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Access to health care in the EU Member States

Markus Wörz, Thomas Foubister and Reinhard Busse

Universal access is usually taken to be a fundamental feature of the health care systems of the European Union (EU) member states. Reform debates in other continents regularly look to the European experience as a model to be emulated or as a showcase for methods of preserving access in contexts of marketization and privatization. In the EU, the principle of universal access is indeed a governing one. It is captured in several country constitutions and health service founding documents, and has been incorporated into the EU Charter of Fundamental Rights as Article 35, whose first part reads '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'.¹

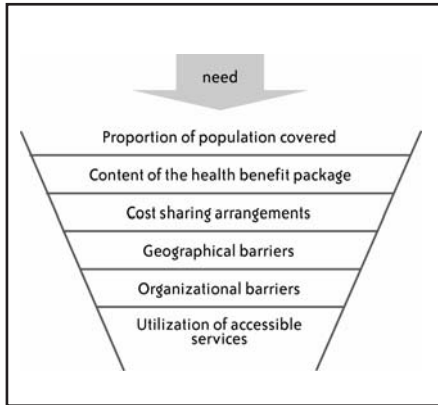
This priority accorded to universal access reflects the belief that access to health care is a precondition for active membership of society. Two strands of thought in particular have informed the development of universal access in the EU – the basic minimum approach and the equalizing approach. The former seeks to ensure that no citizen falls beneath a particular level of subsistence, the latter that the *same* level or quality of health care be *equally* accessible to all, regardless of status. The health care systems of the EU combine both these strands, sometimes in complex ways. Generally, they strive for equality by taking the basic minimum approach and setting this 'minimum' at a level that is sufficiently high so as to afford the private market only a residual role (but a role nonetheless).

Against this background, the precise meaning of 'access' has been the subject of debate. However, there is a consensus view that health care should be distributed according to need. Thus, the World Health Organization (WHO) defines accessibility as 'a measure of the proportion of the population that reaches *appropriate* health services'² (emphasis added). Nevertheless, where universal access is formally in place, barriers may persist whose effects are distributed unevenly across the population (undoing thereby the equality objective). This article discusses access issues arising from the experience of ten EU member states: Austria, Belgium, England, France, Germany, Ireland, Italy, Poland, Hungary and The Netherlands.* We identify six access barriers which we represent in the form of a filter (Figure 1 overleaf), each of which can be thought of as constituting a hurdle to be surmounted if universal access is to be realised.

The first hurdle relates to whether health care coverage is extended to the whole population or not. Primary coverage will usually be via the public system (whether financed on the basis of social health insurance or taxation, or a mixture of the two), but it also may be via substitutive voluntary health insurance (VHI).

* The articles in this issue are based on the research project *Mapping Health Services Access: National and Cross-Border Issues* (HealthACCESS), funded by European Commission DG SANCO, grant number 2003103(790873).

Figure 1: The health care access barrier filter



Strictly-speaking, complementary VHI may also be thought of as playing a primary coverage role, in so far as it provides cover for benefits, or the part of the cost of care, not covered by the public system. Our focus in this article is primarily on public system coverage (for further discussion of issues relating to primary coverage through VHI, see the full project report^{3,4}). The second hurdle relates to benefits covered under this system of primary coverage. These hurdles are fundamental, and conceptually have priority. The remaining four are without strict order of precedence among themselves, and relate to personal and cultural preferences and to supply-side organization and behaviour (here, we take cost-sharing as a supply-side factor, albeit one intended to operate on demand). Access to health care can be impeded by any of these hurdles, either singly or in combination.

The six hurdles

1. The proportion of the population covered for health care

Most EU member states operate systems of universal public coverage, with coverage being extended, in principle, to the entire population, usually defined by residence or citizenship. However, of the social health insurance countries considered here, three have introduced universal systems only recently: Belgium in 1998 (extending coverage for minor risks to the self-employed); France in 2000 (extending entitlement to cover on the basis of citizenship rather than employment status); and The Netherlands in

2006 (extending mandatory health insurance to the whole population).

Universal systems share the following five characteristics: (i) they provide the primary mode of access to health care; (ii) public funding dominates, but there is usually cost sharing; (iii) participation is mandatory; (iv) benefits coverage is broad; and (v) access (and resource allocation) is on the basis of need.

