



# **Quality in and Equality of Access to Healthcare Services**

## **Executive Summary**

**European Commission**

Directorate-General for Employment, Social Affairs and Equal Opportunities

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## 1.1 Background

Ensuring equitable access to high-quality healthcare constitutes a key challenge for health systems throughout Europe. Despite differences in health system size, structure and financing, evidence suggests that across Europe particular sections of the population are disproportionately affected by barriers to accessing healthcare. Studies have also shown that difficulties in accessing healthcare are compounded by poverty and social exclusion, and that poverty and social exclusion compound difficulties in accessing healthcare.

At an EU level, access to healthcare is also a key issue. Listed as one of the common values for EU Member States agreed in June 2006 (Council of the European Union, 2006), access for all to adequate healthcare and long-term care and tackling of inequities in access has also been proposed as a priority objective for the new streamlined EU Open Method of Coordination for Social Protection and Social Inclusion. The Social Inclusion Strategy (European Commission, 2006) also emphasises a strong focus on reducing poverty and social exclusion for EU citizens.

Against this background, the European Commission (DG Employment, Social Affairs and Equal Opportunity) commissioned the European Health Management Association to undertake a study on “*Quality in and Equality of Access to Healthcare Services: HealthQUEST*”. The study has had two key aims.

- First, **to identify and analyse barriers to accessing healthcare**, particularly for vulnerable people at risk of social exclusion. The study therefore looks at barriers to access at the supply side, problems experienced in this respect by certain groups of the population (demand side) and also at the interplay between the two.
- The second aim has been **to review policy initiatives taken by Member States to realise the objective of equitable access for all**. This has included analysing evidence of the effectiveness of policy initiatives and highlighting good practice.

This study is based on detailed analysis provided by studies on the situation of the following eight countries: *Finland, Germany, Greece, the Netherlands, Poland, Romania, Spain, and the United Kingdom*, - countries that represent different ways of organising and funding of health care across Europe. This was complemented with findings from the literature, in particular recent European comparative studies.

## **1.2 Structure of the Report**

The report falls into three principle parts. The first outlines the policy context and methodology of the project. The second looks at the specific barriers focused on in the study, including coverage, cost-sharing, health literacy and supply-side responsiveness. The third part moves on to analyse the specific problems affecting selected groups at particular risk of social exclusion. In each, underlying factors have been analysed and policy initiatives and good practice identified.

Three groups at particular risk of social exclusion and where there are important gaps in research (and sometimes also in policy action) were chosen for in-depth study:

- Migrants (including asylum seekers and illegal immigrants);
- Older people with functional limitations;
- People with mental health disorders (studied as a special case study under the project).

For these groups the study looked across the eight countries to find out what issues they face and the interaction between the difficulties they experience. An in depth review in the form of a case study was undertaken on the access of people with mental health problems on access to mainstream (somatic) healthcare services.

### 1.3 Key findings and policy responses

This section presents nine key findings from the HealthQUEST report and examples of significant policy responses. These findings relate to both the general barriers faced by vulnerable groups and the experience of the specific groups focused on in the project.

#### ***1. Although people at risk of social exclusion benefit from universal health care coverage, there are a number of reasons why some groups risk falling through this safety net.***

With a few exceptions, health care coverage is universal and mandatory for everybody with a residency status in a European Member State, and basic health care coverage is ensured under a public programme irrespective of ability to pay. People at risk of poverty and social exclusion, such as migrants and people depending on social assistance, are frequently among those without public health coverage. This includes people with limited capacity to organise and regularly pay for social health insurance in cases where this is an individual responsibility. Lack of public health care can seriously worsen their poverty risk.

All countries in the HealthQUEST study had clear policy frameworks to provide coverage for their citizens. Indeed both the Netherlands and Germany have recently changed their systems to provide universal coverage. However, the study also found gaps in coverage, for example countries mostly excluded illegal migrants from non-emergency care.

#### ***2. Health baskets under public programmes are fairly comprehensive on paper but vulnerable people suffer both from shortages of services in practice and from the financial consequences of remaining gaps in health baskets...***

Limited coverage of dental care and of mental health counselling are among the more serious gaps in the health baskets of the European health systems analysed in this study. In addition, HealthQUEST found that in some countries, a number of

services are legally included in the health basket but in practice there is often a gap between policy and reality. The evidence suggests that this is a particular issue for members of vulnerable groups when healthcare systems are in transition.

