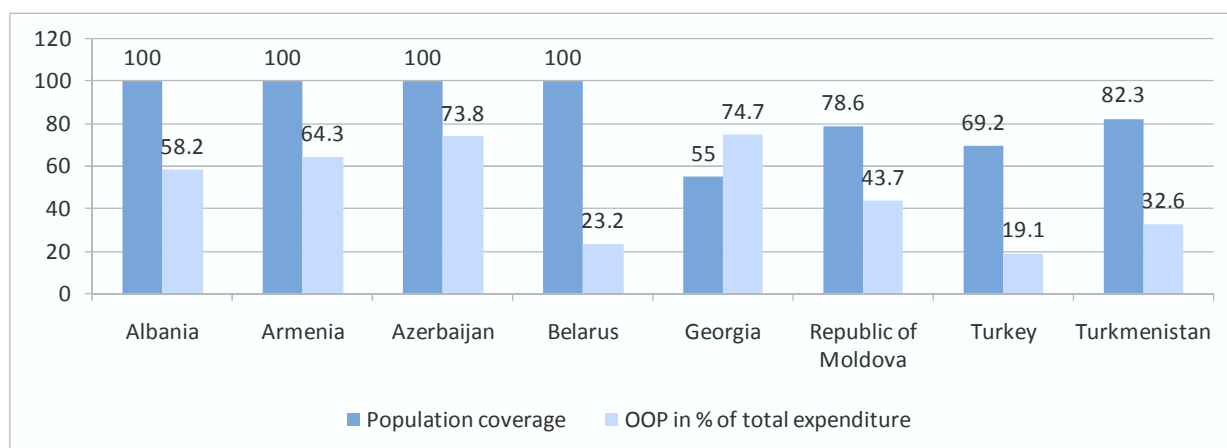
**Out-of-pocket payments** are also prevalent in many CIS countries. High gaps in financial protection are found in Azerbaijan – despite existing statutory coverage of 100 per cent of the population – where they amount to more than 70 per cent of total expenditure. Out-of-pocket payments reach levels of over 60 per cent in Armenia, and exceed 23 per cent in Belarus (figure 7), while in Albania they amount to over 58 per cent despite universal statutory health coverage.

In countries with large gaps in statutory coverage, such as Georgia, Republic of Moldova, Turkmenistan and Turkey, where deficits vary significantly – between 18 per cent of the total population (Turkmenistan) to up to 45 per cent (Georgia) – gaps in financial protection from out-of-pocket payments can be very high: in Georgia, for example, as much as 74.7 per cent of total health expenditure.

Particularly large gaps are found in covering HIV/AIDS treatments, which in several countries account for almost 50 per cent of out-of-pocket payments (WHO databases, 2009/10).



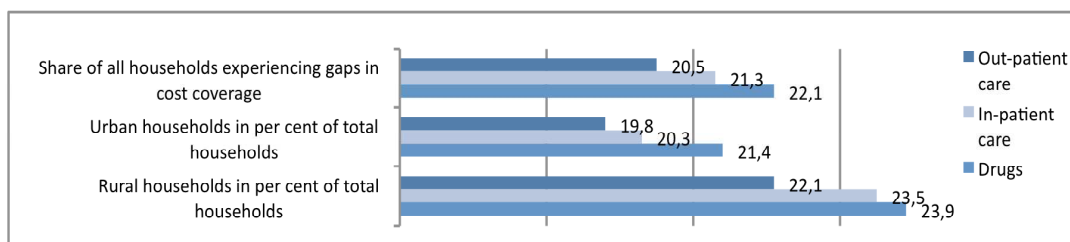
**Figure 7. Statutory coverage and deficits in financial protection from out-of-pocket payments (OOP) as a percentage of total health expenditure, 2007**



Source: Authors, based on data from ILO, 2010a; WHO 2009/2010 database.

A recent household survey in Ukraine – a country proclaiming universal statutory coverage – revealed that in 2009, over 20 per cent of all households experienced gaps in financial protection against health-care costs. This gap was significantly higher in rural than in urban areas for both out-patient and in-patient care, as well as for drugs (figure 8).

**Figure 8. Rural and urban households experiencing gaps in financial protection against health expenditure, Ukraine, 2009 (percentages)**

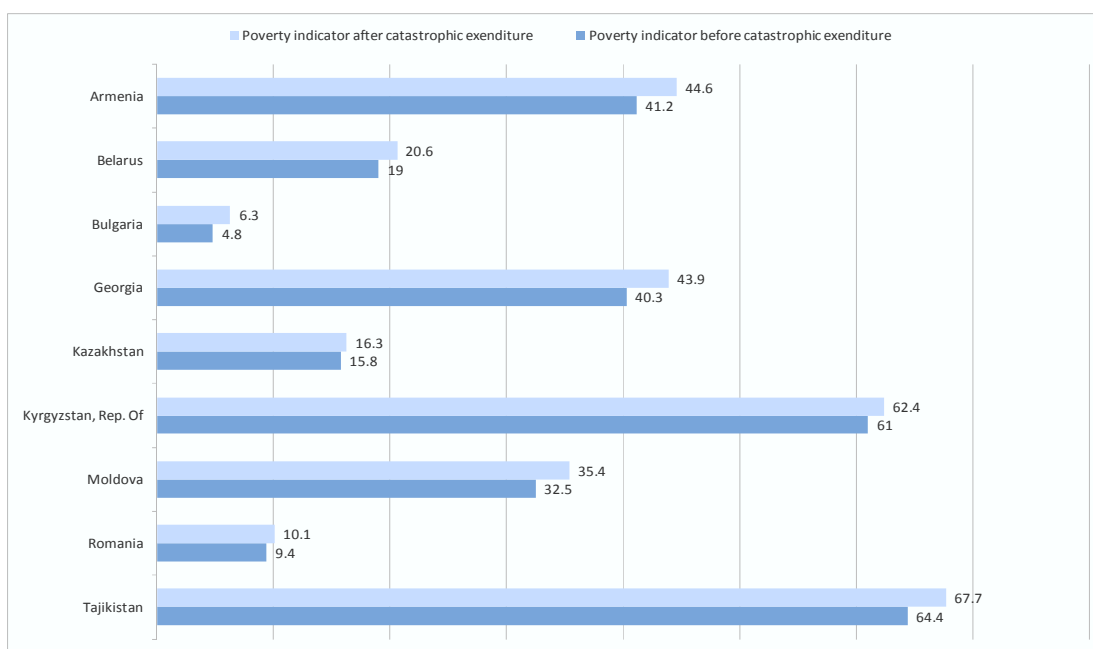


Source: Authors, based on data from State Statistic Committee of Ukraine, 2009.

Inequities in financial protection can lead to **catastrophic health expenditure**, defined as private out-of-pocket expenditure exceeding 40 per cent of the available household income. In the European region, such effects are particularly relevant for female-headed households and in case of complicated birth deliveries.

The impoverishing effect of catastrophic health expenditure in selected countries is demonstrated in figures 9 and 10. Using a poverty line of US\$ 2.15 PPP, figure 9 displays the poverty levels before and after catastrophic expenditures for health care in selected countries of the European region.

**Figure 9. Poverty levels before and after payment of catastrophic health expenditure, selected European countries, latest available year (percentages)**

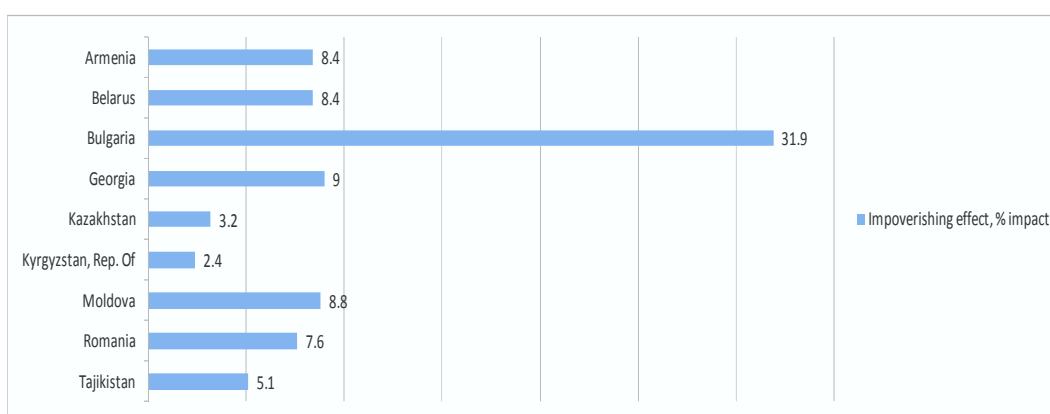


Note: Data based on most recent household surveys; poverty line used: US\$2.15 at PPP.

Source: Authors, based on data from World Bank, 2005.

The impact of catastrophic health expenditure on increases in poverty indicators is shown in figure 10. While such expenditures increased the poverty indicators in Kyrgyzstan by 2.4 per cent and by 3.2 per cent in Kazakhstan, in Romania an impact of 7.6 per cent was observed. In Armenia and Belarus, the impact was measured at 8.4 per cent, and reached 8.8 per cent in the Republic of Moldova. It was in Bulgaria that catastrophic health expenditure had the highest impact on poverty levels, at 31.9 per cent.

**Figure 10. Increase of poverty indicators due to catastrophic health expenditure, selected European countries, latest available year (percentages)**

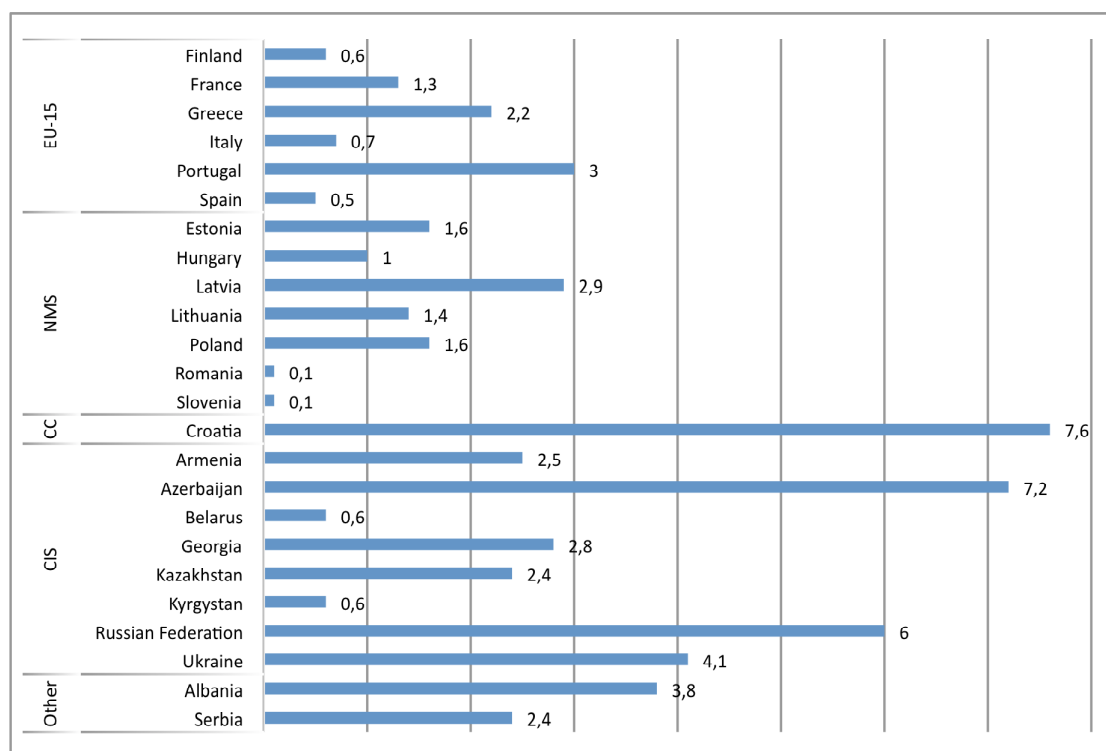


Source: Authors, based on data from World Bank, 2005.

