

# THE ROLE OF THE HEALTH CARE SECTOR IN TACKLING POVERTY AND SOCIAL EXCLUSION IN EUROPE

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# PREFACE

## European Health Management Association

EHMA is a Dublin-based, European membership organisation focusing on managerial issues and on management development in the health sector. It is unique in fostering activities between health service organisations and institutions in the field of healthcare management education and training. EHMA is committed to improving healthcare in Europe by raising standards of managerial performance. EHMA is a forum for:

- Policy makers and senior managers who need to network and share information and intelligence in a rapidly changing health sector.
- Personnel directors and training managers who need a market place and a learning forum where managers express the developmental needs of their organisations, and trainers develop new products to meet these needs.
- Academic institutions and research organisations who can exchange experience and learning amongst their peers across Europe

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EuroHealthNet is a not-for-profit organisation, established under Belgian Law, linking national and regional agencies across Europe with responsibilities for health promotion, disease prevention and public health policies. Its mission is to contribute to a healthier Europe with greater equity in health between and within European countries.

Member agencies prioritise work on addressing health and social inequalities, building the evidence base for health promotion interventions, advocacy for integrated health policy approaches and liaison with other networks, organisations and EU institutions concerning public health issues.

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## EXECUTIVE SUMMARY

This report is an outcome of the *Health and Social Inclusion* project carried out within the framework of the European Community Action Programme to Combat Social Exclusion. It is concerned with the contribution of health care sector to tackling poverty and social exclusion. The results are based on a literature review of highlighting issues with regard to equity of access, affordability and responsiveness. An analysis of five second round National Action Plans and the 2nd Joint Report on Social Inclusion provides insight into whether EU Member States actually accommodate for the health care sector's contribution in their national social inclusion policies and programmes.

The EU common objectives directly appeal to the health care sector's role objectives in the fight against poverty and social exclusion as they call explicitly for safeguarding equal access to quality services and improving the delivery of services. However, the health sector's contribution can reach much further and more 'upstream'. Building on earlier work carried out in the first phase of the project on the cyclical relation between poor health, poverty and social exclusion, the literature overwhelmingly supports the notion that the health care sector can impact on all six bipolar relations of this triangle.

Of the many barriers that may hinder health service access and service affordability, some disproportionately affect people from lower social-economic groups. Horizontal and vertical inequity are a persistent feature across EU health systems: individuals in equal need are not always treated equally and the relative financial burden of health systems finance is not always fairly distributed. This may have serious consequences for overall health. There are a range of policy options to eliminate financial barriers to health care access and alleviate the negative effects of regressive forms of health care funding on poverty and social exclusion.

Responsiveness of health care services to specific groups at particular risk of poverty and/or social exclusion is lacking in many respects. Yet it is encouraging to see that many efforts are being made to improve quality and responsiveness, as well as service access for these groups. Their situation clarifies the strong impact of interlinking social policies. Mutually reinforcing national and EU policy measures in areas such as employment, welfare, health care and social inclusion can take people out of the downward spiral of poverty, social exclusion and ill health. However, the opposite may also happen. Such situations are still prevalent and have a detrimental effect on the health and social inclusion of the people concerned.

While it can be concluded that the health sector can contribute significantly to achieving objectives aimed at reducing poverty and social exclusion, the sector may not always be aware of its contribution. Similarly, those involved in setting and implementing the social policy agenda may not always identify the health care sector as an important ally or even as an 'instrument' to achieve their policy objectives. This is reflected in the fairly limited role of the health care sector in the National Action Plans reviewed.

In discussing health care access, commonplace references to citizens' legal entitlements to health care on equal terms were not elaborated upon further though analysis of actual challenges with regard to access. Some countries did mention waiting list issues, but other questions regarding access to mainstream services often remain uncovered. None of the NAPs paid adequate attention to affordability of health care, or the effects of health care costs on access to services, poverty and social exclusion. Even though Member States have been explicitly asked to acknowledge the special difficulties facing immigrants, the NAPs under review hardly seemed to take the health needs of

immigrants or ethnic minorities into account. When NAPs did address to the needs of groups at risk of social exclusion it was often terms of delivering targeted forms of social services, such as shelters for homeless people or services for drug users. With the exception of the Irish NAP, no attention was paid to the quality of health services.

