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Healthcare in the Light of the Concept of Welfare State Regimes - Comparative Analysis of EU MS

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**Healthcare in the Light of the Concept of Welfare
State Regimes
- Comparative Analysis of EU MS**

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Healthcare in the Light of the Concept of Welfare State Regimes - Comparative Analysis of EU MS

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Abstract: This paper addresses issues related to health care in the context of the debate about the typology of welfare state regimes and comparative studies conducted by reference to the debate. Particular attention has been paid to the phenomenon of decommodification as one of the key dimensions that define welfare regimes identified in the literature associated with this debate. The study presents a health decommodification index, on the basis of which an attempt has been made to assess the decommodification potential of health care, taking into account the situation in the 28 EU Member States in 2012. The identification of a widely understood accessibility of publicly funded health care as a basic measure for assessing the decommodifying features of health programs is an important result of the empirical analysis. The study has also confirmed the views expressed in the literature about the existence of practical obstacles standing in the way of developing a universal typology of welfare states.

Introduction

Although it is difficult to provide a clear and comprehensive definition of the welfare state, the specific characteristics underlying the concept of welfare state are commonly acknowledged. One of the main features of this concept indicated in a textbook definition is that it involves state responsibility for securing some basic, modest standard of living for its citizens. Other presentations concretise this definition by reference to certain areas of state activity and relevant criteria of social justice (Barr, 1992). In contemporary welfare states, especially European ones, attention is drawn to the key role that the state plays in matters relating to social security, health care, education, housing and working conditions as well as to the principles of equal opportunities and fair distribution of wealth.

The issue of the functioning welfare states and their typology has for many years been at the heart of research and interest in many scientific disciplines, and of social policy decision makers. Theoretical concepts are confronted with the effects of policies and programs pursued within the framework of social security systems. As the E. Karpowicz (2006, p.4) states "social policy is primarily a practical activity but that practice has always been accompanied by investigations aimed at resolving the basic concept, at focusing efforts expressing different views and opinions which ultimately determine the practical arrangements". Szarfenberg R. (2009, p.17) emphasizes the importance of social policy models as a tool to simplify its potential complexity what would allow its characterization and comparison in different times and places.

Comparative analysis of social security systems is accompanied by an interest not only in the extent to which welfare states differ from each other and to what extent they are similar to each other but also in how these similarities and differences may explain the effects of implemented social policies. Particularly noteworthy is the Esping-Andersen' (1990) concept of *the three worlds of welfare capitalism*, in which one of the basic criteria for differentiating the welfare state regimes was the extend of decommodification of the status of individuals in relation to the market. For its assessment the author has examined the decommodifying features of social security programs in the 18 OECD countries using selected indicators related to various types of cash benefits under their income maintenance programs. The extent to which the author's criterion of differentiation and assignment of states to individual welfare state regimes works in the health care sector and, consequently, whether the concept of the three worlds is universal constituted and still does constitute the subject of research investigations (Kasza, 2002, Bamba, 2005a, 2005b, Yu, 2012).

This paper furthers this research trend and aims to assess the decommodification potential of the health care systems in the 28 EU Member States based on 2012 data. In order to accomplish this aim two health care decommodification indexes have been constructed using different set of measures. This has allowed to examine the concept of health care decommodification and to enrich inference.

The paper's structure and layout have been subordinated to this very goal. First, the author makes a review of literature on typology of welfare state models, with particular emphasis on Esping-Andersen's concept of 'three worlds of welfare state capitalism'. Then, relying on the research method the author presents the results of empirical study and discusses them in the context of a widely understood accessibility of publicly funded health care. Finally, the author draws conclusions, including those as to the usefulness of G. Esping-Andersen's typology of welfare state regimes in relation to the health care sector.