The number of households affected by financial catastrophe and related inequities in access to health services is significant throughout the European region, as indicated in figure 11: 6 per cent of all households in the Russian Federation, 7.2 per cent in

Azerbaijan, and 7.6 per cent of households in Croatia suffer from health-related catastrophic expenditures.

**Figure 11. Households suffering financial catastrophe from health-related expenditure, selected countries, 2009 (percentages)**

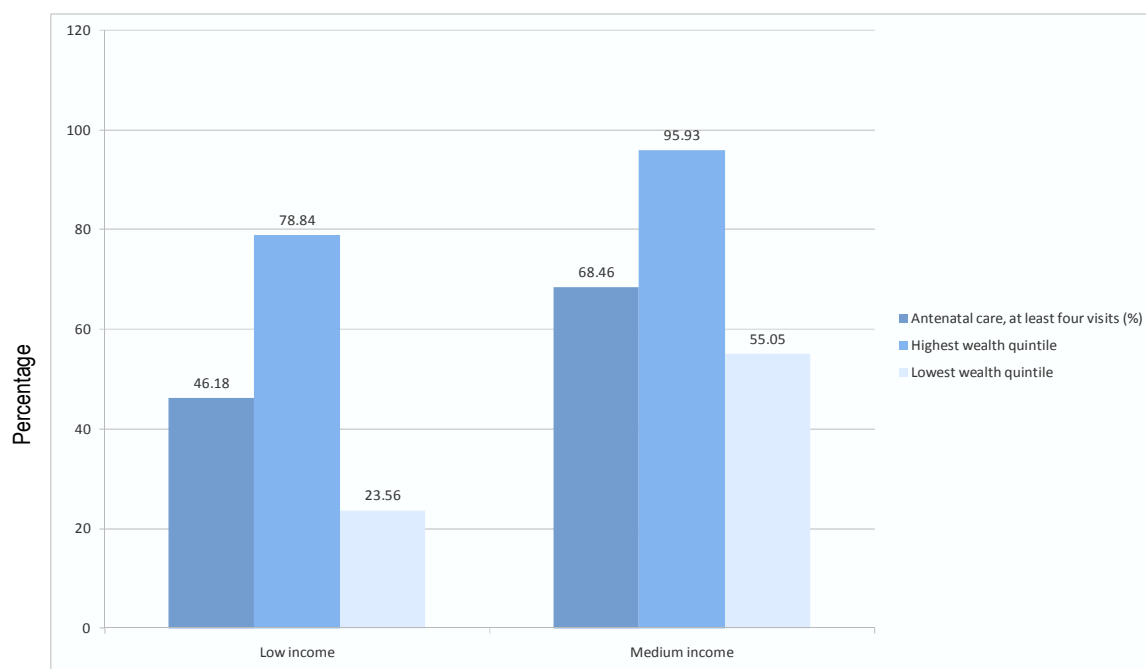


Source: Authors, based on data from ILO, 2010a.

Out-of-pocket expenditures may not only result in catastrophic expenditures and lead to impoverishment, but may also act as a barrier to accessing care in the first place. In the Republic of Moldova, for example, 40.1 per cent of households reported difficulties in accessing health care due to financial reasons, and 15.3 per cent of households were unable to access health services at all due to financial barriers prior to the introduction of mandatory social health insurance in 2004. Although this reform significantly facilitated access for the insured, an estimated 24.3 per cent of the population remain uninsured. The most vulnerable population groups – including the rural self-employed, the unemployed and particularly unemployed women – remain excluded from social health insurance and thus lack protection against out-of-pocket expenditures (Atun et al., 2008).

The fact that **inequities in access are strongly linked to the income status** of those in need is illustrated by data on access to maternal health care in low- and middle-income countries, which include many CEE and CIS countries. These inequities are shown by wealth quintile in figure 12: while between 78 and 95 per cent of women in the highest wealth quintile in these countries had access to maternal health services, this was true for only 23 to 55 per cent in the lowest quintile of the same country group.

**Figure 12. Inequities in access to maternal health services by wealth quintile and national income level of countries, latest available year (percentages)**



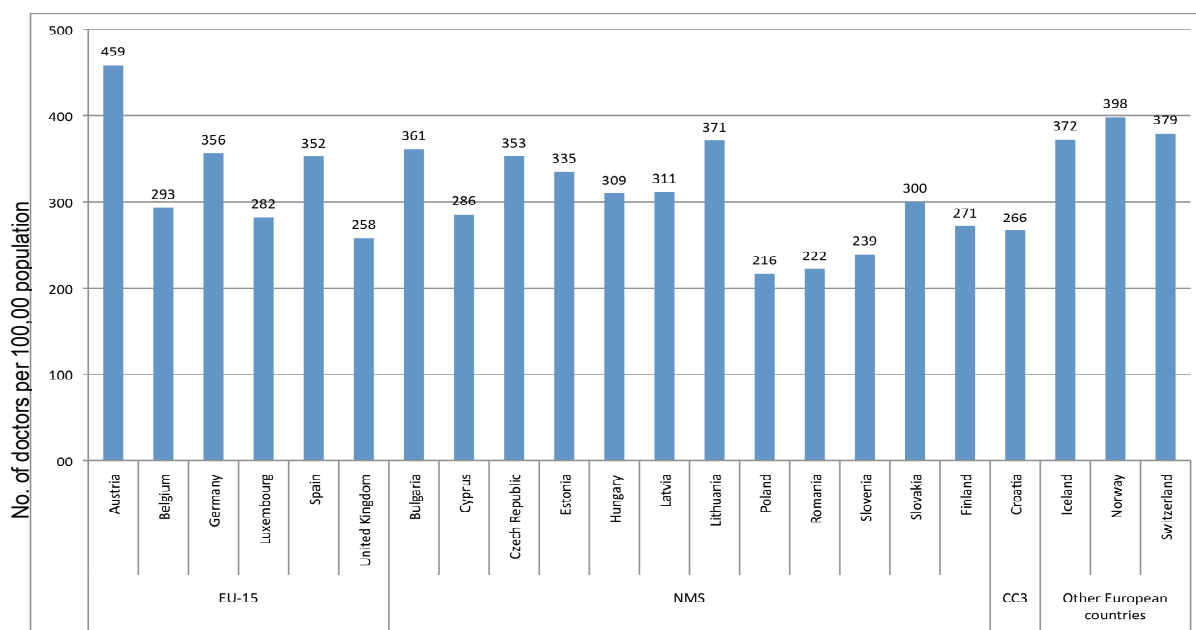
Source: Authors, based on data from ILO, 2010a.

Household surveys based on data on total individual spending on health have found women’s out-of-pocket payments to be systematically higher than those of men (WHO, 2010a), which can be mostly attributed to women’s specific health needs related to pregnancy (also in adolescents), childbirth, contraception and abortion. Even where maternity care should be provided free of charge, in many cases “households pay a substantial proportion of the cost of facility-based services, and the expense of complicated deliveries is often catastrophic” (ibid.). Where women have limited control of economic and financial household resources and expenditures, they are even more disadvantaged in terms of accessing health care (IFAD, 2010). This finding is supported by studies on the impact of the introduction of user fees, which have revealed a greater decline in the use of health care by women than by men (EC, 2009; WHO, 2006). Maternity-related out-of-pocket payments are therefore particularly relevant for poor women, including Roma women and female migrants.

### 3.4. Geographical inequalities in access

Geographical accessibility of health care is strongly determined by the availability of health staff. The density of health professionals can thus serve as a useful indicator to determine accessibility to different levels of care. Figure 13 shows the numbers of practising physicians (excluding nursing and caring professionals) per 100,000 population in selected European countries. While this number is highest in Austria, at 459 per 100,000 population, it is lowest in Poland at 216 per 100,000. The density of practising physicians is also high in Iceland, Norway, and Switzerland, while countries such as Romania or Slovenia display a lower density. A comparably low number of physicians is also recorded in the United Kingdom at 258 per 100,000 population.

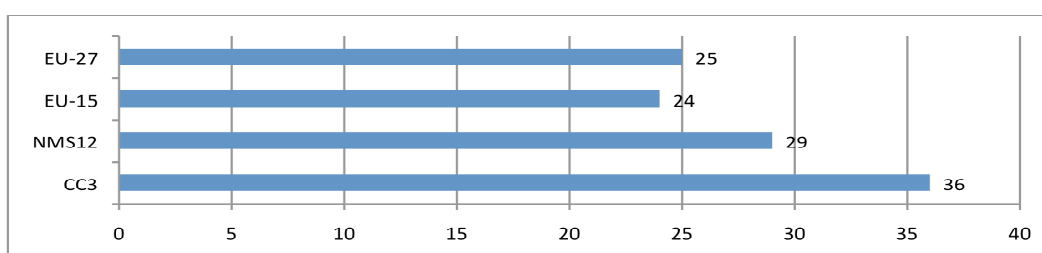
**Figure 13. Number of practicing physicians (excluding nursing and caring professionals) per 100,000 population in selected countries of the European region, 2008 or latest available year**



Source: Authors, based on data from EUROSTAT online database, 2011a.

Research has revealed that distance to health-care facilities such as the doctor's office, hospitals and medical centres is an issue across all countries of the EU-27 and the three candidate countries (CC) Croatia, Macedonia, and Turkey (figure 14). While for all EU-27 countries 25 per cent of respondents reported difficulties, 24 per cent of respondents in the EU-15 against 29 per cent of the twelve New Member States (NMS) faced difficulties in accessing services due to distance. The highest percentage was recorded for the CC3, where 36 per cent of respondents claimed distance as impeding access to medical care.

**Figure 14. Respondents reporting difficulties in accessing medical care due to distance to doctor's office/hospital/medical centre, by country group, 2007 (percentages)**

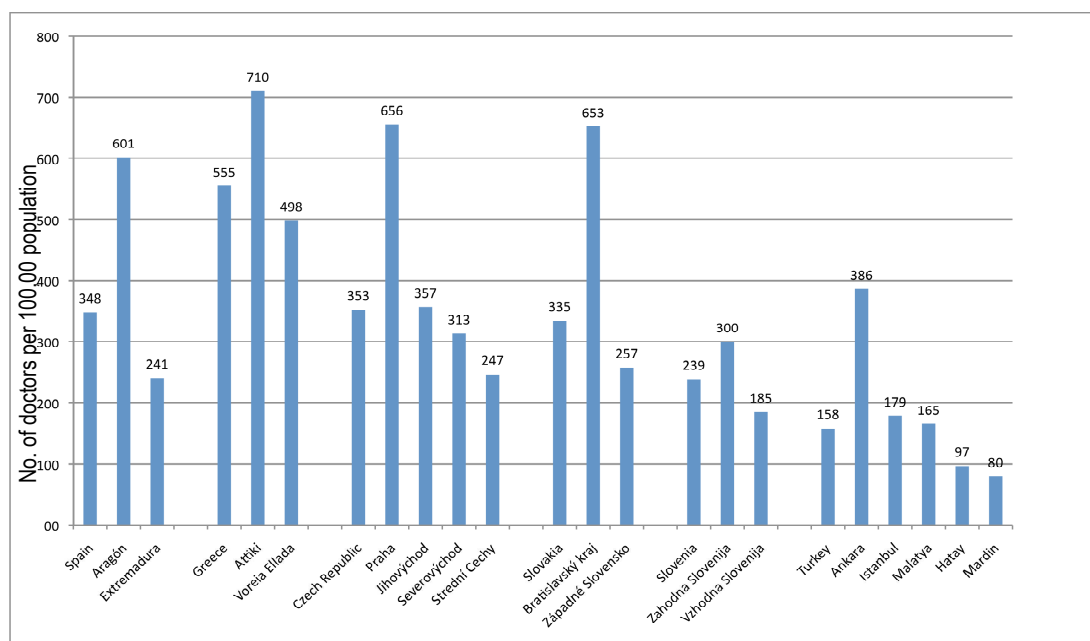


Source: Authors, based on data from European Foundation for the Improvement of Living and Working Conditions, 2009a.

