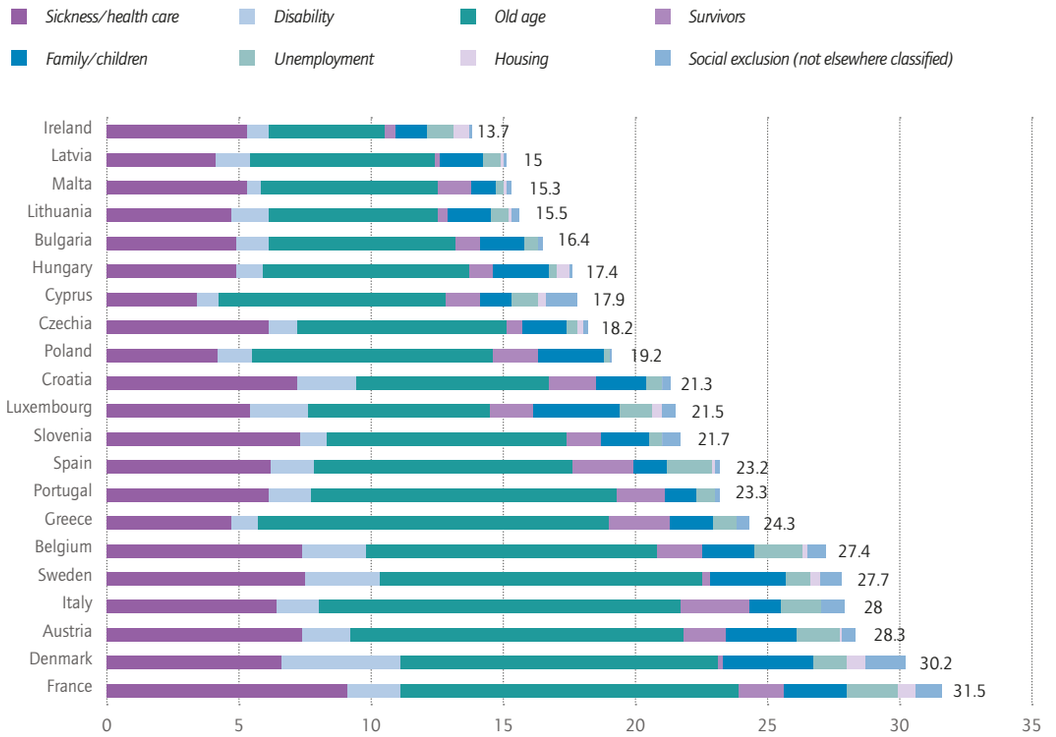
Varying economic and social resilience

Figure 1.12 Expenditure on social protection benefits, by function, as % of GDP, 2018