In Germany, for example, the new policy of universal coverage risks being undermined by low take-up within some groups. Where coverage was increased (e.g. for dental care) this has shown to increase the use of services, especially for disadvantaged groups (Finland).

***3. ...they are also disproportionately affected by the financial burden of cost-sharing arrangements, a burden that is sometimes insufficiently taken into account by existing exemption rules.***

Cost sharing requirements remain significant in many countries. Some countries use private out-of-pocket pay for financing services or medical goods that are not available in sufficient quantity of quality (such as in a timely manner) under public programmes. However, private funding is often regressive and can negatively impact on service, in particular for vulnerable people at risk of social exclusion. In addition, in some countries covered by the HealthQUEST report informal payments are an important issue, which can increase the risk of catastrophic expenditures for vulnerable groups. The evidence suggests that people at risk of poverty profit more from clauses that provide general exemption rules than from payment ceilings that need paperwork with health care administrations or where reimbursement is in retrospect.

Many Member States have made positive policy steps in reducing the burden of cost-sharing. Examples include exemptions and reimbursements in Spain, the Netherlands and the UK (amongst others). Poland is notable for its recent moves to reduce informal payments within its health system.

***4. Significant variations in availability of services can worsen social exclusion in deprived regions, especially in rural areas.***

Evidence from this study suggests the existence of significant variation across regions in terms of public budgets, services and health personnel. These variations impact on the utilisation of healthcare services and restrict access to healthcare for groups at risk of social exclusion, especially for elderly people and those with limited mobility. Inequalities are a particular concern for rural areas, which have worse access to transport infrastructure and healthcare services, lower economic development and higher concentration of elderly people.

Although there remains significant work to be done on this policy area, there are interesting developments, including the Greek KAPI centres for older people in rural areas and the creation of the so-called High Resolution Specialist Centres in Autonomous Communities in Spain.

***5 Organisational barriers can seriously limit access to healthcare for groups at risk of social exclusion.***

Several countries covered by the HealthQUEST report have made progress with policies regulating waiting times (e.g. using waiting-time targets) for elective surgery, a problem that has received significant attention in a number of countries. However, other countries still have important issues with waiting times, and people at risk of poverty usually lack the means to circumvent organisational barriers by accessing the private system. There are other policies that can improve organisational barriers that are due to other factors, such as putting in place 24-hour walk-in centres.

Many Member States have initiated substantial policies in response to concerns about waiting times. Some Member States have also introduced 24 hour health care centres to widen access to non-emergency care.

**6. Low health literacy can compound barriers of access to health care services, and may delay or prevent uptake of insurance coverage.**

The ability of people to understand how to make sound health and health service choices (including the choice of insurance funds) is crucial for reducing population health inequalities and health-related risks of social exclusion. People from vulnerable groups therefore need special social support, for which local government can play an important role.

A number of countries are beginning to address problems of health literacy. In particular, the work in Spain on diabetes and cancer, dealing with care, prevention and self-management provides an interesting and promising approach.

**7. Health protection afforded to migrants often does not cover their needs.**

In most countries covered by the HealthQUEST report migrants who have been granted residency status are generally covered under the same terms as other residents. However, those without residency status are often faced with serious access problems and the risk of very high out-of-pocket health expenditures. Where evidence is available, migrants make lower use of specialist inpatient and outpatient care and tend to have greater reliance on emergency services.

Although this presents a complex problem, particularly in the case of illegal immigrants, some Member States have taken important steps to improve access. Roma health mediators in several Member States provide an important example of good practice.

**8. Older dependent people may receive fewer services than they need and the quality of available service often has deficits.**

The evidence presented in this study suggests that older people often do not access health care as frequently as they need. This reasons for this differ, but include: cost of services; problems with mobility; general shortages of preventive and rehabilitative

services; health beliefs (low expectations); and gaps in training of geriatricians. Problems of access and with quality of health care services can be severe at the interface of health and social service, which often do not work together well. In addition, the limited access to health care services of people living in institutions can put older dependent people at great health and safety risk.

As older dependent people become an increasing proportion of the population their access to health care will become a particular priority. In responding to this challenge Finland, for example, has taken steps to provide comprehensive care assessments for all older dependent people. Some Member States have also increased gerontology training for medical students.

***9. People with mental health disorders suffer from excess avoidable deaths and somatic co-morbidity, suggesting important access hurdles to somatic health care services.***

Many common barriers of access to somatic (mainstream) health care have a particular impact on people with mental disorders. In addition, the evidence also suggests that people with mental disorders also face significant stigmatisation and discrimination. However, the HealthQUEST study has found that people with mental health problems are often not on the health policy radar in relation to their somatic health needs. Furthermore, there is evidence that some mental health reforms have not considered their potential impact on somatic health care provision, such as lack of access to medical personnel in institutions.