While the above data also reflect differences in the design and management of health systems and should be interpreted with care when attempting to compare geographical accessibility between countries, the distribution of physicians within countries indicates inequalities in accessibility of health services in different regions. Figure 15 compares the number of doctors and physicians per 100,000 population in selected regions of some European countries to the respective country average. In Spain, where the average number of doctors and physicians per 100,000 population amounts to 348, this figure reaches 601.3 in Aragón, but merely 240.6 in Extremadura. In the Czech Republic, Prague has a high

density of doctors and physicians at 656 per 100,000 population, roughly 2.5 times as many doctors as in Strední Čechy. The differences in Turkey, which averages 158.2 doctors per 100,000, are particularly striking, with fewer than 80 doctors in Mardin compared to 386 in Ankara.

**Figure 15. Doctors or physicians per 100,000 population within selected countries and their provinces in the European region, 2008 or latest available year**

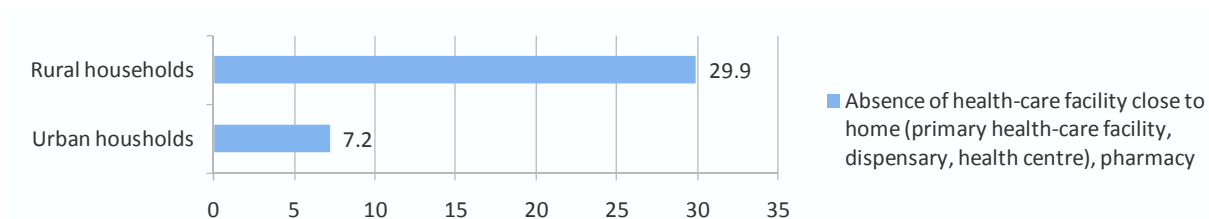


Source: Authors, based on data from EUROSTAT online database, 2011b.

Regional inequities in access linked to infrastructure and availability of health staff show a strong **rural–urban divide**, which is also indicated by figure 15. A higher density of the health workforce in more urbanized areas is found in most countries of the European region. In France, for example, urban areas are served by 458 physicians per 100,000 population, whereas rural areas are served by 122 physicians per 100,000 (OECD, 2009). Coverage rates by family doctors per 1,500 population in Moldova also show significant geographical inequities in access between rural and urban areas: While in 2005, 88.9 per cent of the population were covered by a family doctor, coverage ranged from less than 65 per cent in certain districts (Cantemir, Rezina, Cimislia and Falesti rayons) to 98.6 per cent in Chisinau municipality (WHO, 2008).

In the EU-27, for example, twice as many people in rural (6 per cent) than in urban areas (3 per cent) report difficulties in accessing medical care due to distance to the doctor’s surgery or hospital. In Croatia, Macedonia and Turkey, these figures were 18 per cent for rural and 11 per cent for urban areas (European Foundation for the Improvement of Living and Working Conditions, 2009b, Overview). In the Ukraine in 2009, some 7 per cent of households in urban areas compared to nearly 30 per cent of households in rural areas experienced a lack of available primary care centres, health centres, dispensaries and pharmacies (figure 16).

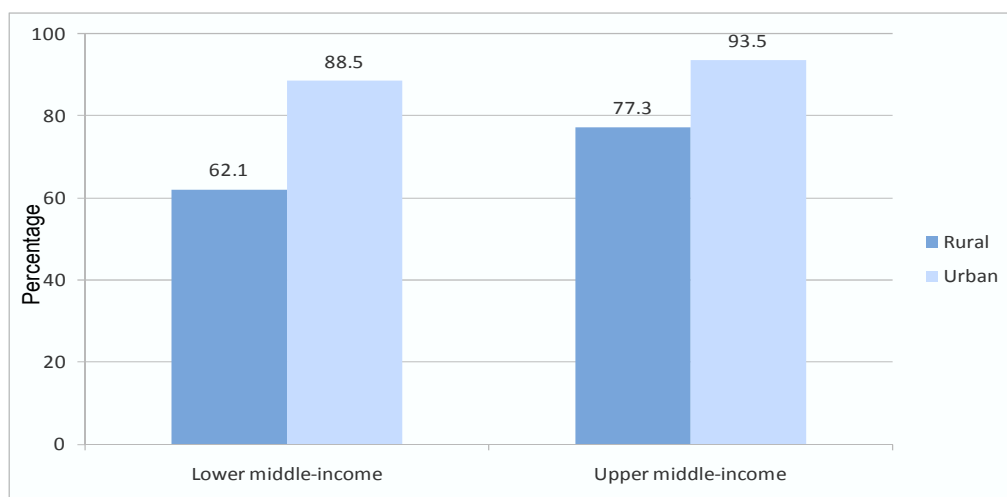
**Figure 16. Rural and urban households experiencing the absence of health-care facilities close to home, Ukraine, 2009 (percentages)**



Source: Authors, based on data from State Statistic Committee of Ukraine, 2009.

Inequities between rural and urban areas can also be observed for **access to maternal health services**. Global data on upper middle and lower middle-income countries, including the majority of CEE and CIS countries, provide related evidence (figure 17).

**Figure 17. Births with skilled birth attendants, urban and rural area, lower and upper middle-income countries (percentages)**



Source: ILO, 2010a.

Globally, in lower middle-income countries – including Armenia, Azerbaijan, Turkmenistan and Ukraine - only 62.1 per cent of births among the rural population as compared to 88.5 per cent of births among the urban population are attended by skilled birth attendants.

Given the **unequal distribution of the health workforce and gaps in availability of services**, those living in rural areas are faced with more serious opportunity costs when they need health services, as well as increased financial barriers linked to travel costs. Due to the more diversified employment structures in rural areas and resulting gaps in social health protection coverage, additional out-of pocket expenditures to overcome geographical barriers can severely impact on access to health care (OECD, 2009).

Legal, financial and geographical gaps in coverage all present barriers to accessing health care, and can lead to impoverishment and catastrophic health expenditure, or result in the most vulnerable not being able to access care at all. Financial affordability at the household level and inequalities in access are therefore closely linked to poverty and income

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disparities, and in terms of eligibility for social health protection are often related to access to the labour market and employment status. The overall performance of social protection mechanisms is also critical in facilitating access to health care. In this regard, socio-cultural aspects related to gender, migration and ethnicity also play an essential role in access to both the broader social protection system and social health protection in particular. The impact of the socioeconomic environment on inequities in access to health care is analysed in the following chapter.



## 4. Determinants of inequities in access to health care due to the socioeconomic environment

The broad European region referred to here – CEE, CIS and some Central Asian countries – is characterized by strongly heterogeneous economic performance and social development. This chapter provides a brief overview of disparities in overall socioeconomic development and progress towards the MDGs in these countries. Key aspects relevant to the vulnerability of the population will be highlighted, focusing on

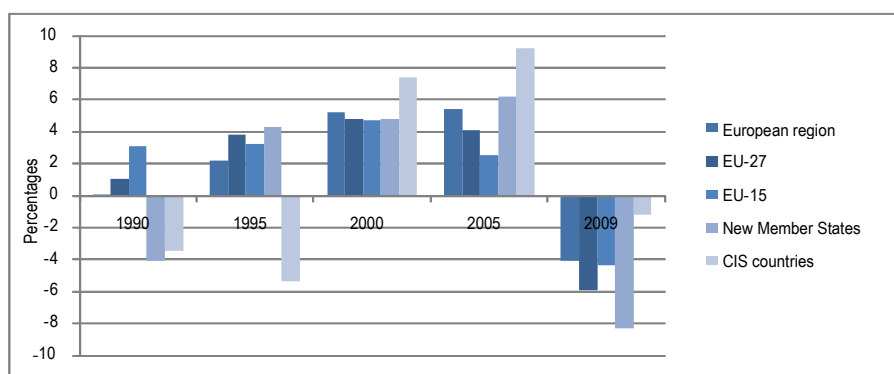
- impacts of labour market structures and employment;
- income disparities;
- poverty rates;
- overall performance of social protection systems.

### 4.1. Economic context and progress towards the MDGs in poverty, gender equality and health

Following the collapse of the Soviet Union towards the end of the 20th century, CEE and CIS countries began to lay the ground for sustainable economic development and to improve social protection. Although some countries were able to benefit from **economic and political restructuring**, as exemplified by the 2004 entrance to the European Union (EU) of eight formerly socialist countries and the 2007 accession of Bulgaria and Romania, progress lagged behind particularly in the many CIS countries that had difficulties in reforming public administration and building active societies. Inequalities and remaining limitations are still evident in terms of institutional structure, economic output and social development (UN, 2010a).

In terms of **economic performance**, CIS countries benefited from stronger economic growth, averaging 7.1 per cent between 2000 and 2008, than the EU-15 which experienced much slower growth rates of 2.3 per cent. New European Member States showed a less significant performance until 2008, which was followed by a decline in output due to the 2008–09 global financial and economic crisis (World Bank, 2010b). Furthermore, the average inflation rate in CIS countries of 10.7 per cent almost doubled the rate of 5.4 per cent recorded by the new EU Member States from 2000 to 2008 (World Bank, 2010b, see figure 18).

Figure 18. Growth rates of real GDP, selected years



Source: Authors, based on data from World Bank, 2010b.

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In terms of **social development**, all European countries show a relatively good performance as regards the global ranking of the Human Development Index (HDI). Yet in 2010, some CIS countries such as the Republic of Moldova, Tajikistan, Ukraine and Uzbekistan were still in the bottom part of the regional ranking and their index values had not recovered from the decline experienced at the beginning of the 1990s. Other countries such as the Czech Republic, Poland or Turkey, however, have significantly improved their ranking in the Human Development Index (UN, 2010a).

The progress of the broader European region towards achieving the **Millennium Development Goals (MDGs)** is characterized by significant inequalities at subregional or national levels: higher-income countries of the European Union and South-Eastern Europe show much more progress towards achieving the MDGs in poverty, gender equality and health than the middle- and low-income countries of the CIS (WHO, 2007).

The improvement towards **MDG 1 on the eradication of extreme poverty and hunger** remains insufficient. Although on average, figures concerning the economically vulnerable in the European region, whose disposable income falls below 60 per cent of the national median, remained stable from 1997 to 2008, stark differences can be noted between countries (UN, 2010a, Appendix 3, table 1). While in some northern and western European countries such as Norway or Switzerland, 10 per cent of the population was classified as economically vulnerable, in many new EU Member States such as Bulgaria, Latvia, Lithuania and Romania, this figure amounts to 20 per cent. Even higher rates of vulnerability can be observed in CIS countries such as Russian Federation and Ukraine. Higher poverty rates in these areas are linked to socioeconomic inequalities, which affect income redistribution, access to education and employment opportunities (ibid.). Despite the considerable progress that has been made over the last 20 years, unemployment rates remain high in many countries – especially in Eastern Europe. Limited growth of formal employment has had important repercussions on poverty reduction.

Many European States have succeeded in halving the incidence of hunger, but in some CIS countries such as Armenia, Azerbaijan, Georgia and Tajikistan, undernourishment rates are still high. In addition, rising food prices in 2007 had serious consequences for food security, as many households had to reduce the quantity and/or quality of food purchased. The Republic of Moldova, for example, suffered from both the surge in food prices and from an internal drought which reduced cereal production and consequently households' food security in 2007 (Meyers and Kurbanova, 2009).

With the aim of eradicating extreme poverty and hunger, European governments have implemented or started to implement poverty reduction strategies. In Albania, Armenia, Kyrgyzstan, Republic of Moldova and Serbia, these have become essential national development strategies towards the successful completion of specific initiatives seeking to reduce poverty and improve living standards (UN, 2010a, Appendix 3, table 1). In addition, in line with the European Employment Strategy (EES) agreed upon at EU level, governments have reduced taxes or provided subsidies in order to attract foreign investors. Such strategies also aim at accelerating economic development and formal employment growth.