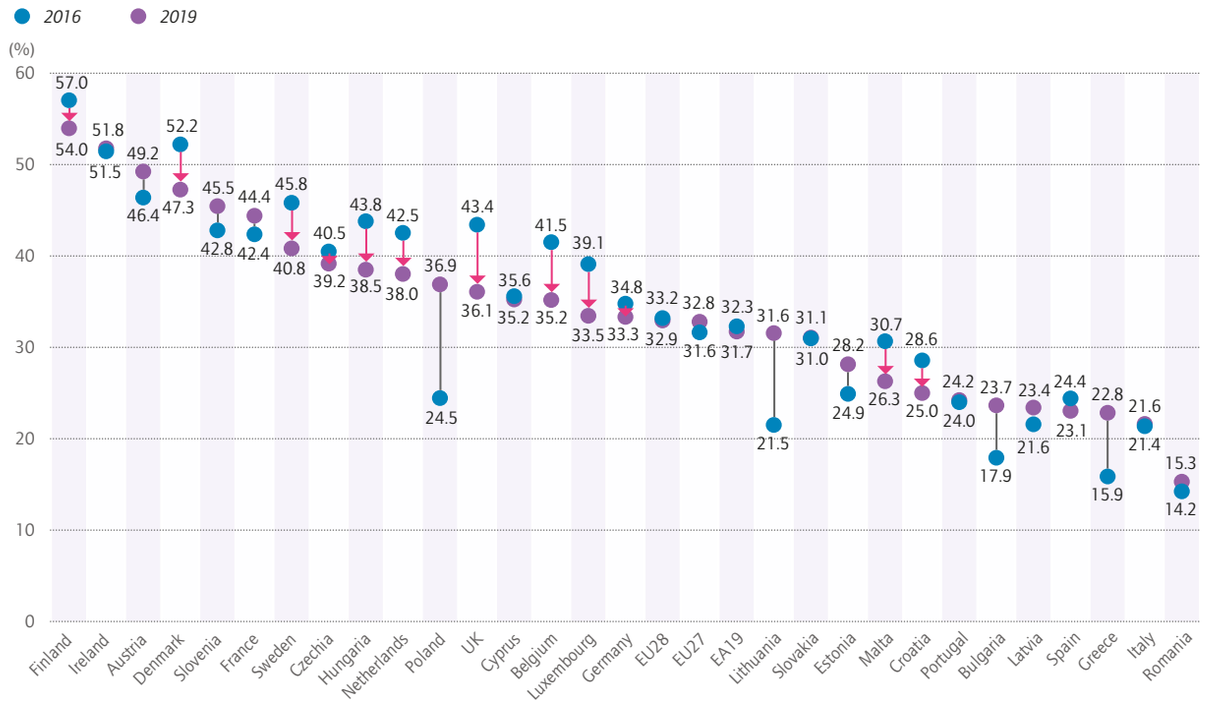
Source: Eurostat SPR_EXP_GDP series).

One of the means of targeting the risk of poverty is through social protection benefits. Figure 1.12 shows social protection expenditure by function (e.g. health/sickness, unemployment, old age) as a share of GDP for the EU Member States for which data by Eurostat was available for 2018. Two observations stand out. First, as a total, the slice of GDP that goes into the various forms of social protection varies, from 31.5% in France to 13.7% in Ireland. In principle, and insofar as social protection provides tools for supporting households in the face of various life and market risks, this variation shows the different degrees to which Member States dedicate resources to tackling not only income inequality but also a crisis such as the current pandemic. Secondly, it illustrates the different relative weight that expenses dedicated to healthcare and unemployment (among other things) have in different countries and thereby the different ways in which they create resilience. In 2018, France dedicated 9.1% of its GDP to sickness/healthcare public expenditure, while Cyprus only 3.4%. On the other hand, France and Belgium spent 1.9% and 1.8% of their GDP respectively on unemployment benefits, whereas Poland, Hungary and Malta only spent 0.2-0.3%.

Nevertheless, public spending on social transfers is alone not a good predictor of how efficiently social transfers mitigate social risks and income inequality. Figure 1.13 shows the effectiveness of social transfers (excluding pensions) in reducing the share of households at risk of poverty in EU Member States and the UK in 2016 and in 2019. This effectiveness is measured here by the difference in percentage points in the at-risk-of-poverty rate when considering market incomes (i.e. before the receipt of any benefits) and the at-risk-of-poverty rate when taking into account disposable income (i.e. after the receipt of benefits and payment of taxes). There is a wide variety in that effectiveness, ranging from almost 60pp in Finland to 15pp in Romania. Other countries with above average at-risk-of poverty rates also have relatively ineffective social transfers, such as Greece, Italy and Spain.

