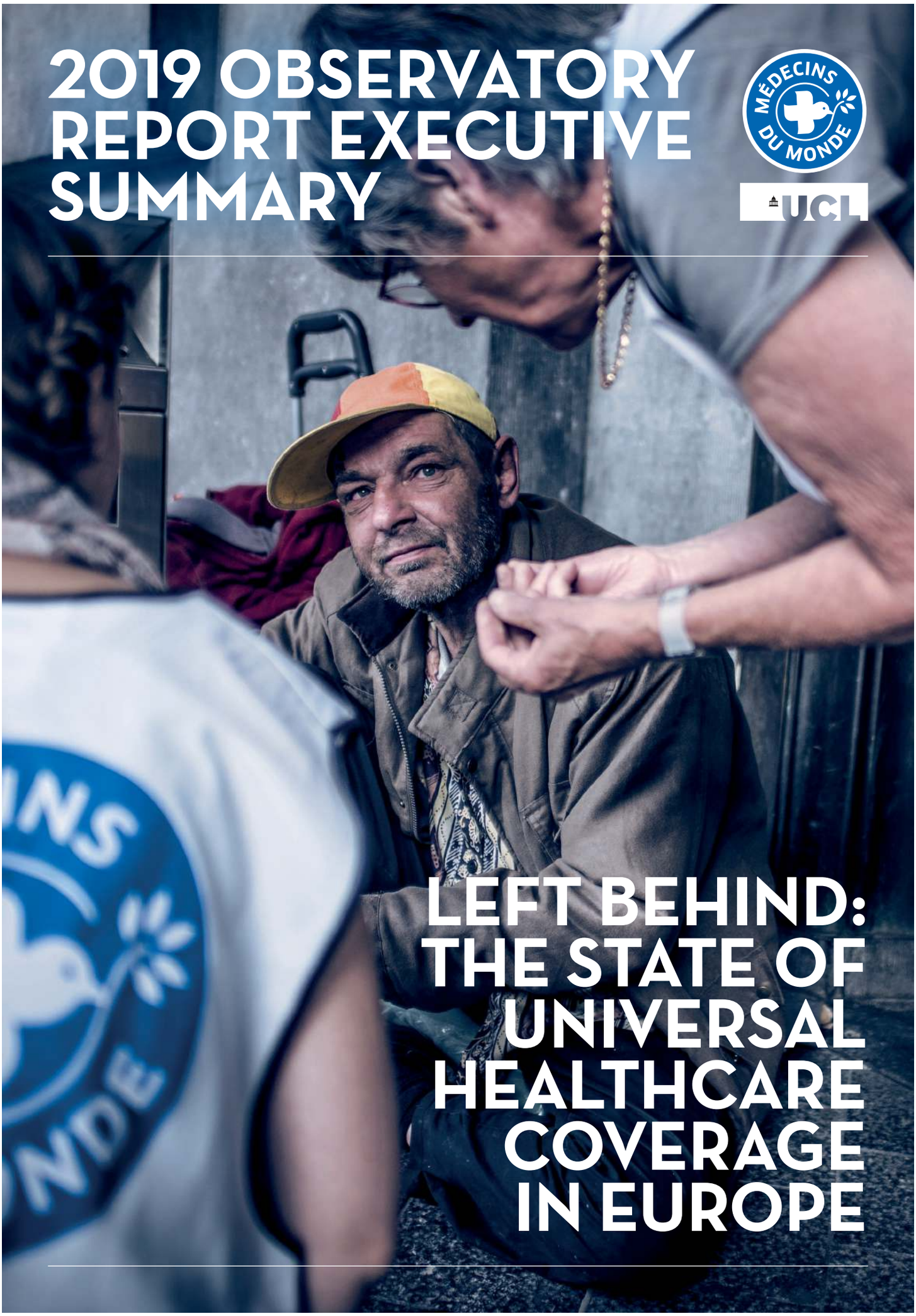
2019 OBSERVATORY REPORT EXECUTIVE SUMMARY



LEFT BEHIND: THE STATE OF UNIVERSAL HEALTHCARE COVERAGE IN EUROPE

EXECUTIVE SUMMARY

This 2019 Observatory Report presents a unique insight into the state of Universal Healthcare Coverage (UHC) in Europe and highlights those who are left behind in European health systems. The report gathers data and testimonies collected from 29,359 people attending Médecins du Monde/Doctors of the World (MdM) programmes in seven countries in Europe (Belgium, France, Germany, Luxembourg, Sweden, Switzerland, and United Kingdom) between January 2017 and December 2018.