As regards **MDG 3 on the promotion of gender equality and women's empowerment**, the European subregions show highly differing results (UN, 2010b).

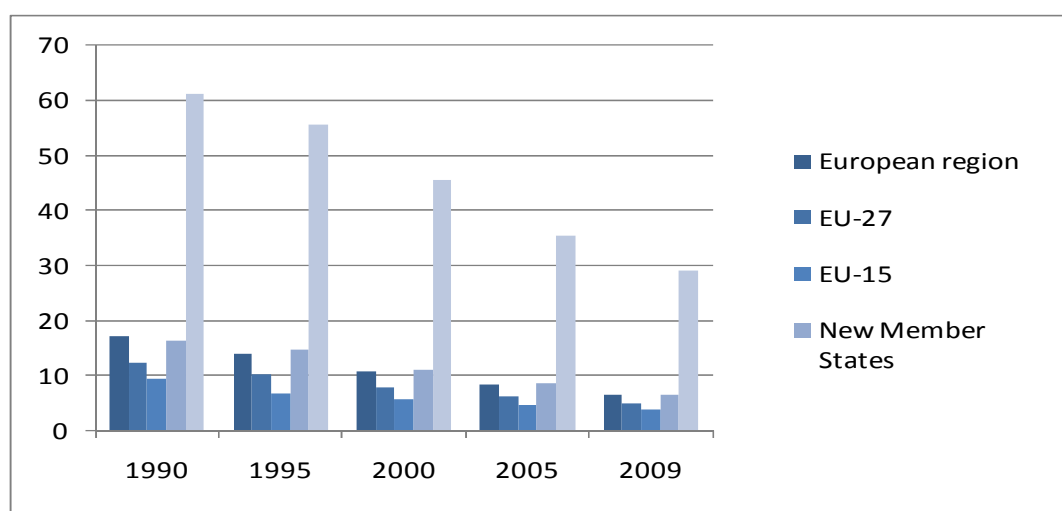
- Gender equality in **education** is nearly achieved in all countries, even if an urban/rural bias still exists: in Azerbaijan, Kyrgyzstan, Turkmenistan and Uzbekistan, for example, disparities in education are more evident in rural areas, where traditional practice does not allow women to continue their studies.
- The **employment** situation of women has also significantly improved in the whole European region, but economically active women are still fewer in number than men

and work in lower-paid or more insecure employment conditions. This is of major concern in the Eastern European countries (Azerbaijan, Armenia, Georgia and Tajikistan where the gender pay gap – i.e. the difference between men’s and women’s monthly earnings – is over 40 per cent. In CIS countries, 49 per cent of jobs are carried out by women, but they are underrepresented in the industrial sector where they account for 30 per cent of the employed workforce (ibid.). Moreover, a high share of the female population continues to work in the informal sector, making women particularly vulnerable to the risk of poverty as this sector notably lacks formal social protection coverage.

- Many women from Eastern European countries migrate to higher-income countries. Their **migrant status** exposes them to a higher risk of poverty and reduces their opportunities to access formal social protection.
- Women’s **access to political power** is still limited. Although women have the right to vote in the entire European region, they are not sufficiently involved in decision-making processes. In northern European countries, women hold more than 40 per cent of total parliament seats, while in Armenia, Georgia, Montenegro and Ukraine women account for less than 10 per cent (World Bank, 2010b). Belarus, Kyrgyzstan, Macedonia, Republic of Moldova and Serbia have adopted a quota system, which has become popular, to tackle gender imbalances in the decision-making process.
- Many countries have mainstreamed gender into their poverty reduction strategies in order to alleviate **female vulnerability**; Kyrgyzstan, Serbia and Turkey, as well as most EU countries, tackle women’s poverty mainly through measures aimed at increasing female employment in the formal sector.

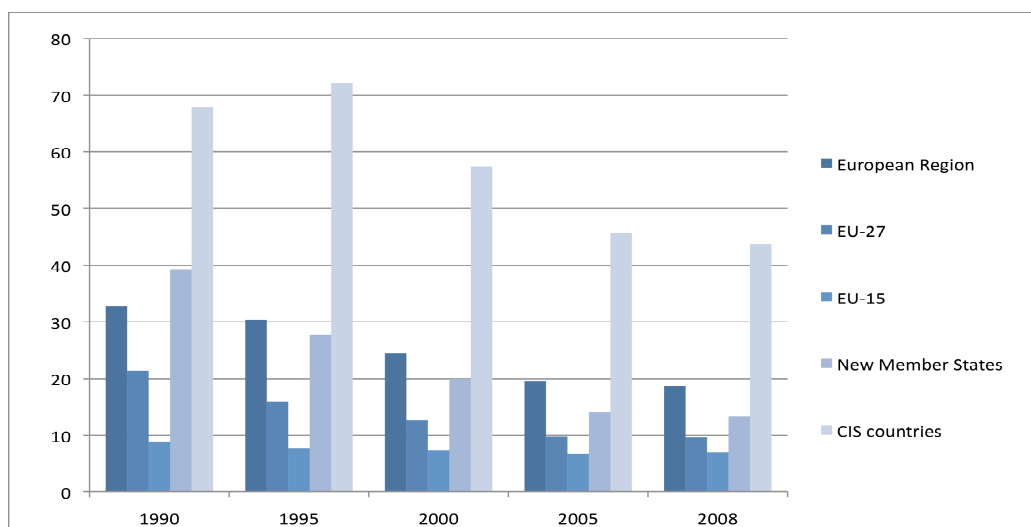
When analyzing **health-related MDGs 4, 5 and 6**, which aim at reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases, trends show an improvement of the overall health condition of the European population over the last decade. While this is broadly, some countries still need to close gaps to improve the outcomes related to the key health indicators. The **under-five mortality rates**, as well as the **maternal mortality rates**, have declined significantly but important variations among countries still exist, as shown in figures 19 and 20.

**Figure 19. Under-five mortality rate (per 1,000), selected years**



Source: Authors, based on data from World Bank, 2010b.

**Figure 20. Maternal mortality (per 100,000 live births), selected years**

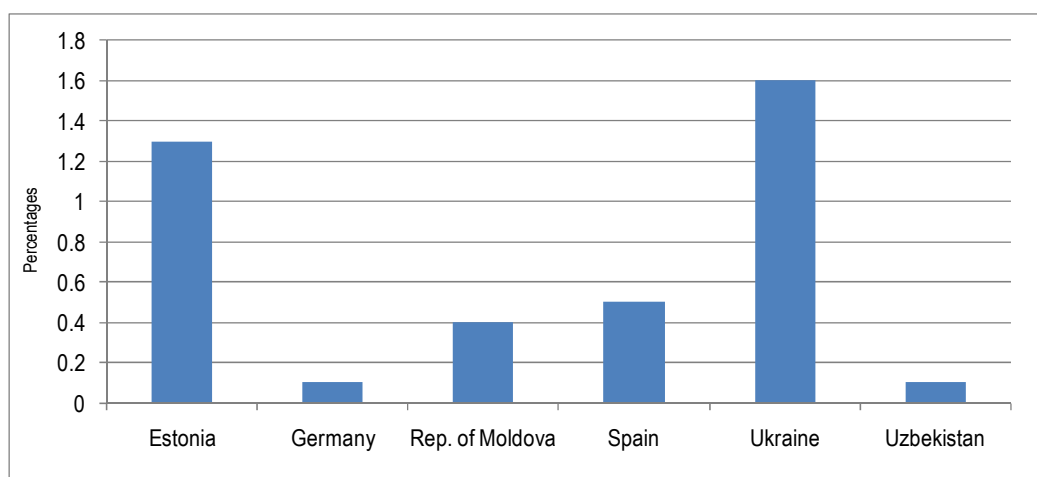


Source: Authors, based on data from World Bank, 2010b.

While over the period 1990–2008, the new Member States (NMS) on average experienced a great decline in both child (–60 per cent) and maternal mortality (–66 per cent), thereby keeping on track towards achieving MDG 4 and 5, progress in reducing child and maternal mortality in CIS countries remains unsatisfactory, calling for increased investment in social health protection. In Tajikistan, for example, despite a steep decline since the 1990s, under-five mortality stood at 61.2 per 1,000 children in 2008, and maternal mortality at 64 per 100,000 live births in 2009. In comparison, average mortality rates in other western European countries lay around 5 and 7 respectively (ibid.).

**HIV/AIDS infection** data show an alarming trend: over the last decade, the entire European region has experienced a serious increase in HIV infection rates. In 2007 Estonia, Latvia, Portugal, the Russian Federation, Spain and Ukraine were affected by the highest rates of the region (ibid.). As shown in figure 21, high prevalence rates of HIV, at 1.6 per cent of the population aged 15–49, were found in Ukraine, and 1.3 per cent in Estonia. Determinants of such high rates in the region can be traced back to socioeconomic inequalities, including poverty and limited employment as well as social exclusion. More comprehensive policies to reduce marginalization and increase health quality are needed. This applies particularly to women working in the sex industry, including migrants and Roma who have been found to engage in high-risk sexual and drug use behaviour (Kabakchieva et al., 2002; Open Society Institute, 2007), rendering them particularly vulnerable to **HIV/AIDS**. In this context, these vulnerable women also require special attention as regards pregnancy and maternity (WHO, 2009).

**Figure 21. Prevalence of HIV, population aged 15–49, selected countries, 2007 (percentages)**



Source: Authors, based on data from World Bank, 2010b.

## **4.2. Employment and the labour market structure**

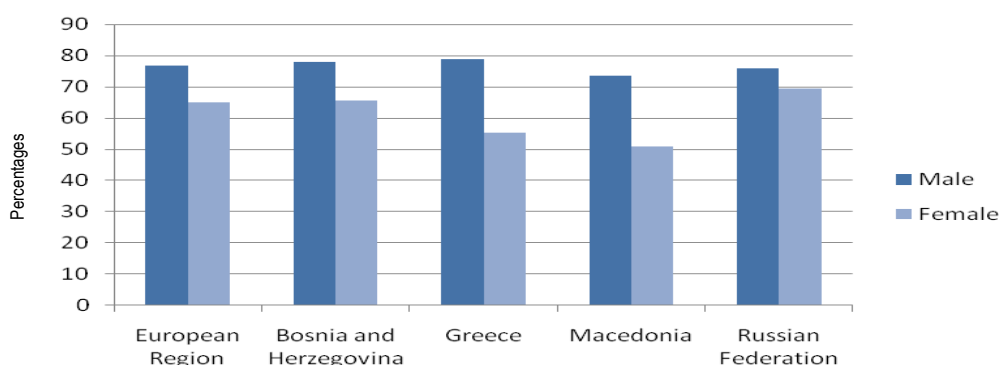
Given the fact that employment status is often part of the eligibility criteria for inclusion in social health protection, labour participation is an important factor in access to health care. The employment of vulnerable groups such as the poor, rural women and others is often characterized by

- lower participation in the labour market,
- higher rates of unemployment;
- part time-employment or contributing as family workers;
- working in the informal economy.

### **4.2.1. Female labour participation**

In all European countries, **female labour participation** is much lower than the participation of men, as shown in figure 22. Moreover, women experience higher rates of unemployment. In 2010, labour market participation in the European region was estimated at 65 per cent for women as compared to 76.9 per cent for men. Even greater inequalities become evident at country level, for example in Greece, where labour market participation is at 55 per cent for females but 80 per cent for males (ILO, 2010a).