Having said that, universal coverage tends to be 'universal' only in principle. The entitlement status of some vulnerable groups may be unclear. Most notably, for failed asylum seekers and illegal immigrants, coverage for health care may be virtually non-existent (see the case study on illegal immigrants and asylum seekers in this issue). Also for legal residents or citizens, problems may arise from the way in which coverage is organized – coverage for the unemployed, for instance, may require meeting certain administrative requirements, as in Austria; contribution record keeping may not function effectively, as in Poland; or coverage may be temporarily lost following changes in employment or marital status if certain administrative requirements are overlooked under some systems of social health insurance.

Ireland and Germany constitute anomalies, since the public system cannot strictly be described as a system of universal coverage. In these countries, it is VHI that provides the primary mode of coverage for part of the population. In Ireland people are eligible for full membership of the (tax-financed) public system if they meet certain hardship criteria relating to income, household size, household expenditure, and further factors including the presence of chronic disease. Those who do not meet these criteria are covered by the public system only for core services (inpatient care) and are subject to user fees. This group must purchase VHI to secure full primary coverage.

In Germany, whose public system is financed largely through social health insurance, employees with a gross income above a specified threshold (€3862 per month in 2004) are able to choose whether or not to opt into the public

system. If they choose not to opt in, primary coverage for health care is through substitutive VHI. Alternatively, they may remain uninsured and pay for care on an out of pocket basis. Some occupational groups are excluded from the public system regardless of income status – most importantly civil servants (whose health care costs are, however, largely reimbursed by the public purse). In Germany circa 88% of the population is covered by Statutory Health Insurance, with a further 10% having full primary coverage through VHI. In 2003, only circa 0.2% had no health insurance at all. However, due to factors such as the welfare reform of 2005 which tightened eligibility criteria for unemployment benefits, this figure may have risen to between 0.3% and 0.5%.

2. Benefits covered by health care systems

Among the ten countries, there is some – but seemingly little – variation in the range of benefits provided to citizens and residents by public systems of coverage for health care (termination of pregnancy being a notable exception). The package framework does, however, differ. In general, benefits packages fall into one of three categories:

- (i) undefined but broadly comprehensive;
- (ii) defined by general categories only (hospital care, outpatient care etc); and
- (iii) explicit lists of benefits (or rather, a combination of lists for some areas of care with a general categories listing for other areas).

We would also note here that policy regarding cost sharing does vary among the countries, and that this means that in effect, some services are better covered in some countries than in others.

There appears to be a trend towards increasing explicitness in the definition of benefits packages (particularly in terms of what is excluded from cover), with potential implications for access. In some cases this is related to the introduction of payment technologies which attach prices to specific procedures. For example, the introduction of 'payment by results' in England may lead to the emergence of a more explicit benefits package in the area

of hospital care, as items without a price attached may eventually not be reimbursable. In addition, criteria for the inclusion of a benefit have tended to become more formal and restrictive. Thus in The Netherlands, with the introduction of universal coverage, the standard package will provide essential curative services that are tested for efficacy, cost-effectiveness, and for the need for collective financing. The erosion across the EU member states of public system coverage for ophthalmic and dental care is well known. Less well known is the gradual withdrawal of coverage for long term care, as much long term care responsibility is shifted from the health sector to the social care sector with its attendant systems of means-testing (see the case study on long term care in this issue).

3. Cost-sharing arrangements

Demand-side cost sharing is present in all ten countries. All impose charges for pharmaceuticals and dental care (except Poland, which does not impose cost sharing for the latter). About half also impose charges for primary and secondary health care. In each country, however, measures are in place to provide some level of protection from high out-of-pocket expenditure for some groups. These include exemptions based on age (children and pensioners), income (those on low income or benefits), and health status or type of illness (for example pregnant women or those with chronic illnesses). Aside from full exemptions, protective mechanisms include the use of discounts; out-of-pocket maxima (annual or monthly); tax relief (this operates only in the Netherlands); and complementary VHI (with access facilitated by the Government for low income individuals in France (see also *EuroObserver* 2004(6)1).

Cost sharing is usually applied uniformly across the public system, but Italy (where health care has been devolved to regional governments) presents an exception, with a significant degree of regional discretion in the application of cost sharing arrangements within a framework set at the national level. Thus, in the case of pharmaceuticals, 10 regions out of 21 do not require cost sharing. Similar variation

is present in cost sharing for non-emergency access to emergency services.