The overwhelming majority of the people that MdM saw did not have healthcare coverage. This report hence, provides evidence that the member states of the European Union (EU) are not meeting United Nations (UN) and the World Health Organization (WHO) standards on UHC, nor respecting the human rights frameworks that protect UHC. This report shows that those excluded from European health systems include the most vulnerable and marginalised individuals – children, including very young children and unaccompanied children; pregnant women; homeless people without any shelter; people without permission or right to reside; and the elderly – suggesting the 2030 Agenda for Sustainable Development pledge to "leave no one behind" is not being upheld in Europe.[1]

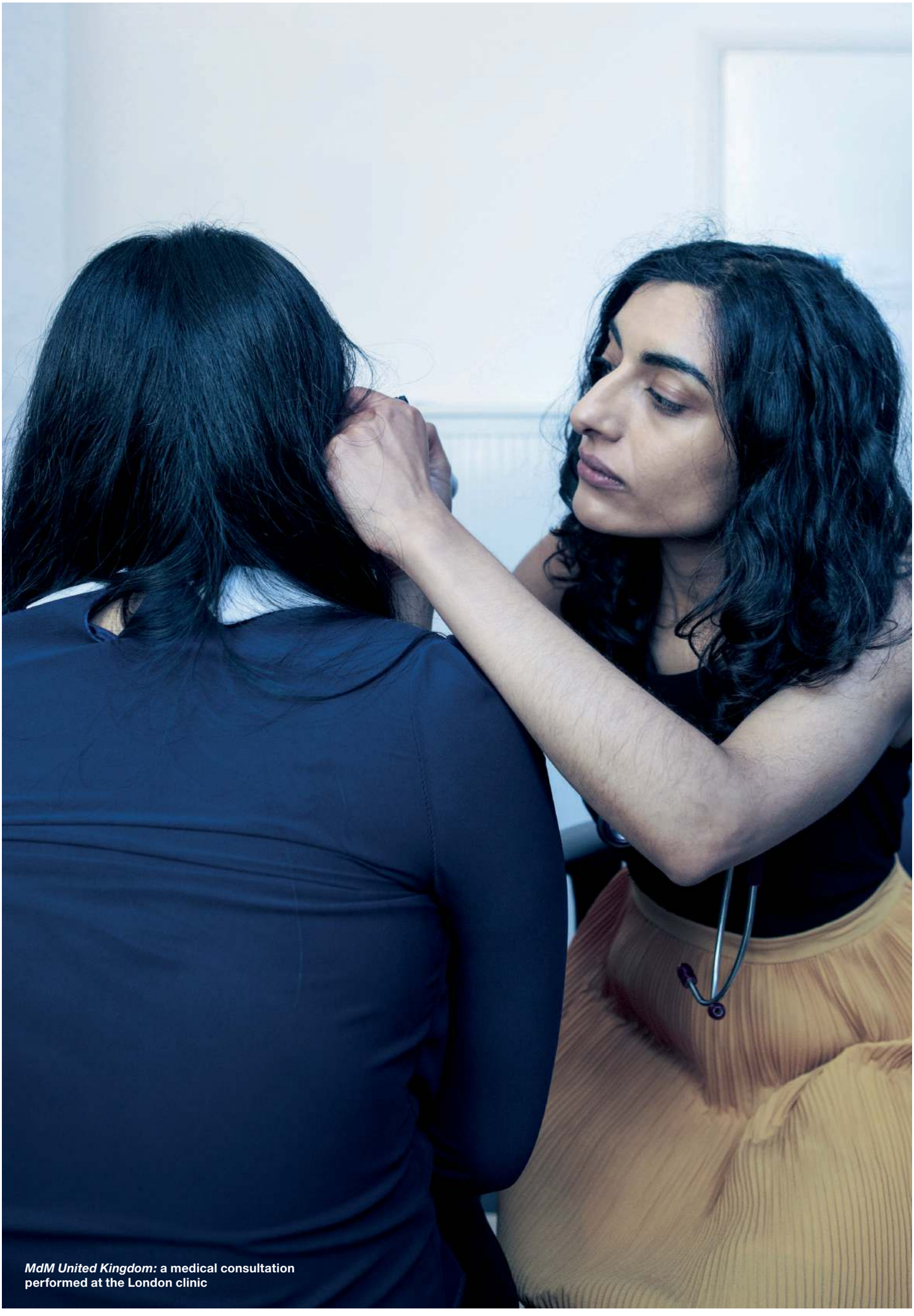
In 2017, the EU took an important step to strengthen the social rights of its citizens through the proclamation of the Social Pillar, which calls on member states to protect the rights of its citizens and measures compliance through a Scoreboard. Article 16 states: "Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality".[2] Nevertheless, this report shows that not only is the EU far from the fulfilment of this right, it also demonstrates that the EU does not have an adequate instrument for measuring the magnitude of the problem. One-fifth of the people we saw were living in a personal flat or house, meaning that the majority fall outside this category and experience different forms of homelessness. MdM also saw children under the age of 16 unable to access healthcare services. Both groups (people experiencing homelessness and children under 16) are excluded in the Social Scoreboard indicator measuring level of compliance with Article 16. For the development of health policies to be effective it is vital to include the most vulnerable groups in health reporting.