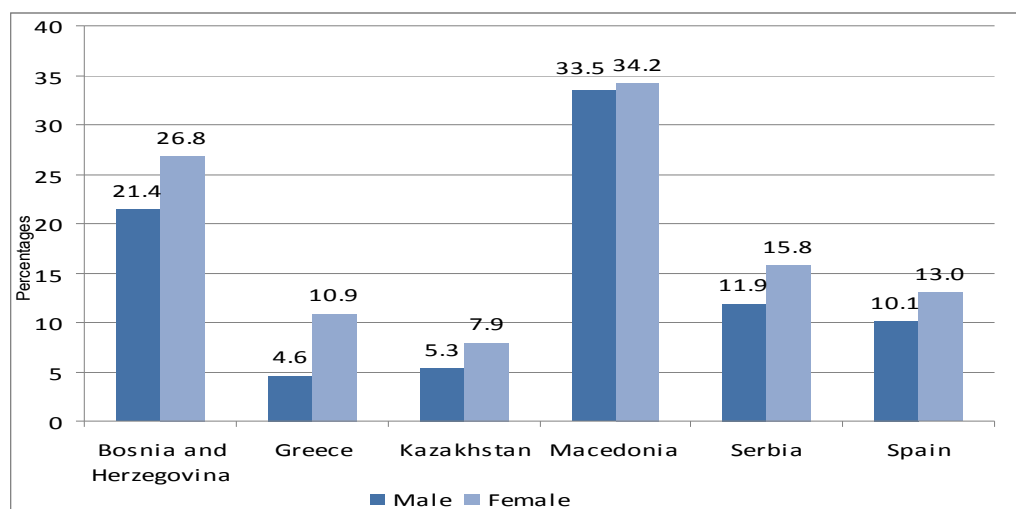
**Figure 22. Labour force participation by sex, European region and selected countries, 2010**  
(percentages)



Source: Authors, based on data from ILO, 2010a.

**Unemployment** as a percentage of the labour forces varies greatly (figure 23), reaching peaks of 34.2 per cent for women in Macedonia against 33.5 per cent for men in 2008, or 26.8 and 21.4 per cent respectively in Bosnia and Herzegovina. Extreme inequalities in unemployment between women and men were observed in Greece, where 10.9 per cent of the female labour force compared to 4.6 per cent of the male labour force was unemployed in 2008 (ILO, 2010a; World Bank, 2010b).

**Figure 23. Male and female unemployment as a percentage of the labour force, selected countries, 2008**



Source: Authors, based on data from ILO, 2010b.

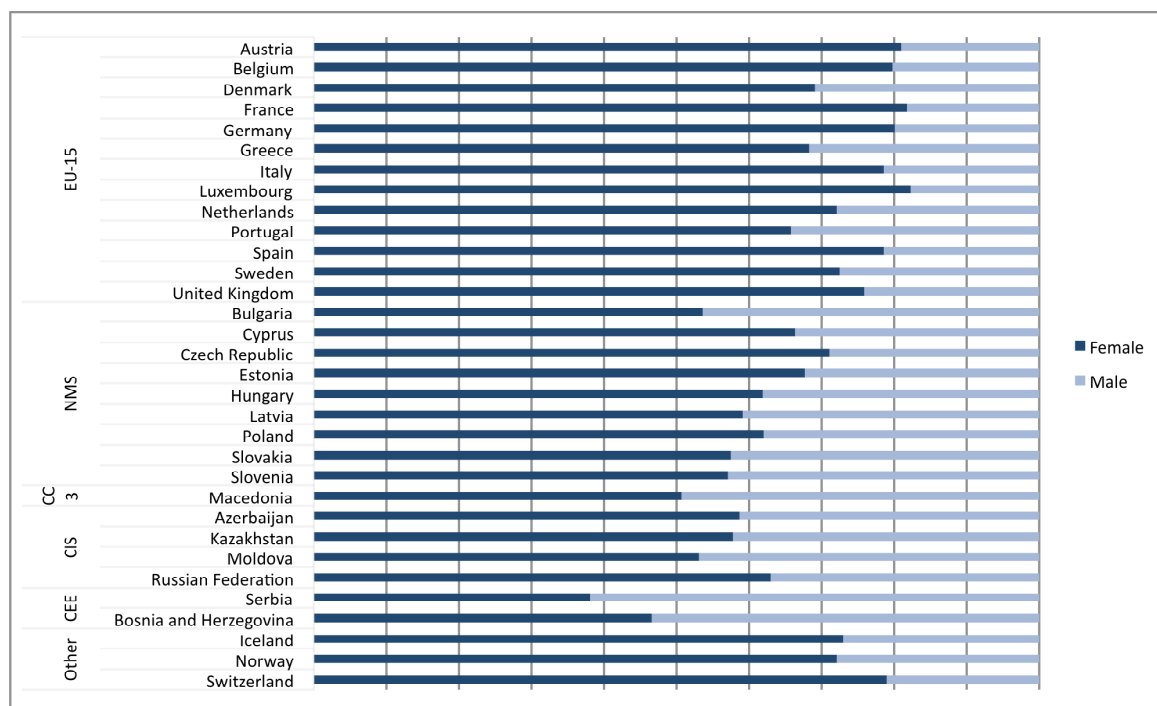
Unemployment is a serious issue affecting the Roma population, with estimated unemployment rates for Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain ranging from 60 to 80 per cent, and up to 100 per cent in isolated areas. In Romania, unemployment among the Roma is four times as high as for the non-Roma population. Linked to their even lower educational levels compared to Roma men, unemployment among Roma women is generally higher than male unemployment (EC, 2010).

**Long-term unemployment**, i.e. twelve months of unemployment or longer, varies between 2.9 per cent of the total active population for men and 3.1 for women in the EU-

27. However, there are again considerable disparities between countries: while in Belgium long-term unemployment reached 3.4 per cent for men and 3.6 per cent for women in 2009, in Spain it amounted to 3.7 per cent for men and 5.0 per cent for women, and in Greece to 2.4 per cent and 6.0 per cent respectively (EUROSTAT, 2011c).

In most countries in the European region, the share of women compared to men in **total part-time employment** is significantly higher (figure 24). This is particularly true for countries such as Austria, France, Germany and Luxembourg, where the share of females in part-time employment exceeds 80 per cent.

**Figure 24. Shares of men and women in total part-time employment, 2009 (or latest available year)**



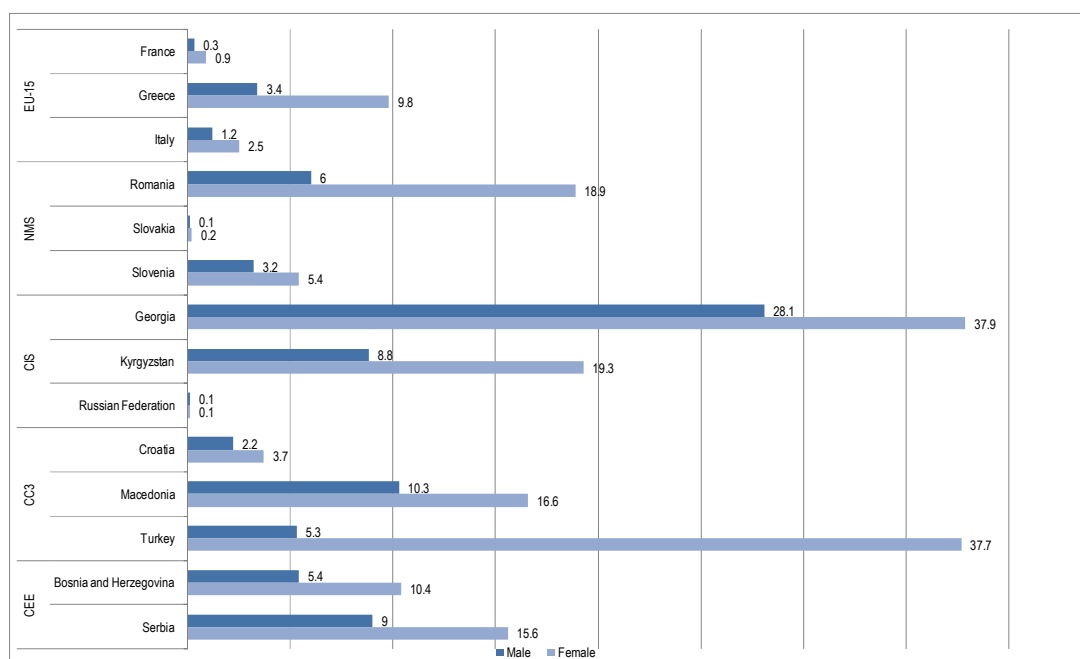
Source: Authors, based on data from EUROSTAT, 2011c.

An important factor affecting female labour participation relates to the traditional role of women in the household. The double burden of household work and pursuit of other income-generating activities results in a triple burden overall for women, particularly in rural areas where women are usually engaged in agricultural work in addition to cash-earning activities (IFAD, 2010).

Female labour is frequently linked to domestic activities occurring as part-time labour, casual work, home work or work in the informal sector. This includes the provision of long-term care to family-members, for example, but also refers to contributing low- or unpaid work to family businesses (UN, 2010a; EC, 2009; WHO, 2006).

In most countries in the European region, the share of employed women working as low- or unpaid contributing family workers is disproportionately higher compared to the share of men, and varies between 0.1 per cent of all wage and salary workers in Russian Federation to more than 37 per cent in Georgia and Turkey (figure 25). The difference between men and women is particularly high in Romania, where 19 per cent of total employment consists of female family workers as compared to 6 per cent of men, as well as in Turkey where only 5.4 per cent of men compared to 37.7 per cent of women in total employment work as contributing family members (ILO, 2010a, Annex).

**Figure 25. Share of contributing family members in total employment by gender, selected European countries, 2008 (percentages)**



Source: Authors, based on data from ILO, 2010a.

#### 4.2.2. Labour market structure

**Labour market structure** differs significantly among European countries, particularly concerning the extent of the **formal and informal economies**, with serious implications for inclusion in social health protection and access to health care.

Some groups are disproportionately engaged in the informal economy, such as women (as shown above) or ethnic minorities including the Roma population, as well as migrants.

Overall, barriers in access to formal employment for Roma are amplified for Roma women by double discrimination regarding their ethnic origin and gender. Consequently, Roma women are predominantly employed in “auxiliary, unskilled, physically demanding work” in the informal economy (EC, 2010).

Migrants, particularly if undocumented, constitute another vulnerable group of workers in the informal economy. Since host countries often provide more possibilities for formalizing the status of male migrants working in the more traditional migrant sectors, attaining a legal status and thus rights and entitlements to health protection can be more difficult for female migrants.

In the broader European region, as elsewhere, a large informal economy is often linked to high poverty rates. Table 2 provides an overview of the combined burden of national poverty rates and the extent of the informal economy in selected European countries. Kyrgyzstan and Uzbekistan, for example, have both large informal sectors and extremely high levels of poverty, with more than 80 per cent of the workforce active in the informal economy and more than 80 per cent of the population living on less than US\$2 a day. The combined levels of informal economy and poverty reach between 50 and 80 per cent in Tajikistan and between 25 and 50 per cent in countries such as Albania, Azerbaijan and Kazakhstan.



**Table 2. Combined burden of poverty (population living on less than US2 per day) and extent of informal economy, selected countries, 2007**

Over 80%	Between 50 and 80 %	25-50 %
Kirgizstan	Tajikistan	Albania
Uzbekistan		Azerbaijan
		Kazakhstan

Source: ILO, 2010a.

In this context of high poverty rates in the informal economy and the frequent exclusion of informal economy workers and their families from social health, due to various reasons including employment status, it is clear that the most vulnerable face increased barriers in accessing health care. This is exacerbated by the lack of availability in the often underserved rural areas in which many informal economy workers live.

### 4.3. Income disparities

Income levels vary widely not only across the European region, but also within countries. Such variations can significantly affect the ability to pay for health services if gaps in scope and coverage result in higher out-of-pocket payments, and may lead inequalities in access to care both within and between countries.