4. Geographical barriers to access

Geographical proximity to health services can constitute a significant barrier to access in terms of costs relating to time and transport. According to a Eurobarometer survey on proximity to health care providers analysed by Alber and Kohler,⁵ on average about 48% of the EU-25 population have access to a hospital less than 20 minutes away (circa 53% of the former EU-15 and circa 35% of the new 10 member states). Concerning proximity to a GP, on average about 82% have access in less than 20 minutes (circa 85% of the former EU-15 and circa 68% of the new 10 member states).

These broad figures can conceal regional variation within countries. In Austria and Hungary, for example, there is significant variation in the provision of hospital beds by region. The Netherlands is among the countries with the highest proportion of people with uniform proximity to hospitals and GPs. Besides its high population density, this is due to regulatory intervention. The Ministry sets a standard for maximum travelling time to hospital of 30 minutes and to a GP of 15 minutes.

5. Organizational barriers to access

Even if the patient is covered for a wide range of benefits, cost sharing is affordable, and providers are close by, there may be organizational barriers to access. Among the most significant of this type of barrier are waiting lists. Waiting lists are a feature of the English, Irish, Italian, Polish and Dutch health care systems – although England and the Netherlands have been able to reduce their lists by, for example, increasing funding, restructuring provision (including sending patients abroad), and reforming reimbursement.

Another barrier may emerge if VHI co-exists with public insurance schemes and both cover the same services. Access inequities have been noted for France, Germany, and Ireland (see the main project report). Even in England, where VHI plays a small role, it is thought that the presence of private medicine can lead

to higher waiting lists in the public system.⁶ A similar problem relates to the persisting use of informal payments in Hungary where ‘brown envelope’ payments grant accelerated access to services for those who can afford to pay.

6. Utilization of accessible services

This hurdle relates to a fundamental distinction: the availability of services and the utilization of services. Availability constitutes a potential; it is not a proof of access. The relation between socio-economic status and utilization of health services has been researched extensively, and one finding has been that there is little income-related inequity in the utilization of GPs but that there is pro-rich inequity in the utilization of specialists, particularly in countries where VHI or private options are available.⁷ Less is known, however, about the relation between other socioeconomic or demographic variables and utilization (see the case study on gender in this issue).

Beyond the coverage barrier

Some of these barriers to access can be considered static, others more dynamic. For example, population coverage is rarely subject to fundamental change, and significant change in the geographical distribution of providers usually takes place only over long time-spans, if at all. In comparison, cost sharing policies and composition of benefits packages have been subject to a greater degree of alteration, and are liable to remain among the more dynamic of the barriers. These areas lend themselves more readily to policy intervention, but because of this policy changes have been common, and therefore there is little evidence regarding the precise nature of the impact of these areas on access. Nevertheless, these levers can be mobilized to effectuate access (for instance though reducing or improving systems of exemption from cost sharing).

We stated above that the health care systems of the EU combine the basic minimum approach and the equalizing approach in what are sometimes complex ways. The presence of universal or near-universal primary coverage for a broad range of health care services (whether via

the public system or – in the case of Ireland and Germany – through VHI for some of the population) represents the clearest manifestation of this accommodation of the two currents underpinning the development of European health care systems. However, this is a strained accommodation. Even in a system of universal coverage, serious access barriers remain which appear to fall disproportionately on those least able to surmount them. If there is one key message to emerge from this broad survey of access issues across the health care systems of the EU, it is that it is necessary to look beyond the presence or absence of coverage per se – and, moreover, beyond the assumption of coverage's universality – if persisting inequities are to be addressed.

The European dimension

In the framework of the EU, the principle of access has played an important role. EC Regulation 1408/71/EEC provides for health care access for migrant workers and their families and some other groups. The material scope of the Regulation, however, only refers to national social security benefits, and health care covered by substitutive VHI or subject to a means-test is not covered by this regulation.⁸ Elsewhere, the European Court of Justice has acted as an engine of integration in the area of health care on the basis of rulings relating to Article 49 of the EC Treaty, which have made access to health care in other member states (under certain conditions) a reality.