Review of the literature

Relying on reviews of pertinent literature one can indicate two models of the welfare state identified by H. L. Wilensky and C. N. Lebeaux, (1968) i.e. the *residual (marginal)* model in which the intervention of social institutions is justified on the grounds of market or family failure, and the *institutional (redistributive)* model in which social support is treated as a universally acceptable first line function of the state (Van Kersbergen, 2012, p.140, Schustereder, 2010, p.18). R. Titmuss (1974) extends this typology by adding to it the so-called *an industrial-achievement-performance* model in which both the entitlement and the scope of social benefits granted to its beneficiaries is dependent upon their merits, performance and efficiency (Van Kersbergen, 2012, p.140, Schustereder, 2010, p.18). Incidentally, N. Furniss and T. Tilton (1977) also distinguished three models of the welfare state and described them as the *positive state* in which social policy is intended to protect the owner of the capital from the difficulties associated with the interplay of market forces and from the demands of revenue redistribution, the *social security state* in which the goal of social policy is to guarantee a minimum income for all citizens and the *social welfare state* in which the goal of social policy is to equalize the conditions of life of all citizens (Karpowicz, 2006, p. 4).

What is particularly noteworthy is G. Esping-Andersen's (1990, 1999) concept of the three worlds of welfare state in which the author distinguishes three types of welfare regimes: liberal, conservative and social democratic. The basic analytical axis in the above typology was, like in most accepted classifications, a juxtaposition of private and public

spheres, while in contrast to previous studies¹, the key dimensions that define the separate regimes are: i) the degree of decommodification referring to the level of individuals' self-sufficiency from the labour market which arises from the existence of cash benefits systems, and ii) stratification or group solidarity models described by the author (G. Esping-Andersen, 2010b, p. 96). The operationalization of adopted dimensions resulted in the assignment of 18 OECD countries to one of the three regimes.

The *liberal* regime is based on market mechanisms. The author assigned to it those states which are characterised by a modest, mean tested, universal systems of social transfers or modest social security systems. This approach to social benefits is an expression of minimal state intervention, individualisation of risk and promotion of market-based solutions. The author indicates that this type of welfare state results in minimisation of the scope of decommodification, limitation of the area of social entitlements and the establishment of a system of social stratification, which is a blend of 'equality in poverty' and 'market-differentiated welfare of the majority' (G. Esping-Andersen, 2010a, pp. 44-45)².

The *conservative* regime, grounded both in the market and in the family, was revealed in countries whose programs and social benefits are universal, their scope generally differentiated on the grounds of professional status and income, and their administration essentially the responsibility of employers. Government intervention in the market is justified by a failure of the family, which determines its subsidiary character. G. Esping-Andersen indicates that the regime results in a moderate level of decommodification, the primacy of the social assistance over entitlements and favouring the consolidation of the existing social divisions as a result of social policy³.

On the other hand, the *social democratic* regime in which the state assumes primary responsibility for the welfare of its citizens is typical of countries where social programs are universal and egalitarian, and benefits granted are of a relatively high level, often close to the amount of the average income. The state actively supports jobs and income protection, which, in turn, translates into a wide range and high level of decommodification. G. Esping-Andersen points out that state involvement and the minimisation of the function of the market leads to the emergence

¹ Most researchers focused on the volume of welfare spending and its share of GDP.

² In the study group the features of the liberal regime were ascertained in Australia, Canada, Ireland, New Zealand, Great Britain and the USA.

³ In the study group the features of the liberal regime were ascertained in Austria, Belgium, France, Germany, Switzerland, Italy, Japan and the Netherlands.

of conditions conducive to a reduction in social divisions and strengthening of social solidarity⁴.

G. Esping-Andersen's concept of the three worlds was for many researchers a reference point for further studies and comparative analyses and the voicing of more or less critical remarks. Some verified the welfare "order" in the 18 OECD countries covered by G. Esping-Andersen (Leibfried, 1992, Castles & Mitchel, 1993, Bonoli, 1997, Korpi & Palme, 1998)⁵, others tested this concept in other countries (Ferrera, 1996, Ferreira & Figueiredo, 2005, Gough, 2006, Walker & Wong, 2005)⁶ or with reference to other social policy areas such as health care and education (Bambra, 2005a, 2005b, Yu, 2012, Czarnecki, 2014), analysing larger sets of countries and more recent data. As a result, objections were raised as to the usefulness of the concept of the three worlds for comparative research (Baldwin, 1996, Kasza, 2002), its theoretical and methodological shortcomings (Lewis, 1992, Gough, 2001, Arts & Gelissen, 2002, Powell & Barrientos, 2011).