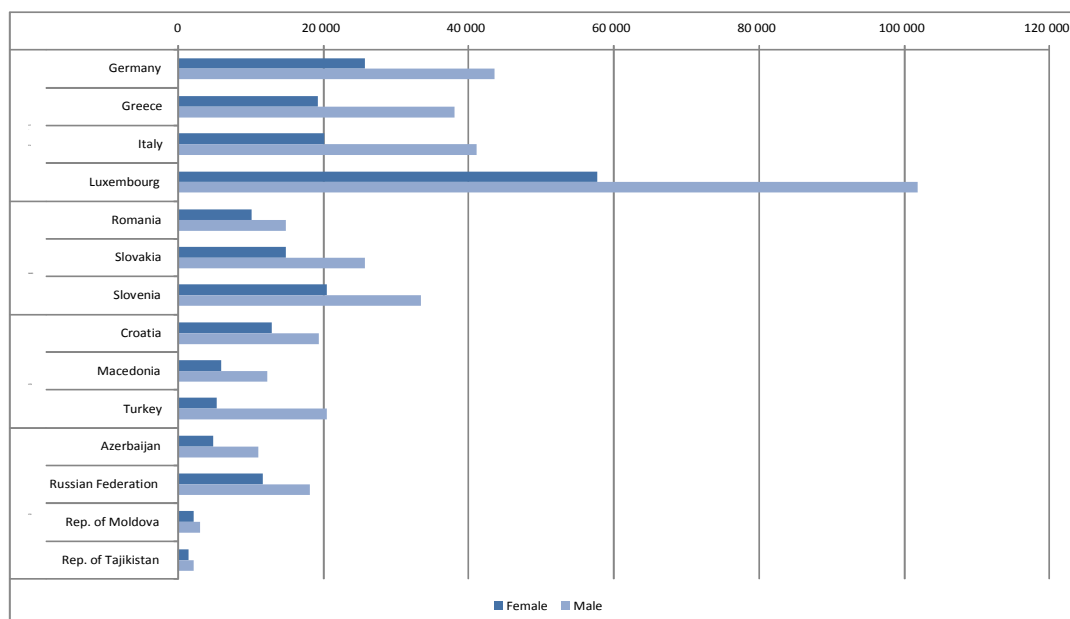
Within countries, income distribution between **wealth quintiles** can be observed to varying extents. In Latvia, the quintile with the highest equivalized disposable income earned 7.5 times as much as the quintile with the lowest income in 2009. This ratio amounted to 7.2 in Romania. While in Bulgaria the ratio of income inequality measured 5.9, it was only 3.1 in Slovenia which is relatively low given average levels of 5.1 for the EU-27 and 4.9 for the European area as a whole. While the ratio in Norway was also low at 3.5, it was high in Greece, Portugal and Spain, at 6.2 and above EUROSTAT, 2011e).

There are also income inequalities between rural and urban areas, with the population living in rural areas showing to be particularly disadvantaged. At EU-27 level, income per inhabitant in rural areas is between 21 and 62 per cent lower than income in urban areas, with an increase in proportional income linked to higher rates of urbanization. Striking inequalities between rural and urban inequalities are especially apparent in the NMS, where income per inhabitant in predominantly rural areas amounts to merely 38 per cent of the EU-27 average income and to 48 per cent for intermediate regions (EU, 2009).

In many countries, specific groups such as women, migrants and Roma have statistically been shown to earn lower income than other groups of the population (WHO, 2010b). Persisting inequalities in income are linked to both a horizontal and vertical occupational segregation: while women more frequently take on labour in lower-paid sectors, they also fill lower-paid positions within sectors despite the same educational attainments as men.

Figure 26 compares the estimated earned income levels of female and male workers in selected European countries. While in Turkey, for example, women workers' earnings are estimated to be only a fourth of that of male workers, in other countries such as Macedonia women's income is about half as high.

**Figure 26. Differences in estimated earned income between female and male workers, selected countries, 1999/2007 (in US\$)**



Source: Authors, based on data from UNDP, 2009.

In the European Union the gender pay gap ranges from less than 10 per cent in Belgium, Italy, Malta, Poland and Slovenia to more than 20 per cent in Cyprus, Czech Republic, Germany, Greece, Netherlands, Slovakia and the United Kingdom, and exceeds 30 per cent in Estonia (EC, 2011b). Notably, such differences also exist in other countries of the broader European region, as well as in both the formal and informal economies.

The gender pay gap has strong implications for inequalities in financial access to health care, especially if gaps in social health protection translate into high out-of-pocket payments. While women in general are affected by such income disparities, female migrants and Roma women in particular, whose income is typically even lower than that of the majority population, are exceptionally vulnerable when in need for care (Berliner Institut für Vergleichende Sozialforschung, 2006).

#### 4.4. Poverty

As shown above, where gaps in social health protection require out-of-pocket payments, those living in poverty experience substantial financial barriers in access to health care.

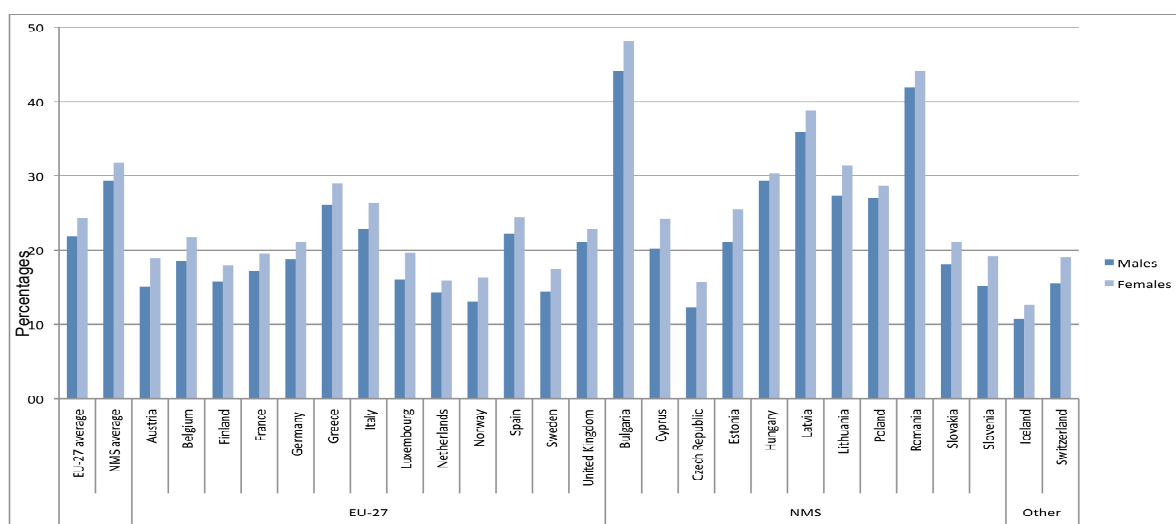
In the wider European region, countries display immense inequalities in poverty levels. While in some countries such as Belarus, Croatia, Hungary and Latvia, 2 per cent of the population still live on less than US\$2 PPP per day, this percentage reaches as much as 7.8 per cent in Albania, 9 per cent in Turkey, and 28.9 per cent in the Republic of Moldova (ILO, 2010a).

In 2008, 17 per cent of the total EU-27 population were at risk of poverty, defined as living below the poverty threshold of 60 per cent of the national medium equivalized disposable income after social transfers. Applying different levels of poverty thresholds across the region, the risk of poverty amounted to 6 per cent for those with an equivalized disposable income less than 40 per cent of the median, to 10 per cent for those with less than 50 per cent of the median, and to 24 per cent for those with less than 70 per cent of the median (EUROSTAT, 2010a). With the lowest and highest thresholds for single persons in the

EU-27 found in Romania at PPS US\$2,859 and in Luxembourg at PPS US\$16,166 respectively, indicating large differences in income and social transfers, Latvia, Romania and Bulgaria showed the highest risks of poverty, while the lowest rates (at 12 per cent) applied to countries such as Austria, Denmark and Hungary (EUROSTAT, 2010b).

In almost all EU-27 countries, there is evidence that women's risk of poverty is more than two percentage points higher than men's (EUROSTAT, 2011f). In 2009, inequalities were found to be lowest in Hungary, where the risk of poverty and social exclusion for women was 0.9 percentage points higher than for men. Relatively low inequalities in risk were also observed in Ireland and the Netherlands, where women's risk was 1.4 and 1.6 percentage points higher respectively. The highest inequalities were found in Estonia and Italy, where women's risk of poverty was 4.4 percentage points higher compared to men. In Bulgaria and Cyprus, women are also shown to be at greater risk by 4 percentage points (ibid., see also figure 27).

**Figure 27. Males and females at risk of poverty or social exclusion, selected European countries (percentages)**



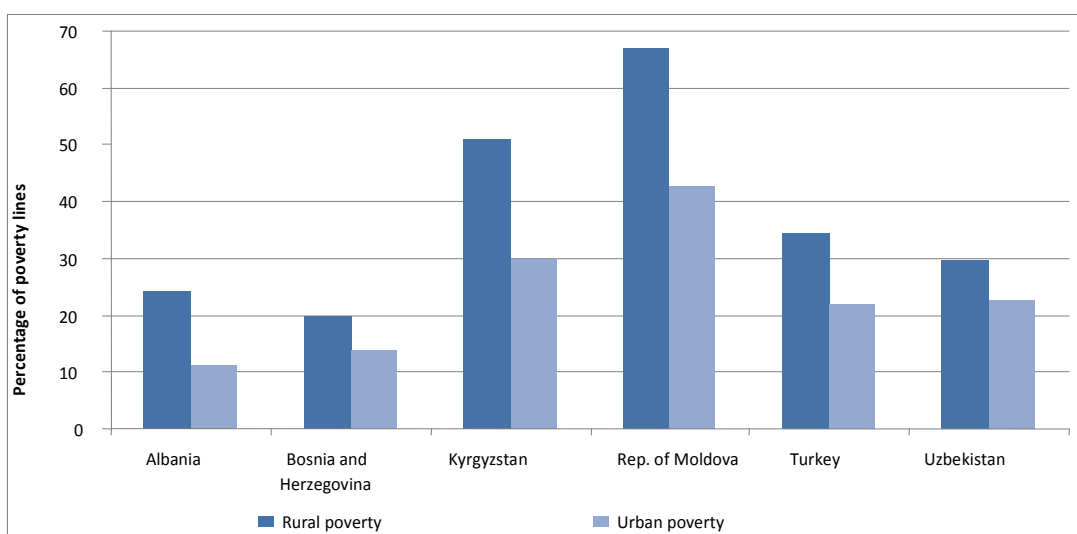
Source: Authors, based on data from EUROSTAT, 2011f.

Women in general, but particularly vulnerable groups including migrants (Orsolya, 2007) and Roma have statistically been found to be affected by higher poverty rates than other groups of the population (WHO, 2010b).

Recent studies show that in Romania and Bulgaria, when applying an absolute poverty line of US\$2.15 PPP per day, about 40 per cent of Roma households are poor, with non-urban households poorer than urban households (Boika et al., 2009; Revenga, Ringold and Tracy, 2002). In 2002, 80 per cent of Roma lived on less than US\$4.30 per day, indicating significantly higher poverty rates than those of the majority population (Milcher, 2006).

Stark variations in poverty headcounts can be observed between **rural and urban areas** at the respective poverty lines, with rural poverty significantly exceeding urban poverty. In 2008, the rural poverty headcount in Moldova stood at 67.2 per cent compared to 42.6 per cent in urban areas. In Turkey, it was at 34.5 per cent and 22 per cent respectively (figure 28).