European integration has the potential to alleviate some access barriers (primarily of geographical and organizational kinds). Many cross-border arrangements, especially in the Euregios between Belgium, France, the Netherlands, and Germany, are seeing improvements in access to hospital and emergency care services in particular. Countries experiencing domestic waiting list problems are also sending (or have sent) patients abroad to take advantage of spare capacity there. Such cross-border arrangements are still insignificant between old and new member states, but are likely to be developed in future.

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Access to health care: Contributions from the gender perspective

Birgit Babitsch and Gabriele Dennert

Gender differences in health

Gender differences in health and health care have been reported in several studies worldwide. Although women report more diseases than men, they have a higher life expectancy compared to men – a pattern which is found more or less worldwide. The gender gap in life expectancy at birth in Europe is about 6.3 years (81.1 years for women and 74.8

years for men).¹ However, figures vary between the 25 European countries.² Living longer than men does not imply for women that they also experience a higher quality of life. On the contrary, data show that women face a higher burden of disease during their life.³ Morbidity data demonstrate different incidence and prevalence rates for a variety of diseases (for example, coronary heart disease), and women and men are

affected differently by the same disease; the patterns vary with age. Several factors to explain the gender differences in health and their interactions have been used, including concepts such as health and illness, living situation, health behaviour, health-reporting behaviour, utilization of healthcare services, and experiences with the health care system.^{3,4}

Gender differences in health care

Studies have shown that gender differences exist in the utilization of healthcare services.^{3,5} Men use services for health promotion, prevention and outpatient healthcare less frequently than women. Hospitalization rates for women exceed those of men up to the age of 55, whereas men are hospitalized more frequently than women above the age of 55 years (EU-15).¹ However, a more detailed description of gender differences in health care for all EU-25 countries is not possible due to the fact that very little data are available that are broken down by gender.¹

The observed differences in utilization can only partly be explained through the existing biological and morbidity-related influences acting on users of health services. Other contributing factors are the perception and self-appraisal of symptoms and complaints by people, their willingness to undertake health promotion or prevention activities and people's different levels of willingness to seek medical treatment.

Access to health care: what role does gender play?

Analysing access to health care requires focused theoretical concepts and the definition of potential barriers to adequate health care services (see Overview). The extent to which a population has access to healthcare services depends on several factors such as the financial, organizational, social, and cultural structures of the health care system and/or society.⁶ Knowing that societies are structured and experienced differently for/by women and men introduces gender as an important perspective when analysing access to health care.

The health needs of women and men, as well as access to health care are directly influenced by the gender divisions and gender inequalities in society. One important goal is to examine gender equality within research by including gender as a horizontal perspective when investigating access to health care. This would allow us to identify if women and men have the same availability of health services and whether they face the same or different barriers to access.

However, the systematic integration of gender into health care access methodologies is currently lacking and only a few studies integrate gender perspectives. Most of these studies focus more on the individual level and investigate the utilization of health care rather than concentrate on the structural level of the health care system and gender-specific barriers to access. Notwithstanding this, existing theoretical frameworks can provide a basis for identifying some gender-related problems to accessing health care.^{7,8,9}

In general, gender-specific barriers to access in health care services can be analysed through investigating:

- The fragmentation of health care services, which creates differential levels of access, especially for women. For example, routine care for women is divided into specialist gynecological and GP services – provision of cancer therapy for gynecological malignomas are often split between gynecology and medical oncology.
- The structure of social health insurance schemes and regulations on coverage eligibility. The gender composition of the labour market leads to a gendered distribution of insured members (in their own right or as dependents), and this has a specific impact on the ability to access health care services, especially for women.
- Gender-specific risk factors for losing health insurance status (for example, losing coverage through homelessness or divorce).
- Barriers to accessing supplementary voluntary health insurance and diffi-

culties in making co-payments due to gender differences in income.

- Gender differences in personal mobility, type of job, and family-related duties increase difficulties for women as often their caring responsibilities can impinge on (adequate) length of hospital stay or have an impact on women's ability to utilize medical rehabilitation services.
- The specific needs of certain groups; for example, single parents, migrant women, homeless women, women with disabilities or women who have experienced violence have differing needs in accessing the supply of health care.
- Different perceptions of symptoms or health reports by female and male patients in the health care system may result from androcentrism in medicine and gender-role stereotyping by health care professionals. For example, female patients are more often at risk of being treated according to male norms; symptoms of myocardial infarction in women are more often not adequately diagnosed because they are labelled as 'atypical', which results in treatment delays and/or inadequate treatment).
- Interaction with other (cross-cutting) barriers to health care, such as barriers related to racism or social class.