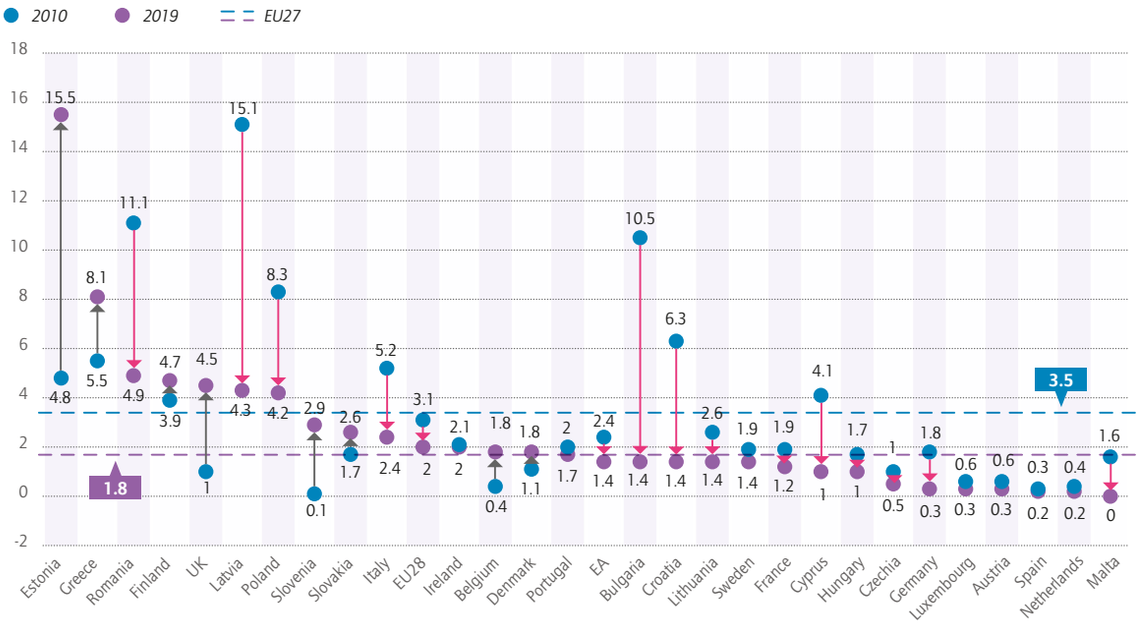
One of the dimensions of social protection which came under scrutiny during the crisis is the capacity of healthcare systems to deal with medical care needs. The pandemic has put an enormous strain on them, and metrics related to their capacity have been largely guiding the tightening and loosening of measures to stem the spread of the virus almost everywhere in Europe. National healthcare systems, however, have not been equally well resourced and accessible to citizens across Europe, meaning there is an unevenness to the capacity of different Member States to deal with the pandemic. Figure 1.14 shows the share of respondents in the EU and Member States reporting unmet needs for medical care due to financial reasons, too long waiting lists, or due to the fact that health facilities were too far to travel to a healthcare indicator from the Social Scoreboard of the European Pillar of Social Rights. In 2019, the share of respondents with unmet needs for medical care due to the above reasons was 2% in the EU28 and 1.4% in the euro area, while it

Figure 1.13 Impact of social transfers (excluding pensions) on poverty reduction EU Member States, 2016 and 2019*



Source: Eurostat, TESPM050 series.
** Data from 2018: Ireland, France, the UK, Belgium, Luxembourg, Germany, EU28, EU28=7-2020, Euro area, Slovakia, Italy.*

Figure 1.14 Self-reported unmet need for medical care (% of respondents), 16 years and over, EU Member States, 2010 and 2019*



Source: Eurostat, series TESPM110 series.
**Data are from 2018: UK, Slovakia, Italy, EU28, Ireland, EU27-2020, Belgium, Euro area, France, Germany.*
Note: Reasons for unmet needs : too expensive or too far to travel or waiting list.

ranged from 15.5% in Estonia and 8.1% in Greece to 0% in Malta. In quite a few Member States, that share was higher in 2019 than in 2010, suggesting increasing constraints on access to medical care. These countries included Estonia, Greece, Finland, the UK, Slovenia, Slovakia and Belgium. While in the majority of these countries, the share of the population which reported unmet medical care needs was still fairly low, it is worth noting that these are all rich countries by global standards, where one would expect that adequate medical care would be universal. More recent data on this indicator are not yet available, but there have been concerns in several Member States that the overflow of Covid-19 patients has led to a high rate of unmet needs for medical care among people with other conditions, because hospitals have had to postpone non-urgent consultations and treatment to dedicate resources to the treatment of Covid-19.