**Figure 28. Variations in poverty headcount in rural and urban areas, selected European countries, latest available year (percentages)**

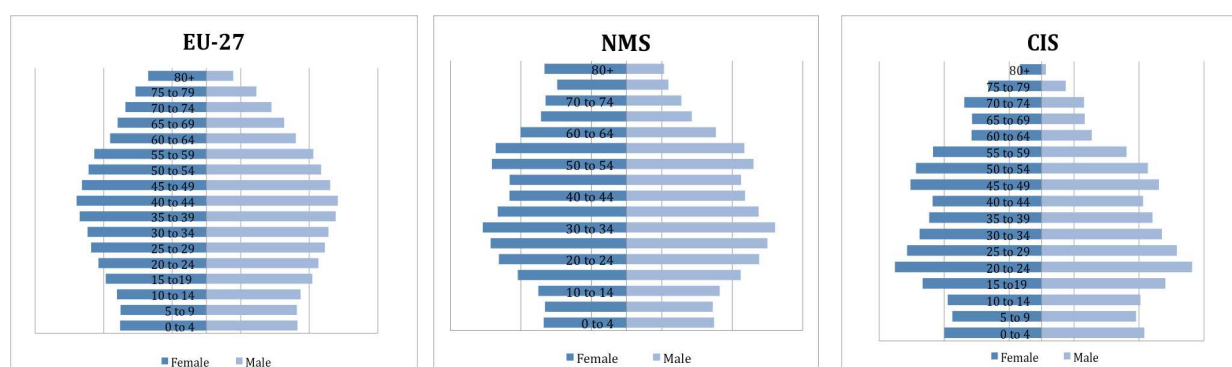


Source: Authors, based on data from World Bank, 2010b.

Within these vulnerable groups including Roma, migrants, or people living in rural areas, women are often at a greater disadvantage. For example, poverty can be an important issue at household level in cases where women have limited control of economic and financial household resources and expenditures (IFAD, 2010), impeding their ability to seek health care when in need.

Notably, **poverty, gender, and age** are closely interlinked in Europe (ILO, 2010a; EU, 2004). Given the high life expectancy of women compared to men, women aged 65 and over outnumber men in the EU-27, and the number of women aged 80 and above is about double that of men. This distribution is even more strongly skewed in the NMS, where the number of women aged 80 and above is almost 2.5 times as high as for men. In CIS countries, where the overall proportion of elderly is lower than in the other country groups, the number of women aged 80 and over is five times that of men (figure 29).

**Figure 29. Population by age and gender in countries of the European region, grouped by EU-27, NMS and CIS, 2008 (percentages)**



Source: Authors, based on data from EUROSTAT, 2008; US Census Bureau, 2011.

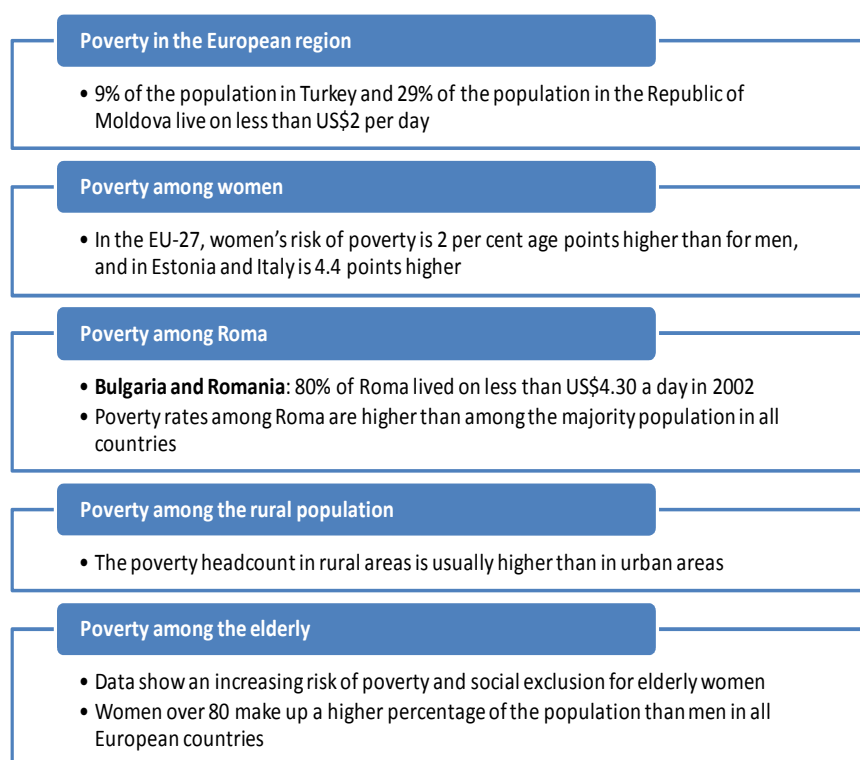
Across the broader European region significant differences in life expectancy for men and women have an impact on the composition of the elderly: female life expectancy ranges

from 73.1 years in Russian Federation, 73.8 in Ukraine to 84.7 in France and 93.1 in Monaco, and is consistently higher than male life expectancy which varies between 60.3 in Russian Federation, 62.8 in Ukraine, 77.6 in France and 85.8 in Monaco (UNESA, 2008).

Despite these intraregional variations, due to overall demographic developments in the European region the majority of the total population aged over 80 is female and the percentage of women among those aged 80+ will continue to increase in future (UNESA, 2010) with strong implications for female poverty in old age: while poverty rates as discussed above show high inequalities between men and women, data on risk of poverty and social exclusion also show striking inequalities between elderly men and women in the EU-27 (EUROSTAT, 2011f).

Figure 30 summarizes some of the key facts on poverty in the European region discussed above.

**Figure 30. Key facts on poverty in the European region**



The combination of **poverty and persisting gaps in statutory coverage** (including long-term care) and eligibility issues which are among the factors impacting on access for female migrants and Roma women, result in an increased risk for women of being unable to access necessary health services throughout their lifecycle.

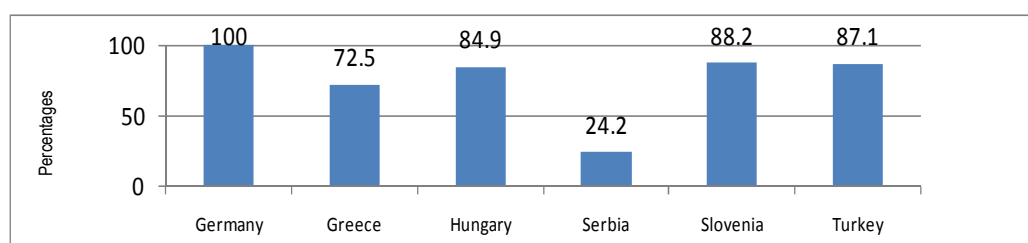
Adequate access to the broader social protection system can alleviate some of the socioeconomic burden on vulnerable groups and thereby also facilitate access to health care. This is considered in the following section.

## 4.5. The broader social protection system

The situation of vulnerable groups is sharpened by insufficient access to social protection benefits such as unemployment benefits, old-age pension schemes and social assistance benefits.

- Only around 30 per cent of all unemployed persons in Central and Eastern Europe and CIS countries effectively receive unemployment benefits to compensate for loss of income. In Western Europe, the figure stands at about 45 per cent (ILO, 2010a).
- Old-age pension schemes leave some 30 per cent of the population in CEE and CIS countries uncovered (ibid.) and thus exposed to the risk of poverty in old age as compared to a coverage rate of 100 per cent in Germany and France. Figure 31 outlines the effective coverage rates in old age for selected European countries.

**Figure 31. Effective social protection coverage in old age, selected countries, 2006** (percentage of total population)



Source: Authors, based on data from ILO, 2010a.

Inequalities in social security expenditure across the European region are reflected in the comparatively low social security expenditure in CEE and CIS countries as compared to Western European countries, amounting to 13.5, 18.9 and 25.1 per cent of GDP respectively. Expenditure on health amounts to 7.1 per cent, 4.8 per cent and 3.6 per cent respectively (table 3).

**Table 3. Social security expenditure, selected countries of the European region, 2009 or latest available year**

Total social security expenditure as a percentage of GDP (population weighted)		
	Total	Health
<b>Western Europe</b>		
• Denmark	27.1	5.9
• France	29.2	6.2
• Sweden	29.4	6.8
<b>CEE</b>	18.9	4.8
• Estonia	12.2	3.2
• Latvia	12.4	3.8
• Lithuania	16.6	5.5
• Romania	14.9	3.5
<b>CIS</b>	13.5	3.6
• Azerbaijan	8.5	0.86
• Belarus	18.4	4.5
• Tajikistan	3.4	0.95

Source: Authors, based on data from ILO, 2010a.

Differences become even more apparent when comparing individual countries. In 2009 total social expenditure was above 27 per cent of GDP in countries such as Denmark, and above 29 per cent in France and Sweden. In Estonia and Latvia, expenditure was just

above 12 per cent, almost 15 per cent in Romania and 16.6 per cent in Lithuania. Among the CIS countries, where social security expenditure is generally low, the range is particularly wide with as little as 3.4 per cent of GDP in Tajikistan to over 18 per cent in Belarus and a few other countries.

Programmes considered to be at risk of being crowded out (figure 32) due to gaps in funding ability include social assistance, unemployment benefit schemes, family programmes and housing support (ILO, 2009). However, such programmes tackle wider socioeconomic inequalities and may have a positive affect on improving public health. Income support, for example, may facilitate access to health services. In countries with extremely low health expenditure (e.g. 0.86 per cent of GDP in Azerbaijan or 0.95 per cent in Tajikistan) adequate social protection is of critical importance for vulnerable groups if inequities in access to health care are to be mitigated.

**Figure 32. Social security programmes at risk in the broader European region**



Source: Authors, based on ILO, 2009.

Gender inequalities in spending can also be observed. In Austria, for example, the data reveal that **fewer women than men benefit from social expenditures** in addition to receiving **lower benefits** in general. In 2006, despite higher female unemployment, total social expenditure for men was twice the expenditure for women (Steiner, 2009). This is mostly attributed to the disadvantageous position of women in the labour market, including the higher proportion of part-time employment.

The **overall institutional and legal environment of social protection** systems affects vulnerable groups including Roma and migrants, and creates barriers to achieving equitable coverage. Key issues relate to gaps in legislation, institutional capacity, efficiency and effectiveness, resulting in

- deficits in statutory social protection coverage, e.g. of migrants, Roma, and particularly those working in irregular contexts or in the informal economy;
- administrative regulations and procedures that require formal – often even full-time – employment, proofs of residency, or other formalities that can rarely be obtained by workers in the informal economy, migrants, Roma and other vulnerable groups;
- inefficient tax and contribution collection systems resulting in underfunding of social protection, with related impacts on availability and quality of benefits and services; and
- deficits in financial protection of income of the vulnerable during sickness.

All the above have an impact on access to health care.





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## 5. Addressing inequities in access to health care for vulnerable groups

As shown in this paper, inequalities in access to health care for vulnerable groups originate from both

- issues related to social health protection and the broader health system, particularly with regard to gaps in legislation, fair financing and allocation, as well as quality aspects, e.g. due to deficits of the health workforce and gaps in infrastructure in rural areas; and
- the broader contextual environment in which vulnerable groups live and work, including factors of income and poverty, lack of access to employment and social protection, status in society, and so on, and in which the poor, women, Roma and migrants are found to be particularly disadvantaged.

Effectively increasing access to health care for the most vulnerable therefore requires a comprehensive approach, which includes:

- extending coverage and effective access in social health protection; and
- reducing poverty and social exclusion through the social protection floor approach.

### 5.1. Extending coverage and effective access in social health protection

In order to achieve equitable access, it is essential to ensure that health services are available in terms of geographical distance and health workforce; to ensure affordability through statutory coverage and financial protection against out-of-pocket expenditures; and to ensure acceptability in terms of quality of both medical interventions and the ethical dimension of health services, related to dignity, confidentiality, respect of gender and culture, choice of provider and waiting times. As regards migrants, this requires a clear disassociation of access to health care from registration and immigration law. Further, it is important that social health protection is organized in an efficient and effective way in order to make the best use of constrained funds.

Against this background, successful policies for addressing inequities in access to health services include:

- **Increasing political commitment to achieve universal coverage and developing fiscal space** through a combination of measures, such as eradicating inefficiencies and allocating sufficient resources.
- **Closing gaps in statutory coverage**, particularly for vulnerable women affected by gaps in eligibility for social health protection arising from part-time work, unemployment or economic activities in the informal economy. As regards migrants, ensuring the right to social health protection may entail introducing the portability of health benefits. Particular attention must be given to undocumented migrants, who should be included in the framework.
- Reducing inequalities in access to health services by **coordinating fragmented health protection schemes**. This could be achieved through developing linkages between sub-schemes aimed at reducing limitations, creating synergies and increasing the extension of social health protection based on risk pooling. This also entails a thorough analysis of the overall performance of social security regarding costs, benefits and sustainability.