Currently, gender-related access to health care and gender-specific barriers can only be partially described. On the one hand, the lack of theoretical frameworks identifying gender-specific approaches impedes necessary research. On the other hand, available data is often not differentiated by gender and as such impedes more detailed analysis.

Although gender differences in utilization of health care have been extensively described, these findings do not entirely answer the question of differential barriers of access to health care services. In future, more emphasis should be placed on examining the structural level and how specific health care systems generate (and potentially strengthen) gender disparities in accessing health care.

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Access to health care: Illegal immigrants and asylum seekers

Thomas Foubister and Markus Wörz

In principle, in the EU member states asylum seekers and refugees have formal access to health care, for they are legal residents. This may or may not be provided within the general public system. In Italy, for example, it is. But in Germany, asylum seekers and refugees are covered under a separate public scheme. Perhaps it should not matter how cover is provided but if it is provided through the general public system it can help to foster integration, whereas if provided through other schemes it might foster isolation or risk turning into a second-class service.

Illegal immigrants and failed asylum seekers, on the other hand, have formal access to emergency services and – usually – to treatment for named infectious diseases, but beyond this basic care there is wide variation within the EU in the cover that is formally provided. In Germany, for example, these groups have the same coverage as asylum seekers and refugees. Less extensively, in Italy the benefits covered after emergency and infectious disease treatment include treatment for drug addiction and family planning services. By contrast, in Belgium no coverage is offered beyond emergency care.

In practice, where cover is formally provided, illegal immigrants and asylum seekers may fail to seek out or access the care to which they are entitled. This may be for several reasons, including lack of information and the presence of language or cultural barriers. But there may be other country-specific factors at play too. Thus in Germany, illegal immigrants may fail to seek care to which they are entitled for fear of disclosing their status. In Austria, where some 4.5% of asylum

seekers remain without health care cover, the relevant factor may be the nature of administrative regulations relating to entitlement, which require asylum seekers to be assigned residence in a federal state before leaving the reception centre, and to remain there; otherwise their cover will be forfeited.¹ Where cover for care is not provided, or is provided but care is not accessed, health care services may be available through informal, charitable provision. Sometimes, where there is no entitlement, care may be provided via the public system in contravention of formal regulations. Across the EU member states, then, there is variation in the cover that is provided to these groups, in how the cover is provided, and in the experience of access to health care (accessibility of services sometimes bearing little relation to formal entitlement).²

England is typical of this complex situation. In England the entitlement rules applying to persons ordinarily resident apply equally to asylum seekers and refugees (including those appealing a negative decision on their application to remain, and those being held in detention by the immigration authorities) – although they forfeit eligibility if they do not apply to remain in the country within three days of arrival.^{3,4} Failed asylum seekers and illegal immigrants are covered for emergency care and 'immediately necessary' care, care relating to named infectious diseases (HIV not included), family planning services, and compulsory psychiatric treatment. In all other instances, they have to pay for their health care. Yet despite these regulations, GPs are able for the time being to use their discretion as to whether to accept illegal immigrants onto their National

Health Service (NHS) lists (an area where the Department of Health is considering tightening up the regulations), and despite a duty to impose charges, NHS hospitals have sometimes failed to adhere to this (although this is likely to be less the case since the duty to impose charges to failed asylum seekers became statutory in 2004).⁵

The Treaty of Amsterdam, which came into force in 1999, assigned competence for asylum and migration policy to the European Community. In 2003 Council Directive 2003/9/EC *Laying Down Minimum Standards For the Reception of Asylum Seekers* was passed. This directive contains provisions aimed at harmonizing conditions for asylum seekers in areas such as schooling, employment, and health care. Regarding health care, Article 15 states that applicants shall 'receive the necessary health care which shall include, at least, emergency care and essential treatment of illness', and that 'Member States shall provide necessary medical or other assistance to applicants who have special needs'. This Article allows for considerable leeway and variance in its implementation. Moreover, it fails to address the issue of access to health care for illegal immigrants and failed asylum seekers. Thus far then, beyond the basic provision of emergency care, there has been little harmonization among the EU member states of health policy towards asylum seekers and illegal immigrants.

