# Access to Health Services in Europe

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Universal access to health services is a commitment made by all European Union Member States. Yet, for many, health services are ‘universal’ in principle only and this principle has not led to equal access to and use of healthcare. Health and access to healthcare in Europe are strongly determined by socioeconomic status, which puts the most socially disadvantaged groups in an unequal position. Access to health services can be significantly restricted or conditional, and the types of services provided may be inappropriate for some social groups.

## Introduction

Eighty million European citizens – that is 17% of the population of the European Union – live in poverty. One child in five is born and grows up with economic and social deprivation. These figures are likely to be even greater if we include that section of the population for which official records are not kept. Although known for its commitment to the universal right to health (a key element of the so-called European social model), and despite the fact that its population has a much better health status than the rest of the developing world, access to health services in the European Union is not straightforward or legally ensured for all.

Recognising health and wellbeing as a human right imposes specific obligations on the global community to build an environment that facilitates the realisation of this right. It was with this obligation in mind that the United Nations Member States committed to achieving the Millennium Development Goals in 2000. However, full realisation of the right to health (globally and in Europe) is often constrained by the existence of inequalities, and their reinforcement. How does this impact upon access to health services in Europe? How does this fit with the European vision for universal social protection, social inclusion and solidarity? This report examines these and other issues in relation to access to health services in Europe.

## Definitions

The World Health Organization (WHO) defines accessibility as “a measure of the proportion of the population that reaches appropriate health services” (WHO, Regional Office for Europe 1998). Research indicates that access to health services is closely linked to the affordability, physical accessibility, and acceptability of services, and is not based merely on the adequacy of service supply (Gulliford et al. 2002). Access to health services, including health prevention and promotion, means that people have the power to demand appropriate health resources in order to protect or improve their health. A certain population may ‘have’ access to specific health services, while other groups within this population encounter obstacles while trying to ‘gain’ access to such services. Social, financial and cultural barriers limit the availability and affordability of health services for such groups.

Universal access to health services is generally considered a fundamental feature of health systems in the European Union. Not only is the principle of universal access explicitly stated in several Member State constitutions, it has also been incorporated into the European Union Charter of Fundamental Rights. Article 35 of the Charter states: “Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices” (Council of the European Union 2001). It is the responsibility of governments to put in place health services, and to enable, promote and improve access to health and health services.

While WHO recommends that primary healthcare[1] should be at heart of every healthcare system, the inclusion of more specialised health services, such as sexual and reproductive health or mental health services, should be considered when assessing access to health services.

Access to health services goes beyond the traditional treatment-oriented approach to health and should also include health promotion and disease prevention. Health promotion defines actions aimed at enabling people to increase control over their health and its determinants such as income, housing, food security, employment and quality working conditions (WHO 2005). Disease prevention refers to measures taken to prevent disease or injury, rather than to cure or treat symptoms.

## Social determinants of health and access to health services

It is well recognised that differences in health status at the population level are closely linked to socioeconomic status. Health is affected by the political, social and economic framework in which people live: the poorer a person, the worse his or her health. Good health or ill health is not a matter of individual choice. Access to health services and the quality of the service that can be accessed are determinants of health in their own right, and have a strong social dimension.

WHO’s final report on the social determinants of health ‘Closing the gap in a generation: Health equity through an action on the social determinants of health’ points out that:

> *The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples’ lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.* (WHO, Commission on Social Determinants of Health 2008)

In the European Union, social affairs ministers agreed in 2010 that:

> *In all EU countries, social conditions are linked to the existence of avoidable social inequalities in health. There is a social gradient in health status, where people with lower education, a lower occupational class or lower income tend to die at a younger age and to have a higher prevalence of most types of health problems.* (Council of the European Union 2010)

Despite overall improvements in health, striking differences remain, not only between Member

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[1] Declaration of Alma-Ata from the International Conference on Primary Healthcare definition (1978): “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination.” (WHO 1978)

States, but within each country between different sections of the population according to socioeconomic status, place of residence, ethnic group and gender – and these gaps are widening (European Commission, Directorate-General for Employment, Social Policy and Equal Opportunities 2010).

## Barriers to access to health services (for different social groups in Europe)

While healthcare systems have contributed to significant improvements in the health status of Europeans, access to healthcare remains uneven across countries and social groups. This varies according to socioeconomic status, place of residence, ethnic group, gender and other stratifying factors (Mackenbach et al. 2008).