This report aims to give a voice to people not included in national statistics. As MdM sees individuals that do not have access to national healthcare systems the report offers insight into the extent of UHC even in countries that have officially achieved universal access.[3] The people seen were often in desperate need of healthcare but unable, for various reasons, to access mainstream services, and respondents frequently reported both poor physical and mental health. A majority of pregnant women had not been able to access antenatal care and many people suffered from chronic disease, some with acute symptoms. Many of the children seen had not received the recommended levels of vaccination.

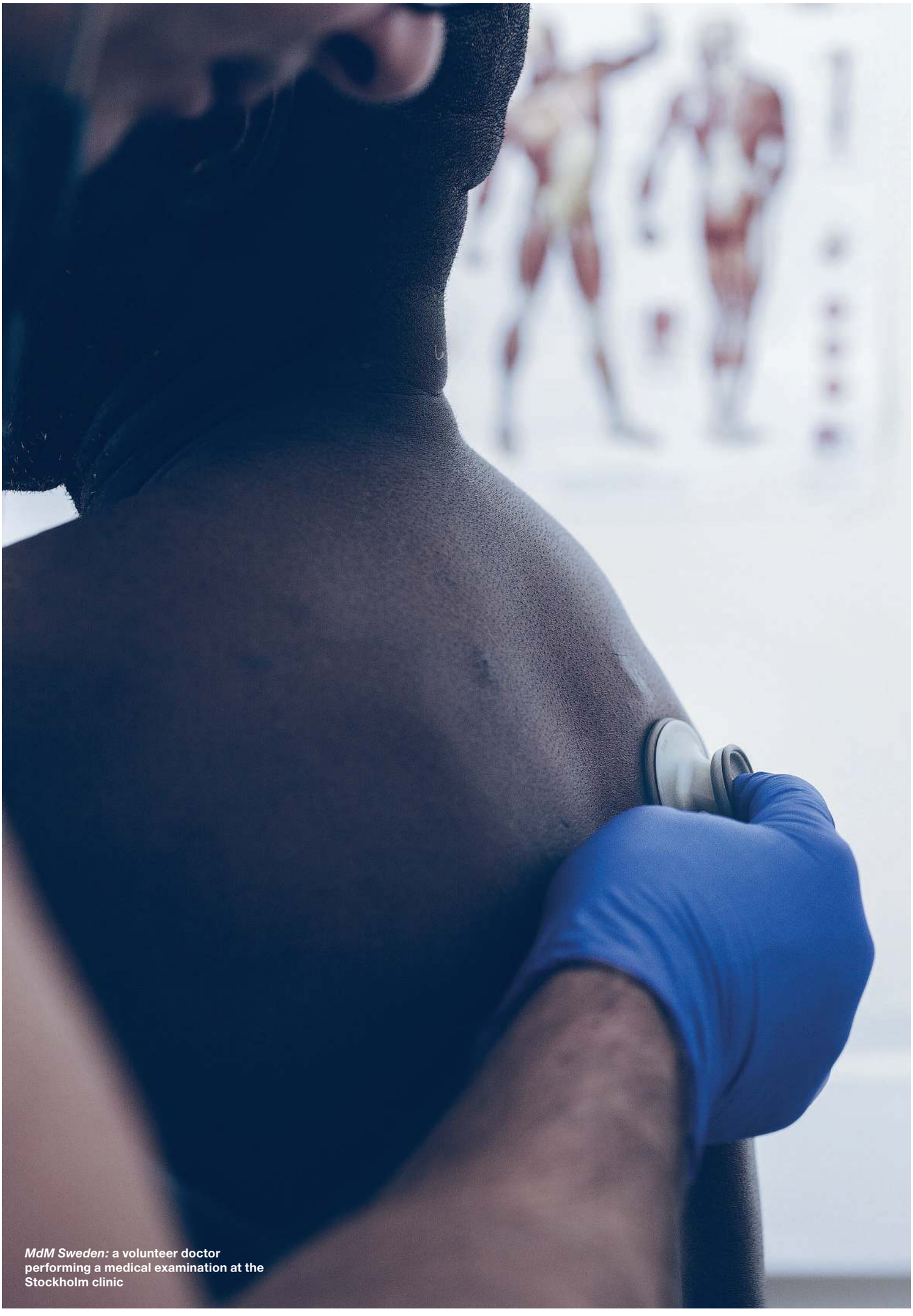
In light of our findings, it is imperative that in order to reach the commitments of the Social Pillar and the UN proclamation of UHC – to first reach those who are furthest behind – European governments and EU institutions need to:

1. improve the accessibility of regular healthcare systems to include full entitlements to health for people in vulnerable situations such as homelessness, migration, and poverty, especially for children;
2. improve methods to identify barriers to health for the most vulnerable by including them in data collection; and
3. implement a rights-based approach as it is the only way we can make sure that no one is indeed left behind.

1. World Health Organization. (2019). *"Universal Health Coverage:."* 2030 Agenda for SDGs. Retrieved 30 September 2019, from , https://www.who.int/health-topics/universal-health-coverage#tab=tab_3
2. The European Commission. (2019). *The European Pillar of Social Rights in 20 principles.* Retrieved 2 August 2019, from https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.
3. World Health Organization and International Bank for Reconstruction and Development/The World Bank 2017. (2017). *Tracking universal health coverage:* 2017 global monitoring report. Geneva: World Health Organization and International Bank for Reconstruction and Development/The World Bank 2017. Licence: CC BY-NC-SA 3.0 IGO.



MdM United Kingdom: **a medical consultation performed at the London clinic**



MdM Sweden: **a volunteer doctor performing a medical examination at the Stockholm clinic**

2017/2018 IN FIGURES

WHO WE SAW:

- 29,359 people attended MdM programmes in seven countries in Europe (Belgium, France, Germany, Luxembourg, Sweden, Switzerland, and United Kingdom) between January 2017 and December 2018. In these countries, MdM conducted a total of 71,094 consultations, comprised of 42,178 medical consultations and 28,916 social consultations.
- 7.5% of the people seen were children (under 18 years) (1,616/21,415), 1.5% were children under 5 years (330/21,415), and 1.7% were adults 70 years and over (356/21,415).
- 81.6% of all individuals seen at MdM country clinics were non-EU/EEA migrants (18,064/22,136), 15.9% were EU/EEA migrants (3,527/22,136), and 2.5% were nationals (545/22,136).
- The highest proportion of people seen came from Côte d'Ivoire at 10.6% (2,345/22,136) followed by Morocco at 6.2% (1,371/22,136), and Bulgaria at 5.8% (1,287/22,136). A total of 175 different nationalities were recorded across the programmes.