The somatic health needs of people with mental health disorders remain a key policy challenge, as do issues around stigmatisation. At present, the UK is the only Member State that has explicitly prioritised general health care for people in this group.

## 1.4 Policy Recommendations

***Vulnerable groups need specific policy attention to overcome the access barriers posed by the ways in which health care systems regulate population coverage, the health basket and cost-sharing.***

Vulnerable people are particularly at risk from cost sharing for health care. Member states may wish to consider putting policies in place – such as exemption or reimbursement rules – to ensure that the organisation of the health system does not unduly disadvantage vulnerable populations.

***Explicitly address health literacy as part of health system reform.***

Member States should ensure that they have clear policies in place to address both supply and demand side health literacy for vulnerable populations.

Member states who are changing their health care systems should pay particular attention to ensuring that active ongoing measures are in place to support vulnerable populations in effectively using the system.

The European Union should ensure that there is a strong evidence base to support Member States in addressing health literacy.

***Prioritise research on the somatic health care needs and access for people with mental disorders.***

The lack of data on access to general health for people with mental disorders is a significant lacuna. This is also evidenced by the fact that, with the exception of UK, no national policies addressing the issue of access to general health care for people with mental disorders were identified

The EU may wish to consider urgently funding research to better understand the somatic health care needs of people with mental disorders and what effective interventions can be made to alleviate this problem.

***Address stigmatisation as a major access barrier for people with mental health disorders.***

The most significant barrier to health care access for people with mental disorder was unanimously felt to be the stigma and discrimination associated with mental ill health.

Member States need to acknowledge the specific needs of those with mental disorders and centrally target the needs of these groups for mainstream health services in national health inequalities programmes, incentivising providers and performance managing to ensure targets are met. Specific treatment guidelines also need to be developed.

***Give special attention to the high co-morbidity and health risks of people with mental disorders.***

Member states should ensure that health policy explicitly addresses the high rates of co-morbidity of people with mental disorders, particularly when people are inpatients in specialist mental health services.

The EU might wish to consider how good practice examples of targeted health promotion action for people with mental health disorders might be disseminated more broadly.

***Reassess services for migrants and asylum seekers without papers.***

Member states may wish to consider how to improve the situation of asylum seekers and migrants with no official status and ensuring that health care is in place for this group.

***Improve the mix of health and social services in place for older people and their families.***

Member states should improve the mix of services by fostering access to prevention, rehabilitation and comprehensive care assessment as well as better care management at the boundary between health and social services.

Evidence suggests that the role of informal carers in supporting older people underpins services to this group in all Member States. Member states may wish to

pay particular attention to creating a policy framework to support informal carers and to enable them to stay in employment.

***Improve the access and quality of services of dependent older people in institutions.***

Member states urgently need to ensure that policies are in place to meet the health care needs of older people cared for in institutional settings. The right skill mix of staff in institutions and more seamless cooperation across the social care and health boundary needs special attention.

***Invest in gerontology, better quality assurance mechanisms and care guidelines for dependent older people.***

Member states should invest more in research on how to improve the knowledge of elderly health and care issues among health and care professions. They should consider investing multidisciplinary research on stigma, anti-discrimination, health promotion, and integrated community-based services.

***Undertake specific impact assessments of major social and health policy changes on the situation of people at risk of social exclusion.***

As Member states change systems for financing health care, including cost-sharing regulations, specific attention in routine data collection should be given to vulnerable groups to ensure that policy measures to prevent exclusion are effective. A culture of monitoring and programme evaluation is required to close serious gaps in research and information systems.

Member states need to pay more attention to allow systematic research into the reasons why some people fail to obtain a regular insurance status. This should be undertaken for countries where certain vulnerable groups are at risk of exclusion from regular health care coverage.

***Give barriers of access for vulnerable groups greater attention in the European Union policy process.***

Among issues of priority for a broader European exchange are affordability of health care for vulnerable groups, health literacy and patient empowerment

***Consider how to address the most pressing questions for further research identified in HealthQUEST.***

The EU may wish to consider whether the most significant questions identified for further research are suitable for funding under the Framework Programme for Research of the European Union. Priority questions for further research include good practice of tailored prevention and health promotion for people at risk of social exclusion, integrated care models, and the situation of people with mental disorders.

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