Methodology of the research

The author's research methodology involves the use of the health decommodification index as one of the possible methods of assessing the level of decommodification characteristics of the health care system. To construct such an index G. Esping-Andersen's method has been adopted (2010a, pp. 77-78). As a starting point the health decommodification index proposed by C. Bambra (2005a) was examined. Then, by analysing the results obtained within this index (index I), the author proposed two new indicators and constructed the second index (Index II).

The first index (Index I) has been constructed through the assessment of three measures (Bambra, 2005, p.34):

- 1) private health expenditure as a percentage of GDP,
- 2) private hospital beds as a percentage of total bed stock,
- 3) the percentage of population covered by the health care financed by public means.

⁴ In the study group the features of the social democratic regime were revealed Denmark, Finland, Norway and Sweden.

⁵ The research resulted, among others, in proposals advocating the assignment of certain countries (e.g. Austria, New Zealand, Japan or Italy) to another regime.

⁶ The research resulted, amongst others, in a suggestion whereby additional regimes should be isolated, e.g. for Southern European countries, Central and Eastern Europe or even certain Asian countries.

The second index (Index II) has been constructed through the assessment of following measures:

- 1) household out-of pocket payment as a percentage of total current health expenditure,
- 2) the percentage of population reporting difficulties in having their basic medical needs met,
- 3) the percentage of population covered by the health care financed by public means.

The degree of decommodifying features of the health care system has been determined by adding the results (points) awarded for the place on the scale (in the ranking of countries) for the above indicators. On the basis of the position of each of the 28 EU countries on the respective scales, between one and three points have been awarded, denoting a low, medium or high level of decommodification, respectively. The point award has been based on the difference between the mean value and standard deviation, in several countries adjusted for extreme values. Sub-index values were then weighted by means of the index of the share of the population entitled to benefit from public services.

The underlying statistics used to compile these indexes have been sourced out from EUROSTAT, OECD and WHO databases, with 2012 data used as the reference year. Whenever 2012 data were not available use has been made of data from the few years adjacent to the reference year, and in the absence of any data use has been made of the EU average with adjustment when necessary for extreme outliers. Table 1 and table 2 below present data (indicators) and author's own calculations used in the paper.

Table 1. Health index data (Index I).

Country	Private health expenditure (% of GDP)	Score	Private hospital beds (% of total bed stock)	Score	Public health system coverage (% of population)	Score
Austria	2,5	2	29,6	1	99,9	9,99
Belgium	2,7	2	14,3*	2	99,9	9,99
Bulgaria	3,3	1	13,2	2	77 ¹	7,7
Croatia	1,5	3	0,6	3	100	10
Cyprus	4	1	49,2	1	83 ²	8,3
Czech Rep.	1,2	3	14,2	2	100	10
Denmark	1,6	2	4,5	2	100	10
Estonia	1,2	3	10,7	2	93,3	9,33
Finland	2,3	2	5,1	2	100	10
France	2,6	2	37,8	1	99,9	9,99
Germany	2,6	2	59,4	1	88,9	8,89
Greece	3	2	30,3	1	79 ³	7,9
Hungary	3	2	3,1	2	100	10
Ireland	2,9	2	14,3*	2	100	10
Italy	2,1	2	31,5	1	100	10
Latvia	2,1	2	8,7	2	100	10
Lithuania	2,2	2	0,5	3	100	10
Luxembourg	1,2	3	14,3*	2	97	9,7
Malta	3,1	1	7,2	2	100	10
Netherlands	1,7	2	100,0	1	99,8	9,98
Poland	2	2	26,8	1	96,6	9,66
Portugal	3,6	1	27,4	1	100	10
Romania	1,1	3	2,9	2	100	10
Slovak Rep.	2,3	2	14,3*	2	95	9,5
Slovenia	2,7	2	1,1	3	100	10
Spain	2,6	2	30,7	1	99	9,9
Sweden	1,8	2	14,3*	2	100	10
United Kingdom	1,5	3	0,0	3	100	10

Sources: author's own calculations based on Eurostat, WHO, and OECD data, OECD/European Union (2014). Health at a Glance: Europe 2014.