DETERMINANTS OF HEALTH AND HEALTHCARE ACCESS:

- 81.7% of people seen reported having no healthcare coverage (14,848/18,164), and only 9.7% of non-EU/EEA migrants (1,418/14,594) and 9.3% of EU/EEA migrants had either full or partial healthcare coverage (286/3,082).
- 92.6% of the people seen were living below the poverty threshold in the country they presented in (7,660/8,268).
- 43.3% – the highest proportion of individuals – lived with family or friends (8,785/20,285). 35.1% were living in other precarious circumstances (7,130/20,285) including: 20.4% who were recorded as street homeless or living in emergency centres (4,141/20,285); 7.3% living in a charity, organisation or hotel (1,483/20,285); 6.4% living in squats (1,292/20,285); 0.7% living at a place of work (134/20,285) ; and 0.4% living in camps or slums (80/20,285). 21.5% of individuals lived in a personal flat or house (4,370/20,285).
- 37.1% of people seen, felt that they could frequently rely on someone in their current town to help support and comfort them, if needed (2,236/6,024). Nevertheless, 44.0% reported that they only sometimes or never had someone to rely on for support (2,648/6,024).
- When asked about barriers to accessing healthcare, 20.8% of responses reported "economic barriers" (3,960/19,020) and 14.3% reported "lack of knowledge of health system/entitlements" (2,718/19,020).

HOMELESSNESS AND HEALTH:

- Only 21.4% of people seen, lived in a personal flat or house (4,308/20,097), 6.5% reported inadequate housing (1,311/20,097), 44.3% reported insecure housing (8,895/20,097), 7.3% reported houselessness (1,476/20,097), and 20.4% reported rooflessness and were therefore living on the streets or in an emergency shelter (4,107/20,097).
- Nationals and EU/EEA migrants had the highest proportion of roofless individuals at 30.3% (154/509) and 29.4% (968/3,287) respectively.
- 30.1% of individuals aged 15-19 (280/930) and 25.2% of individuals aged 20-24 were living on the streets or in emergency shelters and were therefore roofless (490/1,942).
- People that were roofless had lower physical (39.0%; 414/1,061 "bad" or "very bad") and psychological (40.7%; 430/1,056 "bad" or "very bad") self-perceived health status compared to people that reported living in a personal flat or house (22.5%, 760/3,375 "bad" or "very bad" physical health status and 19.2%, 637/3,317 "bad" or "very bad" psychological health status).

HEALTH CONDITIONS AND STATUS:

- The most common pathologies were musculoskeletal (13.8%; 5,476/39,751), respiratory (12.6%; 4,991/39,751), and digestive (12.4%; 4,946/39,751).
- The highest proportion of chronic pathologies were circulatory (17.1%; 2,642/15,495) followed by musculoskeletal (14.2%; 2,202/15,495), endocrine, metabolic, and nutritional (13.8%; 2,127/15,459), digestive (11.7%; 1,818/15,495), and psychological (9.6%; 1,495/15,495).
- The highest proportion of acute pathologies were respiratory (21.2%; 2,518/11,857), followed by musculoskeletal (15.5%; 1,841/11,857), digestive (14.7%; 1,747/11,857), and skin (13.4%; 1,588/11,857).
- The majority of pregnant women had not accessed antenatal care for this pregnancy prior to visiting the MdM programmes (66.9%; 230/344). Notably, 32.3% had not accessed antenatal care and were in their second or third trimester of pregnancy (111/344).
- Nationals reported higher proportions of "bad" or "very bad" self-perceived psychological health (43.5%; 128/294) compared to non-EU/EEA migrants (23.7%; 1,408/5,949) and EU/EEA migrants (28.5%; 505/1,769).