The following recommendations can be put forward with regard to EU-wide efforts to combat poverty and social exclusion:

- future NAPs should explore health care as a more significant component in their plans to alleviate poverty and social exclusion;
- like other key stakeholders, the health care sector should be included in developing and implementing NAPs;
- NAPs should provide information on horizontal and vertical equity of access to health services;
- NAPs should include an analysis of specific health needs of disadvantaged groups and communities, as they should include measures on how these needs will be met through mainstream services as well as specific services;
- NAPs should include an impact assessment of health system finance on poverty and social exclusion;
- NAPs should support measures that counteract negative consequences of health systems finance for people living in poverty and for groups that are disproportionately affected by ill health.

# INTRODUCTION

## The Health and Social Inclusion project

Within the context of the European Community Action Programme to Combat Social Exclusion, EuroHealthNet carried out a literature review to investigate how the field of public health and health promotion can contribute to efforts reducing poverty and social exclusion<sup>1</sup>. This review was a key element in Phase I (December 2002 – August 2003) of their project entitled *Tackling Health inequalities and Social Exclusion: a European perspective*, which also included a 'health audit' of first round National Action Plans (NAPs) 2001 – 2003.

The review provided insight in how health, poverty and social exclusion are interrelated. Socio-economic health determinants, social capital, and inequalities in health were central issues, as was the contribution from the public health and health promotion sector. In addition, the review explored how ill-health can intensify the isolation and vulnerability of specific groups, such as older people, people with disabilities or people with chronic illness.

Phase II of the project, Health and Social Inclusion (December 2003 – December 2005) builds on the outcomes of this analysis with regard to the correlation between health inequalities, poverty and social exclusion in Europe, and is particularly concerned with the contribution that health related policies, programmes and interventions can make to tackling social exclusion. Co-ordinated by EuroHealthNet on behalf of NHS Health Scotland, Phase II allows for cross-national exchange of good practices, more in-depth analysis, and a strong eye for opportunities to work across sectors. As a partner in Phase II, the European Health Management Association (EHMA) was asked to provide a perspective from the health care sector.

EHMA's particular role in the Health and Social Inclusion project is threefold:

- to review publications that highlight the health care sector's contribution (policies, programmes, interventions, services) to the fight against poverty and social exclusion. This review was to include a focus on equity in access to health services;
- to provide a 'health care audit' of a selected number of second round National Action Plans (2003-2005) and the Joint Reports on Social Inclusion; and
- to identify good practices of health care sector contributions.

## EHMA and its experience with the EU social policy agenda

EHMA is a not-for-profit organisation with 230 member organisations in 27 European countries. EHMA seeks to improve health through better management by acting as a bridge-building organisation - creating links between countries; between academia and practising managers; between managers, doctors and nurses; and between specialist managerial areas. It focuses on all aspects of healthcare management. EHMA also plays a significant part in the development of EU health policy, for instance as a member of the High Level Process of Reflection.

Involvement in the Health and Social Inclusion project is not EHMA's first involvement with the EU's social policy priorities. Other recent examples are:

- *Managing Diversity in Health and Social Services*: an examination of anti-discrimination best practices within and by health and social care organisations, focusing on ethnic minorities, disabled people, and older people. The project has been led by the European Social Network - a network of Directors of Social Services - with EHMA as the second partner.

<sup>1</sup> Stegeman I and Costongs C. Health, Poverty and Social Inclusion in Europe: literature review on concepts, relations and solutions. Brussels, EuroHealthNet, September 2003.

- CARMEN: the Care and Management of Services for Older People in Europe Network, providing a multi-stakeholder perspective and a range of good practices on managing integration of social and health services for older people.
- HealthAccess, which is an exploration of barriers to citizens' access healthcare in selected Member States, and of the implications for cross-border healthcare.