Data availability: (*): EU adjusted average value; (1) 2011; (2) 2007; (3) 2013.

Table 2. Health index data (Index II).

Country	Household out-of-pocket payment (% of total health expenditure)	Score	Self-reported unmet need for medical examination (% of population)	Score	Public health system coverage (% of population)	Score
Austria	16,7	2	0,3	3	99,9	9,99
Belgium	20,4	2	1,7	2	99,9	9,99
Bulgaria	43,1	1	8,2	1	77 ¹	7,7
Croatia	12,8	2	3,6	1	100	10
Cyprus	47,2	1	3,5	1	83 ²	8,3
Czech Rep.	15,3	2	1	2	100	10
Denmark	12,9	2	1,2	2	100	10
Estonia	18,4	2	8,3	1	93,3	9,33
Finland	19,6	2	4,6	1	100	10
France	7,8	3	2,3	2	99,9	9,99
Germany	12,2	3	1,6	2	88,9	8,89
Greece	28,8	2	8	1	79 ³	7,9
Hungary	29,1	2	2,8	2	100	10
Ireland	16,9	2	2,2	2	100	10
Italy	18,6	2	5,6	1	100	10
Latvia	34,3	1	12,3	1	100	10
Lithuania	31,8	2	2,3	2	100	10
Luxembourg	11,6	3	0,7	2	97	9,7
Malta	32,3	2	1,1	2	100	10
Netherlands	6,0	3	0,5	3	99,8	9,98
Poland	24,3	2	9	1	96,6	9,66
Portugal	31,7	2	3,3	2	100	10
Romania	19,5	2	10,7	1	100	10
Slovak Rep.	23,2	2	2,2	2	95	9,5
Slovenia	12,5	2	0,1	3	100	10
Spain	22,1	2	0,7	2	99	9,9
Sweden	17,4	2	1,3	2	100	10
United Kingdom	9,0	3	1,4	2	100	10

Sources: author's own calculations based on Eurostat, WHO, and OECD data, OECD/European Union (2014). Health at a Glance: Europe 2014., Data availability: (1) 2011; (2) 2007; (3) 2013

Results

Analysis of the results shows that the adoption of different measures for the assessment of decommodifying features of health care systems has a significant impact on the final results, both in terms of the indexes values attributed to each of 28 EU MS and consequently of their position on the indexes scale.

In the case of the first index (index I) the potential spreads out between 17 points (Cyprus) and 60 points (United Kingdom), the average value of the index for all EU countries being 38 points. The research method adopted has yielded a distinction into three groups of countries, revealing low, medium or high level of decommodifying potential, respectively. The group of low decommodification index countries (index value ranging from 17 to 24 pts) consists of four countries – two so-called the new Member States⁷, i.e. the already mentioned Cyprus, and Bulgaria, as well as Portugal and Greece. By contrast, the group of high decommodification index countries (index value between 50 and 60 pts) consists of six countries, including five new Member States (Romania, Czech Republic, Lithuania, Slovenia, Croatia) and the UK. The remaining 18 countries, including six new Member States, belong to a group of medium decommodification index level countries, with the index ranging between 27 and 49 points.

The results presented in the framework of this index give rise to doubts especially when one compares the index scores of such countries like Netherlands (30 pts) and Greece (24 pts), Germany (27 pts) and Bulgaria (23 pts), or Luxembourg (49 pts) and Romania (50 pts). Although, the index scores in compared countries are very close to each other in reality these countries differ in many aspects of health care provision. As an example one can point to significant differences in the level of general government health expenditure per inhabitant in Euro/PPS in these countries: in Netherlands (3250) compare to Greece (1217), in Germany (2725) compare to Bulgaria (500), or in Luxembourg (3348) compare to Romania (587)⁸.

⁷ Countries which joined the EU in 2004 (Cyprus, Czech Republic, Estonia, Latvia, Lithuania, Malta, Poland, Slovenia, Slovakia, Hungary) and later in 2007 (Bulgaria and Romania) and in 2013 (Croatia).