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RECOMMENDATIONS

***"Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality"*[4] (Article 16, European Pillar of Social Rights)**

European governments and the EU have committed[5] to ensuring UHC and leaving no one behind. Our data shows the gaps that need to be bridged in order to reach those furthest behind in UHC. The following recommendations for political action can be drawn from the analysis:

ENSURE THAT MONITORING INSTRUMENTS PROVIDE RELEVANT INFORMATION ON EXCLUSION FROM HEALTHCARE

Unmet need for healthcare has been recognised as an important aspect of social protection by EU member states and is thus, included in the Social Scoreboard monitoring EU member states' performance in relation to the European Pillar of Social Rights. However, the population base for the indicator "self-reported unmet need for medical care", drawn from the EU Statistics on Income and Living Conditions (EU-SILC) is defined as "people living in private households above 16 years of age". The data from this 2019 Observatory Report indicates that 78.4% of our participants do not live in private households and 4.4% are under 16 years. The unmet healthcare needs described in this report are thus not represented in the official reporting. People living in communal housing or institutional care, undocumented people, homeless, or children under 16 years are left out. To create a valid evidence base for policymaking, we recommend the following:

To the EU Commission:

1. Ensure that the EU-SILC and other monitoring instruments of the EU Social Pillar include information on people living in communal housing or institutional care, undocumented people, homeless, and children under 16 years.
2. Provide systematic and continuous information on the results of the monitoring and additional analyses within all tools of the European Semester cycle.
3. Based on these results, the EU Social Protection Committee should systematically and explicitly advise the member states and the EU Commission with country-specific policy recommendations targeting inequalities and exclusions in health.

To the EU member states:

4. Governments should agree, support, and adapt nationally any initiative from the EU Commission aimed at improving the EU Social Pillar and its Social Scoreboard to implement new surveillance indicators of the Joint Assessment Framework (JAF) and particularly the EU-SILC.
5. The EU member states should actively develop and employ additional methods, such as participatory qualitative research to include currently excluded groups in health reporting. Specifically, government officials need to meaningfully include service providers, civil society organisations as well as affected communities, into the development of methods and data analysis for country assessments.

ENSURE THAT THE RIGHT TO HEALTHCARE IS NOT UNDERMINED

Barriers in accessing healthcare reported by our service users clearly show that member states' governments' policies can be a hindrance to the fulfilment of everyone's right to health. For example, undocumented migrants, or non-EU/EEA migrants without a right or permission to reside, (55.4% of our participants) do not have access to healthcare in some countries because their data is shared with immigration authorities when they seek medical care (Germany and the United Kingdom) or coverage of costs. They thus avoid accessing healthcare due to fear of expulsion. In most countries, EU/EEA migrants (16.2% of our participants) lack access to healthcare if they are unemployed or not insured in their country of origin. Some groups are only entitled to restricted healthcare services, such as asylum seekers (8.8 % of our participants) in Belgium, Germany, Luxembourg, and Sweden. Preventive care and management of chronic disease, which are both often excluded from entitlements, are integral parts of UHC. Limiting the service package to acute or emergency care is against the right to health and has shown to be more costly.[6]

To the EU Commission:

6. The EU needs to translate Article 16 of the European Pillar of Social Rights, "everyone has the right to timely access to affordable, preventive and curative health care of good quality"[7] into concrete and ambitious policy work. The EU Commission should communicate a roadmap leading the member states to long-term efforts to achieve the principles in the pillar.
7. The Fundamental Rights Agency should systematically report to EU member states on breaches of the right to health and discrimination against people who have been denied access to healthcare. Those reports should also be included in the semester reporting cycle.

To the EU member states:

8. Governments should reaffirm and fulfil the right of every human being within their jurisdiction, without distinction of any kind, to the enjoyment of the highest attainable standard of health. This includes a comprehensive people-centred approach, with a view to leave no one behind. To do this and fulfil their obligation under the Agenda 2030 they should without delay ensure full entitlements to promotive, preventive, curative, rehabilitative, and palliative health services for everyone living in the country, regardless of immigration status. EU member states should take special care to ensure equitable access to sexual and reproductive health and rights, children's right to health and endeavour to reach the furthest behind first, including refugees and migrants, both EU/EEA citizens and those of other nationalities.

4. The European Commission. (2019). *The European Pillar of Social Rights in 20 principles.* Retrieved 2 August 2019, from https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.