### Outline of this report

This report presents EHMA's findings with regard to two questions: what information does existing literature provide about the health care sector's contribution to the fight against poverty and social exclusion, and how have EU Member States accommodated for this contribution in their National Action Plans? The good practices EHMA identified through its membership are incorporated in EuroHealthNet's general overview of project outcomes and will be published separately.

Acknowledging the previous work carried out by EuroHealthNet, this report complements Stegeman and Costongs' review carried out in Phase I of the project, and builds on its concepts and definitions. It does have a strong focus on equity in access to health services, but also looks at how the health care sector can play a more 'upstream' role in the fight against poverty and social exclusion.

The report consists of four parts. Part I sketches the context of the review. It describes the key elements of the EU strategy against poverty and social exclusion as the main frame of reference. This is followed by a brief summary of the Council of Europe's suggestions with regard to access to health services, particularly for people in marginal situations. Part I then concludes with an attempt to 'translate' these intergovernmental policy suggestions into implica-

tions for the health care sector's role in breaking the cyclical relation between ill health, poverty and social exclusion as described by Stegeman and Costongs.

Part II looks at access to mainstream health services, trying to find out what barriers may affect equal access and whether some of these barriers may be of particular importance to people at risk of poverty and/or social exclusion. Are individuals in equal need indeed treated equally within health systems that can also be considered fair in financial terms?

After discussing access and affordability in Part II, Part III zooms in the responsiveness of health care services. What do we know about the specific needs of people at risk of poverty and social exclusion when it comes to access and responsiveness of health care services? Are there ways of addressing these needs in an appropriate manner through either mainstream or specific services? Given the limitations of this review, the focus will be on the needs of a select number of groups the European Commission has mentioned as being at particular risk of poverty and/or social exclusion: minority ethnic communities, Roma and travellers, women, older people, and people with mental health needs.

Part IV reports on how second round National Action Plans (2003-2005) from Ireland, Spain, Sweden, Poland and the Netherlands have accommodated for the health sector's contribution. More particularly, it provides insight in the extent to which each of these plans address accessibility, affordability, responsiveness and quality of health care services and incorporate measures to improve these issues. It also includes a reflective section on the Commission and the Council's 2nd Joint Report on Social Exclusion.

# PART I

## PART I.

# EUROPEAN OBJECTIVES IN TACKLING POVERTY AND SOCIAL EXCLUSION: POTENTIAL FOR THE HEALTH SECTOR'S ROLE

### 1.1 EU policy objectives

The European social policy agenda and particularly its strategy to fight poverty and social exclusion provide the framework for this report. Consequently, the objectives of this strategy are the starting point of this review, as are its definitions of poverty and social exclusion<sup>3,4,5</sup>.

#### Four common objectives for EU Member States

Based on article 136 and 137 of the Amsterdam Treaty and the decision of the European Council of Lisbon (March 2000) to take steps towards the eradication of poverty, in December 2000 the Nice European Council adopted four common objectives in the fight against social exclusion and poverty:

- to facilitate participation in employment and access by all to the resources, rights, goods, and services. Within the scope of this objective, Member States are urged to put into place policies which aim to provide access for all to healthcare appropriate to their situation, including situations of dependency;
- to prevent the risks of exclusion;
- to help the most vulnerable;
- to mobilise all relevant bodies.

These objectives were to guide not only a European Commission programme to encourage co-operation in the field of poverty and social exclusion, but also the individual Member States in drawing up their National Action Plans in this area through the 'open method of co-ordination'. This is a structured form of collaboration, where EU Member States work towards achieving common objectives with regard to jointly identified challenges while respecting the principle of subsidiarity.

#### The link with health and health care

To allow Member States and the Council to monitor progress towards the four objectives, the European Commission's Social Protection Committee agreed on a list of 10 primary indicators of social exclusion. Two of these are directly related to health: life expectancy at birth, and self perceived health status.

Meanwhile, in their first joint report on Social Inclusion (agreed at Laeken, December 2001), the European Council and European Commission confirmed the widespread understanding that poor health is both a cause and a consequence of wider socio-economic difficulties<sup>6</sup>. Breaking the cycle of poverty was identified as one of the key concerns and Member States were strongly advised to mobilise all relevant stakeholders and link different policy systems.