Legal, financial, cultural and geographical barriers to access exist including lack of insurance coverage (especially affecting those without residency or citizenship, migrants, ethnic minorities, the long-term unemployed and the homeless in countries with social security contribution systems), inability to afford the direct financial costs of care (affecting low-income groups), lack of mobility (affecting disabled and elderly persons), lack of language competence (affecting migrants and ethnic minorities), and lack of access to information (affecting the poorly educated and migrants/ethnic minorities), as well as time constraints (particularly affecting single mothers). Specific gender issues overlay all of these barriers.

Financial barriers to access to health services particularly affect low-income groups and chronic patients. Poverty and income inequalities can affect insurance coverage and ability to meet the cost of certain (specialised) types of care (such as reproductive, mental, anti-retroviral, dental, ophthalmic, ear and rehabilitation healthcare). The increasing role of private health insurers and out-of-pocket payments (the amount of money paid by the patient and not reimbursed) may increase inequalities in access to health services as some social groups (women, low-income groups, the elderly, and those employed in the irregular economy such as informal carers and especially older women [AGE Platform Europe 2010]) are less likely to be covered by private insurance.

Cultural barriers to access to healthcare include health literacy and health beliefs and affect specific social groups. The distinct roles within, and behaviours of, specific social groups in a given culture give rise to differences and inequalities in access to healthcare, as well as to differences in risk behaviours and health status. Cultural prejudices, stereotypes and lack of knowledge among healthcare providers about the particular needs of certain social groups and the types of care appropriate for them may deepen access inequalities. Certain traditions and cultural practices can mean that some groups of immigrant women and women of ethnic origin experience more difficulties when trying to access health facilities and information on sexual and reproductive health.

Uneven geographical coverage and provision of healthcare is another obstacle to access to healthcare services. Large cities and more densely populated areas are typically better supplied with healthcare facilities, services and workers. Small, rural and remote areas often lack both basic and specialised healthcare services and workers. Due to physical distance and the particular landscape (islands or mountains), people can experience problems when accessing healthcare facilities. Lack of accessible and affordable transport is more likely to affect socioeconomically disadvantaged groups.

## Main groups at risk and access to health services in Europe

Europe has a great diversity of vulnerable groups that may experience unequal access to different types of health services. Socially disadvantaged groups are sometimes denied access to services or experience barriers. Although it is not possible to list all of these groups, they include Roma people, people with physical disabilities, people suffering from chronic diseases, people suffering from mental disorders, the unemployed, people with poor working conditions, those experiencing homelessness, immigrants, refugees and asylum seekers, undocumented migrants, the elderly and women.

In relation to gender inequalities, a range of barriers can prevent women from enjoying their fundamental right to health and health services. These barriers may stem from factors within the health system itself – gaps and specificities in the coverage of health insurance, the scope of the public health benefits, payment co-sharing, geographical factors such as distance or lack of infrastructure, organisational factors like waiting lists and opening hours, or lack/inappropriateness of information. They may also stem from factors related to the characteristics of the service user – income, education, age, language, disability, sexual identity, cultural background and civil status (Huber et al. 2008). All of these are significantly more likely to negatively affect women, as the health insurance and healthcare systems are frequently connected to women's position in the labour market and their employment and civil status (such as being married, single, widowed or divorced). Moreover, some of the typical gaps in health services in several EU countries include limited coverage for dental and ophthalmic services, and limited access to specialised services (obstetric and mental health services). Several treatments are prohibited or constrained in some countries on moral and bio-ethical grounds including fertility treatments and abortion (Huber et al. 2008). In countries with a politically present Catholic Church (like Ireland or Poland), such health services are considered inappropriate and even illegal, and are, therefore, unavailable.

Migrants, asylum seekers and undocumented migrants are at high risk due to difficult living and working conditions, as well as their specific migration history. They often face considerable barriers in accessing health services. Barriers exist not only due to legal status, but due to lack of interpreters/mediators, lack of information on the system at all levels, as well as a lack of cultural sensitivity and appropriateness of services provided. The combination of higher health risks, social isolation and deprivation, and less access to health services puts the health of these groups at higher risk (Huber et al. 2008).