Moreover, national policies to ensure that an adequate level of health care is made accessible to all these vulnerable groups are underdeveloped – as testified to by the work of NGOs such as Médecins Sans Frontières and Médecins du Monde, who are currently providing health care to asylum seekers and illegal immigrants in several EU member states.⁶ If the health care needs of these vulnerable groups are not met by the public health care systems of member states, effectively it will be left to NGOs such as MSF and other charitable organizations to provide services.

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Access to health care: Long-term care in England

Thomas Foubister

Long term care (LTC) for older people in England has features present in many of the other European Union LTC systems. These include shifting responsibility for LTC from the health sector to the social care sector; lack of clarity regarding who is responsible for what services; erosion of coverage (social care is generally more reliant on means-testing than health care); system complexity; and inequities that emerge as a result of these features.

Prior to the NHS and Community Care Act of 1990, LTC with a medical or nursing component was financed by the National Health Service (NHS). Other LTC was financed by central government and provided by local government authorities. Following this legislation, non-NHS LTC would be financed by local authorities on the basis of local taxation, a government transfer, and means-tested user charges. Depth of coverage was thus reduced – the user now being subject to means testing – unless the user had health care needs (when the care would be covered in full, including accommodation and personal care).

Another change followed in 2000 with

the introduction of a distinction between need for medical care and need for nursing care. Now only LTC with a medical component would be covered in full through the NHS (known as 'NHS Continuing Care'). LTC with a nursing component but without a medical component would be located within the social care provision administered by local authorities. 2003 saw a partial reversal of this policy, following a 2001 Court of Appeal ruling that nursing care provided in a LTC context was eligible for NHS reimbursement. The NHS has extended coverage to nursing care once again, but has not reintroduced coverage for other components of LTC when nursing care, but not medical care, is present.

Before LTC is delivered, users are assessed to determine the required care 'package' and the depth of coverage for which they are eligible. They are assessed by the local authority and by the local NHS Primary Care Trust. The assessment process will first determine whether the user is eligible for NHS Continuing Care. One of four criteria has to be met for NHS coverage to be provided: the



complexity of the user's health needs requires regular supervision by a member of an NHS team; the user requires the supervised, routine use of specialist equipment; the user's health condition is rapidly deteriorating and requires regular supervision; or the user is in the final stages of a terminal illness. Users not deemed eligible for NHS Continuing Care are assessed for nursing care requirements, to be funded by the NHS. There are three bands of nursing care, each with a different level of reimbursement. All other LTC requirements are funded by the local authority on a means-tested basis, which takes account of not only income but of assets such as the user's home.

The use of means-testing for LTC has been subject to criticism on grounds of equity, as has the variation in the level of charges imposed by different local authorities for the same care.¹ A further strand of criticism focuses on the problems that arise from how eligibility for NHS Continuing Care is determined. Both the NHS Ombudsman² (the NHS complaints body) and House of Commons Health Select Committee³ have been vocal in their criticism of current arrangements from the equity of access perspective. They highlight the following key problems.

1. Central guidelines for eligibility for NHS Continuing Care are guidelines only, and are interpreted and applied differently in different places, 'leading to hardship and injustice for some' (Ombudsman).
2. The current criteria 'take insufficient account of mental health needs' (Health Committee).
3. The criteria for high band nursing are worded similarly to those for NHS Continuing Care, leading to some arbitrariness in the provision of full coverage (Health Committee).
4. Criteria are applied differently in different cases within the same areas and the quality of patient assessment varies (Health Committee).
- 5 Evidence has shown that some individ-

uals are not offered an assessment for NHS Continuing Care when such is their right; these have had to discover by other means their right to such an assessment (Health Committee).

The Department of Health has drafted new proposals for determining eligibility for NHS Continuing Care so as to bring nationwide uniformity to the process. These new criteria are to be put out to consultation, but the draft criteria leaked to *The Guardian* is reported by this newspaper to reflect a 'harsher assessment regime [which] would force many more families to rely on local authority supplied social care'.⁴ If the new criteria do bring uniformity to the process of determining eligibility for full coverage for LTC, this would be a positive step from the equity perspective; however, making NHS Continuing Care more difficult to access reflects yet a further shift of LTC responsibilities from the health sector to the social care sector and a further erosion of coverage offered in the area of LTC.

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