⁸ Eurostat database: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha_hf&lang=en

Table 3. Health care decommodification indexes.

country	Index I		Index II	
	Index score	decomodification level*	Index score	decomodification level *
Austria	30	medium	50	high
Belgium	40	medium	40	medium
Bulgaria	23	low	15	low
Croatia	60	high	30	medium
Cyprus	17	low	17	low
Czech Republic	50	high	40	medium
Denmark	40	medium	40	medium
Estonia	47	medium	28	medium
Finland	40	medium	30	medium
France	30	medium	50	high
Germany	27	medium	44	medium
Greece	24	low	24	low
Hungary	40	medium	40	medium
Ireland	40	medium	40	medium
Italy	30	medium	30	medium
Latvia	40	medium	20	low
Lithuania	50	high	40	medium
Luxembourg	49	medium	49	high
Malta	30	medium	40	medium
Netherlands	30	medium	60	high
Poland	29	medium	29	medium
Portugal	20	low	40	medium
Romania	50	high	30	medium
Slovak Republic	38	medium	38	medium
Slovenia	50	high	50	high
Spain	30	medium	40	medium
Sweden	40	medium	40	medium
United Kingdom	60	high	50	high
<i>Mean</i>	38		37	
<i>Standard Deviation</i>	11		11	

Sources: author's own calculations.

(*):high > Mean + SD; medium: between (Mean - SD) and (Mean + SD); low < Mean - SD

In the case of the second index (index II), both the span of the decommodifying potential of health care systems in the countries studied (values ranging from 15 and 60 pts) and its average value for the EU 28 (37 pts) have not changed significantly. On the other hand, the index of 16 Member States has changed, which, in turn, has led to a shift in the position of the Member States on the index scale and, consequently, the current assignment of some of them to the three decommodification level groups distinguished (Table 3). For example in the case of Croatia, but also Romania and Latvia, the score of the second index compared to that of the first index has decreased by 30 and by 20 points (for the last two countries) respectively, while in the case of Holland, but also Austria, France and Portugal, it has increased by 30 and by 20 points (for the last three countries), respectively. Thus, the group of low level decommodification countries (index values ranging from 15 to 25 pts) now features Cyprus, Bulgaria, Greece and Latvia and the group of high level decommodification countries (index values between 49 and 60 pts) includes Slovenia, the United Kingdom, Luxembourg, Austria, France and the Netherlands. The remaining 18 countries are classified as medium level decommodification countries, with the index ranging between 27 and 49 points.

Discussion

The use of two health decommodification indexes in the study has enriched inference. The first one which has been taken as a starting point for analysis was developed by C. Bambra who, for the purpose of her study, extended G. Esping-Andersen's concept of decommodification for the health care sector, which she defined as 'the extent to which an individual's access to health care is dependent upon their market position and the extent to which a country's provision of health is independent from the market' (2005a, p. 33). In order to enhance comparability between the health care and the labour market decommodification indexes C. Bambra has examined the same 18 OECD countries and made reference to the same period of study (1980) as G. Esping-Andersen did. She has chosen three indicators⁹ to operationalize the basic analytical axis consisting in a juxtaposition of the private and public health care sectors. To illustrate this relationship she has considered, in turn, three aspects of the functioning of health care systems, namely: financing, provision and accessibility of health care services.

⁹ The availability of statistical data in reference to the time period of C Bambra's study might had been a decisive factor for the choice of these indicators.

During the evaluation of this approach in the context of the definition of decommodification of health care as suggested by the author, it has been noted that the three indicators proposed by C. Bambra do not allow to capture a complete and real picture of the extent of market dependence / independence in both areas.

The first indicator e.g. private health expenditure as a percentage of GDP refers to 'the extent of private enhancing by identifying the extent of a country's total income that is spent on private health care' (Bambra, 2005a, p.34). Thus in the nominator next to household out-of pocket payment, are included expenditure of private insurance, of non-profit organizations serving households and of corporations (other than health insurance). It is worth also to be aware that the adoption of the GDP as a denominator may lead to misinterpretation of the level of the indicator due to the differences as to the direction and the rate of changes of GDP and of healthcare spending. Such can occur especially in times of economic change.

