More than 1.5 million extra people have unmet need for healthcare since the beginning of the economic crisis in Europe. The advent of the Great Recession has placed Europe’s health systems under severe pressure, with real terms cuts to funding in many countries. Accounts in the peer-reviewed literature and popular media have catalogued examples of vulnerable groups and individuals unable to access necessary care. Although there have been case-studies of Spain, Greece and other individual nations, to our knowledge there has been no systematic attempt to quantify changes in unmet need for medical care across the European Union. Here, using data from the EU-wide Statistics of Income and Living Conditions (EU-SILC), we quantify the increase in self-reported unmet need for medical care across the European Union. Here, there has been no systematic attempt to quantify changes in the Great Recession has placed Europe’s health systems under severe since the beginning of the economic crisis in Europe. The advent of more than 1.5 million extra people have unmet need for healthcare in some countries, are creating barriers to healthcare access in Europe. Despite clear evidence that such charges reduce both necessary and unnecessary utilization of care, they have been extended and expanded in the Czech Republic (2011), France (2010), Italy (2011), Latvia (2009), the Netherlands (2010) and Romania (2011), a process that has continued subsequently, as in Spain (2013). In contrast, nations that have reduced user fees, such as Croatia in 2011, have experienced declines in unmet medical need.

Another hypothesis is that cost-saving reforms have reduced access to care. Cuts to healthcare services, involving closure of facilities (e.g. in Greece), reduced opening hours, and shrinking numbers of healthcare personnel can also worsen access to care.6 7 Several policy charges outside the health sector, such as reduced affordability of transport, might create further financial barriers to access. In practice, it is likely to be a combination of factors, with the balance varying among countries. Thus, all of these factors combine in Greece, which may explain the marked increase in unmet medical need; between 2007 and 2011 unmet medical need attributed to greater costs of care rose by ~39%, whereas unmet medical need attributed to transport costs was 2.8 times higher in 2011 than in 2007.

Finally, it is possible that recent policy reforms which restrict access of migrants and other vulnerable groups such as homeless persons and drug users, who tend to be under-represented in surveys, are taking a toll beyond what can be seen with EU-SILC data. In Spain, a royal decree in 2012 restricted access to the National Health Service for undocumented immigrants. The Czech Republic similarly has rewritten eligibility criteria to include only those who are permanent residents. In the UK, migrants from outside the European Economic Area will face additional costs to obtain healthcare services. By excluding certain groups from the social contract, states are undermining the principle of solidarity on which most European healthcare systems are based. Future targeted research is needed to investigate trends in unmet need among these high-risk groups.

Irrespective of which reasons are most important, our observation of rising unmet need is a cause for concern. Many European nations have long benefited from universal access to care. Even though Europe’s recessions may be coming to an end, this promise remains under threat.

Acknowledgements
We would like to thank the reviewers for their helpful comments.

Funding
AR and DS are support by a Demetrig EU FP7 grant. This study was carried out with financial support from the Commission of the European Communities, grant agreement no. 278511. The study does not necessarily reflect the Commission’s views and in no way anticipates the Commission’s future policy in this area. DS is also funded by a Wellcome Trust Investigator Award.

Conflicts of interest: None declared.
Since 2008, the onset of economic crises in Europe has resulted in profound social dislocations and steep rises in unemployment. At the same time, austerity measures and structural reforms have crippled the capacity of welfare states to effectively respond to heightened demands for their services. Yet, while these phenomena can be observed across Europe, five countries stand out: Greece, Ireland, Portugal and Cyprus were bailed out by the international community—comprising European institutions and the International Monetary Fund—in exchange for wide-ranging policy reforms, and Spain opted into a period of austerity. Here, I document how these policy responses affected health coverage and examine challenges ahead.

Among the countries in crisis, Greece experienced the deepest economic downturn, with unemployment rising from 7.8% in 2008 to 27.5% in 2013. As health insurance there is tied to employment status, by 2014 >23% of the population (2.5 million) became uninsured. In addition, health budget cuts and revenue-raising measures (increased co-payments and user fees) introduced as part of the country’s bailout furthered the inability to access or afford health services. In response to popular pressure, the government introduced two schemes to increase access, but both failed to live up their promise. First, a new health voucher scheme, introduced in 2013, was intended to provide a limited bundle of services to 230,000 people, yet, in the first 17 months of