The most universally disadvantaged group of people living in Europe is the Roma. The great majority of the Roma population is found at the very bottom of the socioeconomic scale. The Roma suffer from worse health than other population group in the countries where they live due to their higher exposure to a range of health-damaging factors (WHO, Regional Office for Europe and Council of Europe Development Bank 2006). Poverty, inadequate education, unemployment and low levels of social integration result in poor health outcomes. Discrimination and unregulated civil status (including lack of personal documents, birth certificates and insurance) make it particularly difficult for Roma to access health services. Pregnant Roma women are most likely not to have an ID card, excluding them from pre-natal and birth assistance. For similar reasons, Roma people cannot benefit from health screening programmes and Roma children cannot take advantage of health checks or immunisations. When more frequent use of healthcare services is required (due to chronic disease or old age), it can be extremely difficult for Roma people to meet out-of-pocket healthcare payments or to make pension/disability allowance claims. In relation to access to health services for Roma people, a number of additional barriers have been identified, namely, lack of knowledge of disease prevention, lack of knowledge about health service rights and lack of physical access to services. Many Roma are not registered with a general practitioner, which may be due to a lack of documents, as well as reluctance on the part of health service providers to accept Roma patients. Their access to health services may also be influenced to a certain extent by their beliefs and cultural norms, evidenced by the fact that Roma people tend to access services for severe problems only, as hospitalisation is sometimes perceived as preceding death (WHO, Regional Office for Europe and Council of Europe Development Bank 2006).

## EU initiatives on access to health services

The Treaty on the Functioning of the European Union (TFEU) makes it clear that the main competence over health services lies with Member States (Article 168) (European Union 2008). However, Member State authorities have to respect the shared overarching values of universality, access to good quality care, equity and solidarity, which are widely recognised through the European Council Conclusions on Common Values and Principles in European Union Health Systems (Council of the European Union 2006).

Although the main competence lies with the Member States, several EU actions and initiatives impact on access to health services, such as the Open Method of Coordination on Health and Long-term Care, the Cross Border Healthcare Directive and the Anti-Discrimination Directive.

Access to health services is one of the priorities of the Open Method of Coordination on Health and Long-term Care, which aims to facilitate the exchange of best practices among Member States. Unfortunately, according to NGOs, this method has not received enough political support to deliver concrete results (Social Platform 2009).

The European Union is currently negotiating two Directives that could impact upon access to health services at the national level. The draft Directive on the application of patients' rights in cross-border healthcare (Commission of the European Communities 2008a) aims to improve the possibility for patients to obtain cross-border healthcare. Although cross-border healthcare represents only 1% of public expenditure on healthcare, increasing patient mobility could put over-stretched budgets under more pressure. Cross-border care is not a total solution, but may be an instrument to improve accessibility, quality and cost-effective care. Its potential – and its relationship with the quality, equity and cost-effectiveness of care – needs to be carefully evaluated.

Member States are also negotiating a draft Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation (Commission of the European Communities 2008b). While the EU has already legislated on racial discrimination and gender equality, there is no consistent level of protection in the European Union against discrimination on the grounds of religion, disability, age or sexual orientation. The current draft Directive would offer a common legal framework of minimum protection against all forms of discrimination across all 27 Member States, including discrimination in relation to access to health services. Although Member States will remain free to organise their own health systems, they will have to ensure that all people living in their territory have access to health services and are not discriminated against on the basis of their sex, gender, race, disability, sexual orientation, religion or age.

## Conclusion

> *[EU] Member States are committed to accessible, high-quality and sustainable healthcare and long-term care by ensuring access for all to adequate health and long-term care and that the need for care does not lead to poverty and financial dependency; and that inequalities in access to care and in health outcomes are addressed.* (European Commission, Directorate-General for Employment, Social Policy and Equal Opportunities 2009)

And yet, universal access to health services tends to be 'universal' in principle only. Inequalities in access to and use of health services prevail in all Member States of the European Union, and they are on the rise. Health and access to health in Europe are strongly determined by socioeconomic status, which puts the most vulnerable groups in an unequal position when trying to access health services both in terms of prevention and treatment. Access can be significantly restricted or conditional, and the types of services provided may be inappropriate for the certain groups.

With the current economic downturn, most European governments have already decided to cut spending on social and public sectors – health is one of the sectors that has been targeted for cuts. This may translate into more out-of-pocket payments for people, which will impact on people with low resources increasing their vulnerability. Less affordable and accessible health services will inevitably mean increased inequalities in the European Union; this will impact on its future social progress and development. ▪

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