The second indicator, in turn, i.e. private hospital beds as a percentage of total bed stock relates to only one mode of health care provision i.e. inpatient services provided by hospitals and thus reflects the ownership of the private means of production to a limited extent. Moreover, in contemporary health care systems the public payer contracts the services from both public and private providers of health care.

The third indicator, i.e. the percentage of the population covered by publicly funded health care, is an important measure of the extent of general access to these goods and services, nonetheless cannot be treated as a perfect measure of public health services accessibility due to the fact that in all health care systems individuals are required to contribute to their cost at the point of use.

In order to address above mentioned shortcomings, the author has proposed two new indicators, which, analysed in conjunction with Bambra's third indicator has led to the construction of the second index. It has allowed to focus analysis on issues related to a widely understood accessibility of publicly funded health care goods and services, that in the view of the author is considered to be a key to the assessment of the decommodifying potential of health care system. The reasoning behind the author's approach is briefly discussed below.

For the purpose of this study the health care decommodification refers to the extent to which an individual's access to health care is not dependent on their market position. Such approach follows the first part of C. Bambra definition *à rebours*. This approach is also in line with G. Esping-Andersen notion of decommodification, which 'occurs when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market' (1990, pp.21-22). Such a broad conception of

decomodification has been also adopted by other researchers, including O. Pintelon (2012, p.8) who defined it 'as any state intervention removing individuals from total dependence on market forces' and J. Vail (2010, p. 313) according to whom decommodification refers to 'any political, social, or cultural process that reduces the scope and influence of the market in everyday life'.

The specificity of the health care sector stems both from the common perception of health as a value *per se* and as a precondition for economic prosperity. From an individual's point of view good health is valued because it allows to provide happy and productive lives. From a society's point of view protection of citizens' health is valued because it has an impact on 'economic outcomes in terms of productivity, labour supply, human capital and public spending'(EC, 2013, p. 1). For that reasons, health care on European ground is regarded as one of the pillars of the European contemporary welfare states, and the functioning of national health systems is one of a key element of EU's broader 'social infrastructure'. It includes both a system of overarching values the most important of which are: the universality of health services, accessibility of high quality health care, equity and solidarity, and a common to European health systems set of rules of conduct governing quality requirements, safety of provision of health care services based on scientific evidence and ethical principles, patient involvement, redress, privacy and confidentiality (EC, 2006).

Analyzing the above values and principles at the level of their practical implementation, one should emphasise that health systems vary across the EU MS. The underlying reason for their variety has been, and continues to be, the choices of systemic solutions made as part of the underlying historical and cultural development as well as of economic and political conditions, including those relating to the rules governing the award of entitlement to public health services or their funding mechanisms and the organization of these benefits.

Firstly, the entitlement to public health services in EU MS can be either recognized as a universal entitlement of all citizens or a subjective right arising from an insurance contract. Thus the public means for health care can be generated either via a tax system or a social health insurance or by a combination of both. As pointed out in Table 1, the public coverage of health care costs for a core set of services is either universal or close to it in all EU Member States. The exception is for example Cyprus, where the public health system, although financed through general taxation, does not secure universal coverage except for these with a low income level. As a consequence, approximately 17% of Cypriots, mainly those of high annual income as well as EU citizens who are not eligible for public health care in

their home countries and all legal and illegal immigrants from non-EU countries living in Cyprus, must pay out of pocket to access the public health system, or purchase health care from the private sector (HIT, 2012, p 35). In Greece (79%), two main rules of entitlement co-exist: one on the basis of citizenship for outpatient services provided by the national health system (ESY) and second on the basis of occupational status and insurance contributions for different type of services either provided or financed by insurance funds, ESY or private providers (Economou, 2010, p 18). Both in Cyprus and Greece, have been taken health reform, including these relating to the extension or consolidation the coverage by the public health care, due to the need to implement the recommendations of the adjustment program (Kawiorska, 2014). The relatively low level of public coverage indicator is also observed in Germany (89%). In this country the possibility for opting out of the Statutory Health Insurance (SHI) system and switching to Private Health Insurance (PHI) is seen by certain groups of people as a pragmatic way to save money or, in the case of self-employed individuals, as a necessity since many of them are not eligible for SHI coverage (Busse R., Blümel M., 2014, p 53.). The low level of public coverage indicator can also be observed in Member States where social health insurance is closely related to the labour market. In these countries the share of uninsured population increases with economic downturn, being a reflection of decreases in the labour market participation. Examples are Bulgaria (77%), Greece (79%), Estonia (93%) or Poland (97%)¹⁰.