<sup>3</sup> As defined in the Charter of the Fundamental Rights of the European Union

<sup>4</sup> People are said to be living in poverty if their income and resources are so inadequate as to preclude them from having a standard of living considered acceptable in the society in which they live. Because of their poverty they may experience multiple disadvantage through unemployment, low income, poor housing, inadequate health care and barriers to lifelong learning, culture, sport and recreation. They are often excluded and marginalised from participating in activities (economic, social and cultural) that are the norm for other people and their access to fundamental rights may be restricted.

<sup>5</sup> Social exclusion is a process whereby certain individuals are pushed to the edge of society and prevented from participating fully by virtue of their poverty, or lack of basic competencies and lifelong learning opportunities, or as a result of discrimination. This distances them from job, income and education opportunities as well as social and community networks and activities. They have little access to power and decision-making bodies and thus often feel powerless and unable to take control over the decisions that affect their day to day lives.

<sup>6</sup> Social Protection Committee. Report on Indicators in the field of poverty and social exclusion. Brussels, European Commission, October 2001.

<sup>7</sup> European Council (EPSCO). Draft Joint Report on Social inclusion. Brussels, report 15223/01, 2001.

This joint report also identified eight core challenges that to a greater or lesser degree need to be addressed by all Member States:

- to develop an inclusive labour market and promoting employment as a right and opportunity for all;
- to guarantee an adequate income and resources to live in human dignity;
- to tackle educational disadvantage by prevention and lifelong learning opportunities;
- to preserve family solidarity while promoting gender equality and to protect the individual rights and benefits of family members and the rights of the child;
- to ensure good accommodation for all;
- to guarantee equal access to quality public services (health, transport, social, care, cultural, recreational and legal);
- to improve delivery of services;
- to regenerate areas of multiple deprivation.

Thus, equal access to health care services became an explicit element of the European agenda with regard to poverty and social exclusion, as was the improvement of the delivery of those services.

#### Added priorities over time

Since their adoption in December 2000, the relevance of the four common objectives has been confirmed. Yet, when the objectives were reviewed at the Employment, Social Policy, Health and Consumer Affairs Council in December 2002 the issue of gender was introduced as a significant factor affecting social exclusion and poverty. At that occasion the Council also acknowledged the special difficulties facing immigrants as regards their social inclusion.

Reviewing the 'second wave' of NAPs Inclusion (2003-2005) against the backdrop of a continuing uncertain global economic and political climate, the Council and Commission urged Member States to give particular attention to six key policy priorities<sup>8</sup>:

- Promoting investment in and tailoring of active labour market measures to meet the needs of those who have the greatest difficulties in accessing employment;
- Ensuring that social protection schemes are adequate and accessible for all and that they provide effective work incentives for those who can work;
- Increasing the access of the most vulnerable and those most at risk of social exclusion to decent housing, quality health and lifelong learning opportunities;
- Implementing a concerted effort to prevent early school leaving and to promote smooth transition from school to work;
- Developing a focus on elimination poverty and social exclusion among children;
- Making a drive to reduce poverty and social exclusion of immigrants and ethnic minorities.

Council and Commission also noted that obstacles to access in health care seem to persist in most Member States, and that these impact most severely on the most disadvantaged population groups. Numerous Member States announced cost-containment plans in relation to medical care covered by their social protection schemes. However, none of the 2003-2005 NAPs referred to the effect of these plans although this type of measures could well result in persons with low or modest incomes having worse access to care and treatment in the future, unless such access is guaranteed by the Member States.

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<sup>8</sup> Council of the European Union. Joint report by the Commission and the Council on social exclusion (Report 7101/04). Brussels, 2004.

### Support from EU Public Health policy and programme

The EU's social policy agenda is not the only framework within which the negative spiral with regard to health, poverty and socio-economic disadvantage can be tackled. The Community's Public Health Action Programme (2003 – 2008<sup>9</sup>) includes key objectives on socio-economic health determinants, and more particularly on reducing health inequalities. Furthermore, social and economic factors are considered as crosscutting lifestyle determinants. The programme emphasises the importance of integrated approaches and of establishing links with other Community programmes and actions.