5. United Nations. (2019). *Political Declaration of the High-Level Meeting on Universal Health Coverage, "Universal health coverage: moving together to build a healthier world".* New York, NY: United Nations. Retrieved 7 October 2019, from https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf

6. Bozorgmehr K. & Razum, O. (2015). Effect of restricting access to health care on health expenditures among asylum-seekers and refugees: a quasi-experimental study in Germany, 1994–2013. *PLoS ONE, 10*(7), e0131483. Retrieved 3 October 2019, from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0131483.

9. EU member states should implement laws and practices to ensure "firewalls" between those working in the provision of social services and healthcare on the one hand and the immigration authorities on the other so that undocumented migrants can access healthcare services without fear.

MAKE HEALTHCARE SYSTEMS MORE ACCESSIBLE

In addition to the legal framework, our data also shows that barriers within the regular healthcare system need to be addressed in order to allow wider access. An important pillar in the provision of care is to ensure that it is available, accessible, acceptable, and of high quality (the UN availability, accessibility, acceptability, and quality criteria).[8] However, the data shows a multitude of barriers affecting a person's ability to access healthcare:

- Language: In more than 35.8% of social consultations at MdM sites, an interpreter was used (5,994/16,760).
- Lack of information: our data shows that a lack of understanding of the healthcare system is a major barrier in accessing the services that are needed (14.3%; 2,718/19,020).
- Cost: our data shows that economic barriers, such as cost of consultation, cost of treatment, and cost of insurance are perceived as serious barriers for people to access healthcare (20.8%; 3,960/19,020).

To the EU Commission:

10. Make sure that financial instruments such as the European Social Fund Plus (ESF+) are available to fund initiatives and programmes responding to the healthcare needs of those who have been excluded from healthcare. Funds must be made available in the new Multiannual Financial Framework of the EU to encourage innovative low threshold accessibility healthcare services throughout Europe.

To the EU member states:

11. Reduce administrative barriers to the healthcare system often experienced by people in vulnerable situations, such as homelessness or migration.
12. National healthcare systems need to provide comprehensible and targeted information on services and entitlements, eg for migrants and homeless people.
13. National healthcare systems need to ensure sufficient availability and financing of translation services necessary for adequate communication between patients and healthcare professionals, also using technological support systems.
14. National healthcare systems should issue clear guidelines and training for healthcare professionals for non-discriminatory healthcare provision, including on specific vulnerabilities, healthcare needs, and existing referral services.
15 Low threshold health services and support structures for people in vulnerable situations, such as homelessness and in migration should be set up and securely funded. Mobile clinics and outreach of healthcare professionals have proven effective to target the most excluded and to recover trust in the healthcare system. Coordination between social services and healthcare providers needs to be improved in order to provide effective follow-up treatments and housing, especially for homeless people suffering from chronic illness, drug users, mental health patients, and discharged hospital patients.

CREATE HEALTHIER LIVING CONDITIONS

The conditions under which people are born, grow, live, work, and age determine their health more than their ability to access healthcare. A health in all policies approach is thus urgently needed, in which the health consequences of policies in all sectors are systematically considered.

With its focus theme "housing", this report clearly shows that people that were roofless have a lower self-perceived physical health status (38.1%; 404/1,061) than people living in a personal flat or house and are at the same time more likely to experience barriers in accessing healthcare. Measures for affordable housing and improved conditions in shelters are thus important for improving health outcomes and reducing health inequities.

To the EU Commission:

16. Innovative solution towards integrated and coordinated social and healthcare services that take into account the specific needs of homeless people should be supported, funded, and disseminated through various financial instruments, especially the ESF+. In order to be effective, the initiatives should be low threshold, flexible, needs-based, dignified, and organised in a people-centric way (outreach and drop-in rather than appointment-based).

To the EU member states:

17. National governments in close cooperation with affected communities and civil society should ensure that there is a legal base for the right to housing, improve data on housing conditions, implement preventive measures against homelessness, and provide sufficient and adequate shelters.

7. The European Commission. (2019). *The European Pillar of Social Rights in 20 principles.* Retrieved 2 August 2019, from https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.

8. United Nations. (2000). *CESCR General Comment No. 14: the right to the highest attainable standard of health (Art.12).* Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000. Geneva: Office of the High Commissioner for Human Rights. Retrieved 15 October 2019, from https://www.refworld.org/pdfid/4538838d0.pdf.