Secondly, as mentioned earlier public coverage for health care is not a perfect indicator because the range of medical goods and services publicly covered as well as the type and level of cost-sharing that applies to those goods and services vary considerably across European countries (OECD, 2014, p. 108). This variation applies both to form (direct payment, cost-sharing, informal payments) and level of household out-of-pocket payments for health care. Hence the other indicator, i.e. the share of household out-of-pocket expenditure¹¹ in total current health care expenditure has been

¹⁰ The ongoing financial crisis of 2007 meant that in most EU countries people out of work for a longer period of time lost their entitlement to unemployment benefits and, consequently, their entitlement to free health services, and equally affected self-employed people who were not able to pay health insurance premiums due to a drop in their income. The crisis also manifested itself in an increase in the number of people employed under contracts that did not guarantee employer's contributions to the system.

¹¹ Household out of pocket expenditure can comprise both the direct payment for purchasing health care goods and services in the private market and the required contribution to the costs of publicly financed goods and services at the point of use. In some countries it also comprises unofficial payments that may allow patients, for example, to avoid a long waiting list or to receive more care or of a higher-quality.

taken into account for the purpose of this analysis. This indicator captures the financial burden on household budgets. Analysis of this ratio (Table 2) indicates a very large diversity of its size across the EU Member States in 2012. The least financially burdened were households in the Netherlands, France and the UK, where the size of the household expenditure did not exceed 10% of total current health expenditure, while the most burden was borne by households in Cyprus, Bulgaria and Latvia, in which the share was several times higher and represented an equivalent of 47%, 43% and 34%, respectively.

Thirdly, in the context of assessment of the decommodifying potential of healthcare programmes, the situation of the patient, who is the primary recipient and the potential beneficiary of health services should be an important aspect of the analysis. It has been done by the incorporation into the analysis of the third indicator that refers to the percentage of the population reporting difficulties in having their basic medical needs met. This indicator makes it possible to take into account patients' subjective opinion on what they feel are barriers to medical services accessibility. In 2012, in the EU-28, just 3.4 % of the population reported unmet need for medical examination or treatment of which 67% were reported due to a lack of funds, 29.4 % due to a long waiting lists and 5.9% due to the distance to the place where medical services are provided, or the lack of means of transport¹². Just as in the case of the analysis of the previous indicator, also in the case of the indicator in question, one can tell big differences in the situation of the citizens of the EU Member States. The highest percentage of the population reporting difficulties in access to medical services, ranging between 8 and 12% was ascertained in Latvia, Romania, Poland, Estonia, Bulgaria and Greece, while the lowest, not exceeding 1% of the total population, in Slovenia, Austria, the Netherlands, Luxembourg and Spain (Table 2). In countries with the highest proportion of the population reporting difficulties in access to the benefits, lack of funds or too expensive treatment were indicated as their main reasons (Romania - 90%, Latvia - 85%, Greece - 81%, and Bulgaria - 72%), together with long waiting lists (Estonia - 77% and Poland - 56%).

Discussed above three measures underlying the construction of the second index has enabled to assess the decommodifying potential of health care provision taking into account a widely understood access to health care benefits financed from public funds in the Member States.

¹² EU statistics on income and living conditions (EU-SILC): Self-reported unmet needs for medical examination, by sex, age and reason (%) [hlth_silc_03], Eurostat database (07.01.15)

The indicator that refers to the public coverage of health care costs for a core set of goods and services illustrates the extent of general access to these goods and services that depends on the rules governing the award of entitlement to public health services. In other words it illustrates the extent to which the adoption of certain rules of governing can protect citizens against the economic fluctuations.