- **Making essential benefits affordable and available and of adequate quality**, for example by introducing fair burden sharing based on the capacity to pay, and ensuring availability of the health workforce in rural areas. Further, adequate benefit packages should be envisaged with the ultimate goal of attaining the requirements laid out in related ILO Conventions. When defining benefit packages, policies must consider the health-care needs of specific groups such as women, female migrants and Roma, and ensure close coordination of existing programmes such as in the area of HIV/AIDS and TB among migrants and Roma, and crucial links to maternal health as well as long-term care, especially in rural areas. In some cases this may require expanding the scope of benefits in cash or in kind, such as including transport costs in rural or underserved areas, or services that are essential for migrant and Roma women, including dental care and long-term care.
- **Strengthening governance** through social dialogue, and raising institutional capacities for effective management, supervision, monitoring and evaluation. This will allow for efficient and effective use of funds as well as long-term success and sustainability of social and economic developments.

## 5.2. Addressing wider socioeconomic inequalities through the social protection floor approach

In addition to improving the overall performance of and access to social health protection for the vulnerable population, given the socioeconomic determinants for both health and access it is important to tackle the underlying issues identified in the broader socioeconomic environment.

By tackling the wider socioeconomic inequalities, the suggested policies that refer to the overall responsibility of the government enable synchronized strategies to address a variety of

- **policy areas**, including health protection, education, housing, food, water, sanitation, unemployment and ageing; and
- **population groups**, including persons with disabilities, families, women, children, people living with HIV/AIDS, as well as migrants and ethnic minorities such as the Roma.

Thus, it is important to coordinate social and health protection policies with a view to poverty alleviation. Poverty and social exclusion can be minimized through a number of policies that have proven efficiency, including

- **Providing income security and benefits in kind** to mitigate the impacts of poverty, unemployment, and old age for those in need. Income support should include children, pregnant women, the elderly, and people with disabilities. Improving access to housing and education can also contribute to mitigating inequalities in access to health care, for example of Roma women, by promoting knowledge about rights and entitlements, but also by enhancing employability in the formal sector through providing social security or enabling professional development.
- **Increasing labour market participation** of the most vulnerable, including the provision of training and skills advancement matched to the changing needs of the labour market, job placement services, care services for children and the elderly, and ensuring accessibility to the workplace, i.e. availability of public transport (WHO, 2010c).

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- **Supporting the transition from the informal to the formal economy.** Social protection – as outlined in the framework of the **Social Protection Floor Initiative (SPF)**<sup>2</sup> – is designed to address the vulnerability of populations through a holistic approach. It consists of a methodology that aims at filling gaps and deficits in the various areas that result in such vulnerability or that hinder vulnerable groups from progressing, including in income generation and health. It is specifically suited to ameliorate the deplorable situation of vulnerable and socially excluded women suffering from poverty, low wages and precarious employment whilst receiving little recognition regarding their specific needs in terms of social health protection and as caregivers.

The SPF builds on the human right to social security and health as enshrined in Articles 22, 25 and 26 of the Universal Declaration of Human Rights, and on the ILO Declaration on Social Justice for a Fair Globalization (ILO, 2008b). It gives particular attention to the provision of protection for the most vulnerable, including women, migrants, and ethnic minorities, by advising on ensuring access to a basic set of guarantees (ILO and WHO, 2010), including:

1. essential *social rights and transfers*, in cash and in kind; and
2. an essential level of *goods and social services*.

The set of guarantees aims to counteract and soften the economic consequences of financial shocks and crises, including those arising from gaps and deficits in effective access to health care. More specifically (ILO, 2011), the SPF aims at achieving:

- access to a nationally defined set of essential health-care services through national health services, social or national health insurances or other forms of social health protection;
- a minimum level of income security for children through family/child benefits in cash and in kind, aimed at facilitating access to nutrition and to basic services such as education, health and housing;
- income security combined with employment guarantees and employability-enhancing policies for those in active age groups who are unable to earn sufficient income in the labour market, including through social assistance to the poor, unemployment insurances or public work schemes; and
- income security, e.g. through basic pensions, for all residents in old age and with disabilities that exclude them from the labour market (see figure 33).

Given financial constraints, some countries will need to adopt a gradual approach to implementing elements of the SPF. The SPF framework can serve as a tool to identify priorities and ensure a coherent, well-coordinated implementation of the various SPF policies. The concept thus serves as a vital and flexible policy tool for a country-specific implementation process; it allows for the definition of priority policy areas or target groups, and leaves room for sequencing, newly introducing and reforming social protection

<sup>2</sup> The Social Protection Floor Initiative was adopted by the United Nations System Chief Executive Board in 2009 in response to the global financial and economic crisis. Promoting access to essential social services, it aims to mitigate the socioeconomic impacts of financial shocks and crises (see ILO and WHO, 2009).

policies, and for exploring synergies between different sectors. It thus promotes building on existing social protection measures, schemes or systems and takes national development strategies into account (ILO and WHO, 2009).

**Figure 33. Pillars of the Social Protection Floor**



Source: Authors.

This flexibility also applies to the mode of delivery of particular guarantees, which can be adapted according to countries' capacity and ability to free fiscal space, as well as to the feasibility of effectively reaching the most vulnerable groups. Guarantees may be granted (ILO, 2010b):

- on a universal basis to all inhabitants of a country;
- through compulsory, contributory broad-based social insurance schemes with provisions made for those without contributory capacity;
- based on needs assessment; or
- tied to conditionalities.

When addressing inequities in access to health care, ILO Conventions provide guidance, in particular the Social Security (Minimum Standards) Convention, 1952 (No. 102). This Convention defines social security as the protection that a society provides to its members through a series of public measures against loss of work-related income (or insufficient income) caused by sickness, disability, maternity, employment injury, unemployment, old age, death of a family breadwinner, lack of access to health care, or insufficient support for childrearing.

Convention No. 102 also includes specific provisions concerning social health protection, such as benefits in cash, medical benefits and medical benefits also in case of maternity. However, maternity is more specifically dealt with in the Maternity Protection Convention, 2000 (No. 183) and its accompanying Recommendation (No. 191). ILO Conventions on social security aim at including all vulnerable people such as women workers engaged in atypical forms of dependent work, and their families (ILO, 2003). Further international labour standards relevant to promoting equal treatment and decent work for all, with particular relevance to women, the poor, Roma or migrants, include:

- Medical Care and Sickness Benefits Convention, 1969 (No. 130);
- Invalidity, Old-Age and Survivors' Benefits Convention, 1967 (No. 128);
- Employment Promotion and Protection against Unemployment Convention, 1988 (No. 168);

- 
- Equality of Treatment (Social Security) Convention, 1962 (No. 118);
  - Equality of Treatment (Accident Compensation) Convention, 1925 (No. 19);
  - Maintenance of Social Security Rights Convention, 1982 (No. 157).

Generally, ILO Conventions and SPF policies promote protection for all those in need irrespective of nationality (e.g. migrants), for the whole population and based on equal treatment (e.g. of Roma women).<sup>3</sup> Achieving universal access to health care can be enhanced through social dialogue and the participation of all stakeholders by establishing inclusive and participatory policy and implementation processes.

Inclusive social protection floor policies can contribute to realizing human rights to both social security and health for vulnerable groups, while increasing productivity, reducing poverty and simultaneously pushing towards more equality and political stability.

<sup>3</sup> See ILOLEX for further information on ILO Conventions and Recommendations.



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## 6. Conclusions

Equitable access to health care through universal social health protection coverage remains an overarching goal throughout the broader European region and within countries.

In the region, social health protection is characterized by similarities in overall objectives: achieving universal coverage, and the predominant choice of social health insurance and national health systems as the key financing mechanisms which have the potential to achieve equitable access to health services.

In a number of countries, overall design as well as standards of effectiveness and efficiency in the organization and financing of social health protection result in deficits leading to inequalities in effective access to health services of vulnerable groups including poor women, migrants and Roma. These deficits relate to:

- gaps in legislation and in kind benefits that exclude vulnerable groups, such as limitations in the scope of benefits that do not reflect the particular needs of women or the elderly population, and thus lead to inequalities;
- deficits in financial protection against high out-of-pocket payments that reduce access to health services and exclude the most vulnerable: the poor, the unemployed, low- and part-time workers; these groups often consist of women, migrants and Roma. Deficits in financial protection are aggravated by gaps in social protection systems and lower uptake rates of social protection transfers in rural and urban areas, pointing to the need for better information about rights and entitlements;
- disparities within countries in terms of infrastructure and health workforce in rural and urban areas. This relates to the availability of qualified health workers, specialized care, pharmacies, essential medicines, emergency care, and distance of required health services, as well as access to health information.

More specifically, at the **national level** gaps in access to health care for women, female migrants, and Roma often relate to inadequate funds and allocations through insufficient per capita spending, and deficits in the health workforce. At the **household level**, low income, unemployment, household expenditures, and high out-of-pocket payments for health care, that can have impoverishing effects or may be catastrophic, hamper access to care for the most vulnerable. At **the individual level**, poor women, migrants and Roma have been identified as disproportionately disadvantaged with regard to social and economic exclusion, due to insufficient coverage by social health protection mechanisms and to facing greater difficulties in overcoming financial barriers to health care. Thus employment status, labour market structure with a varying extent of informal economies, income level, poverty, and other socioeconomic and demographic developments as well as individual determinants including sex and socio-cultural issues, constrain the accessibility, affordability and acceptability of health care.

However, there are significant differences among European countries in terms of gaps in statutory coverage and equitable access to health care. The main differences are observed among the country groups of the EU, CEE, CIS and further Central Asian countries. Within countries it is poverty, the gender pay gap, constraints in labour market participation, the impacts of informal work arrangements and the rural–urban divide that constitute important barriers to access. As a result, the inequalities in access of women, migrants, Roma and other vulnerable groups may well be violating human rights to health and social security, and be slowing down progress in achieving the MDGs by 2015 and other national policy objectives.

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Against this background, reducing the persisting inequalities should be a high priority for countries of the European region. Addressing these issues requires an inclusive approach that acts on structural and systemic issues in both social protection in general and social health protection.

Besides broader policy approaches, such as enabling a transition of informal to formal economies and regularizing the legal status of migrants and Roma, it is suggested that social health protection be embedded into the social protection floor approach as endorsed by UN agencies and led by the ILO and WHO. This requires:

- **Addressing ill health, poverty, unemployment, old age and disability** by providing at least a basic set of benefits and services in kind and in cash. ILO Convention No. 102 and the ILO Decent Work Agenda can guide the relevant policy approaches. The concept of social health protection as defined by the ILO is based on the core values of equity, solidarity and social justice, and aims at universal coverage. It requires a legal framework that allows all residents to equitably and effectively access at least an essential benefit package of adequate quality if in equal need. Specific strategies might have to be implemented for migrants and Roma. These include developing decent work conditions, and protecting rights and the valuable role of workers, employers, communities and civil society.
- **Reducing legal and financial constraints** by extending legislation to the whole population, creating fiscal space, allocating sufficient funds for effective social (health) protection systems, increasing risk pooling and rationalizing existing schemes.
- Setting priorities to close gaps and provide effective access to health services for vulnerable groups including poor women, migrants and Roma in social health protection by ensuring **affordability, availability and quality of health care, and efficient and effective organization as well as adequate financing in all geographical areas.**
- Meeting the needs of migrants and Roma as regards health benefits by **clearly dissociating access to care from immigration law and other legal constraints that hinder equitable access, and ensuring socio-cultural sensitivity in the provision of care and social security benefits.**
- Anticipating demographic ageing by **improving the interface between health and social services and adjusting benefits for chronic diseases and long-term care** to cover the growing female elderly population.



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