The indicator that refers to the ratio of household out-of-pocket expenditure on health care to the total current health care expenditures reveals a real level of financial burden of households that arises due to the various funding mechanisms of health benefits adopted by the country. This indicator is commonly considered as one of the measures of health services accessibility in practice.

The last indicator that refers to the self-reported unmet need for medical examination or treatment shows the scale of encountered barriers to access of those seeking health care. Both the scale and the reasons of these barriers can indirectly reveal the outcome of the countries' systemic solutions, including those related to financial and some of organisational aspects of health care provision.

The concept of the three worlds and further comparative research conducted by reference to it together with the findings of this study allow to formulate two main conclusions. Firstly, in terms of values and principles the health care programs in EU MS that aim to protect against the risk of loss of health differ from social security programs that aim to protect against the risk of loss of income. The former based on the principle of universal citizenship and equality, exhibit characteristics typical of high decommodification level regimes, whereas the income security programs implemented in those countries, if based on the principle of individual risk and professional performance, will exhibit characteristics typical of medium or low decommodification level regimes.

Secondly, analyzing the above values and principles at the level of their practical implementation the extent of a widely understood accessibility of publicly funded health care good and services varies across the EU MS. These results show that even convergence of the values and principles between health programs and income security programs in such countries like Denmark, Finland, or Sweden wouldn't necessarily lead to reveal of similarities in decommodifying potentials of both types of programs.

It should be also pointed out that presented assignment to a different decommodification level groups of countries has been partially determined by the methodology applied. The use of the mean value and standard deviation as the criteria for determining the intervals for fitting countries into different groups has led to the assignment of certain countries to the same group despite a large distance between the values of the indicators

and vice versa, in the inclusion of countries into different groups, despite a small distance between the values of these indicators for these countries. This confirmed some criticism about the drawbacks of the adopted methodology (Bambra, 2005a, Castles & Mitchel, 1993, Powell & Barrientos, 2011).

The results of the study also confirm criticism voiced in existing literature as to the usefulness of the concept of the three worlds for comparative studies. Thus, the present study fits into a trend of empirical studies that reinforce the view presented, among others, by researchers such as G. J. Kasza (2002), pointing to the existence of practical obstacles to the development of a universal typology of welfare states due to a lack of internal coherence of national social security schemes. This lack of coherence is due to the specific nature of the various fields in which social programs (e.g. education, health care and social security) are implemented, as well as to variations in the shaping of policies within each of these fields, a diversity of players, and the dynamics of change within individual social policy areas, including the effects of convergence with respect both to the practical and normative solutions used in different countries (Kasza, p. 282). In the light of the study dedicated to EU MS, the argument referring to the effects of convergence has a significant meaning due to the various initiatives undertaken by the EU institutions aiming to promote and coordinate health policies in the Member States.

Conclusions

The importance of G. Esping-Andersen's concept of the three worlds can be gauged from the stand point of the intensity of the ongoing scientific debate about the proposed typology of welfare state regimes, as well as from in terms of the fact that the debate continues to this very day. The issues discussed in this paper are part of the mainstream of the debate, and they focus on the assessment of the decommodifying potential of health systems in the light of the concept of welfare state regimes. This study has confirmed that health care is essential in contemporary European welfare states and that state involvement is equally essential for the functioning of health care systems in the EU. The extend to which the state involvement in health care area secures the individuals' access to health care regardless of their market position should be indicated as a basic measure for assessing the decommodifying potential of health care benefits. The analysis proves it that convergence of the values and principles underpinning the health care systems of the EU Member States does not in itself determine that the result of their practical implementation will be an identical or a similar scope of a

widely understood access to health care benefits financed from public funds in the Member States.

The extension of a set of indicators that would allow the continuation of studies, for example, of the assessment of existing social inequalities in accessibility of health services or a sense of security or satisfaction of patients using public health care is an open issue. Such studies undoubtedly will contribute to a more definitive conclusion as to the real decommodifying potential of health care systems in the UE MS.

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