The essential contribution of public health in the quest for a wealthier Europe was underlined by the European Commissioner for Public Health and Consumer Protection, David Byrne. He also acknowledged the importance of a mutually reinforcing relationship between social, economic and health policy objectives. Health is a driver for economic development, which is why health inequalities between and within Member States present a serious challenge to Europe's social and economical values and objectives. Similarly, wealth may also drive health. Byrne therefore suggested mobilising a larger share of the EU's Structural Funds for health-related investments, particularly in the new Member States<sup>10</sup>.

### 1.2 Recommendations from the Council of Europe

The Council of Europe and social rights  
Although the Council of Europe's mandate and geographic scope is entirely different from that of the EU institutions, its adopted recommendations do resonate within its member

states and thereby also within the EU. It is therefore not surprising that, in their 2004 joint report on social inclusion, the European Commission and European Council refer to the helpful work of the Council of Europe in strengthening access to social rights.

The Council of Europe actively promotes access to social rights as a key component of the social cohesion in the European societies. Rights to housing, employment, social protection, health and education are set in the European Social Charter. The Council of Europe has developed a number of reports, guidelines and assistance activities designed to improve public policies and services, and help people to access their social rights. Many of these activities focus on the access to social rights for people in vulnerable situation, such as the unemployed, the homeless, refugees, orphans, discriminated minorities or people in poverty.

### Recommendations on health care for people in marginal situations

With regard to healthcare services for people in marginal situations, the Council of Europe recommended the governments of their member states to develop a coherent and comprehensive policy framework that secures and promotes the health of persons living in insecure conditions; protects human dignity and prevents social exclusion and discrimination; and ensures supportive environments for the social integration of persons living in marginal situations or in insecure conditions<sup>11</sup>. Member states were also urged to strengthen and implement their legislation in order to ensure human rights protection, social solidarity and equity.

<sup>9</sup> COM (2000) 258 final.

<sup>10</sup> Byrne D. Partnerships for Health: non paper. Brussels, European Commission DG Health and Consumer Protection, 2004

<sup>11</sup> Council of Europe. The Adaptation of Health Care Services to the Demand for Health Care and Health Care Services of People in Marginal Situations. CoE Recommendation Rec (2001) 12 and explanatory memorandum.

Furthermore, governments were asked to improve multisectoral co-operation as to increase the ability of their social system to participate in preventing health problems for persons. Role, responsibilities and co-ordination of the various agencies and social institutions involved should be clearly specified in order to prevent these persons living in insecure conditions from falling into marginal situations.

Finally, the Council recommended governments to develop comprehensive, effective and efficient health systems for a timely and adequate response to health needs in order to ensure equity and equal access to health care services. Systems were to take health needs and available resources into account, and should be able to identify, assess and treat health problems of persons living in marginal situations.

The Council also presented a range of measures that could advance the implementation of their recommendations. These are discussed below. When deciding on and implementing specific measures to improve access to health services to people living in marginal situations or in insecure conditions, governments are urged to pay particular attention to the risk of stigmatisation of these people.

The Council advised member states to take account of the fact that new groups and individuals may at any time find themselves in a marginal situation. One of the best policies for improving the health of people living in marginal situations, therefore, is to ensure equal access to social and health systems for everybody whatever his/her economic and legal status.

### Suggestions with regard to access and affordability

With regard to accessibility to preventive, promotional and curative health services and programmes, regional/local systems for identifying people living in marginal situations should be developed. Health promotion and preventive services should be organised at local level with particular emphasis on outreach activities toward people living in marginal situations.

Emphasis should be put on the primary health care network for providing affordable health services to persons living in marginal situations. Provision and delivery of emergency health services should not depend on advance payment but be guaranteed irrespective of the ability to pay for it. Specific measures should be taken for financing basic health care services to persons living in illegal situations. Health care of people living in illegal situations should be provided with respect for their anonymity.

Innovative organisational approaches should be encouraged, aimed at increasing flexibility of health care provision (adjusted opening hours, telephone booking system, etc.). Persons living in marginal situations or in insecure conditions are often poorly informed. Communication should be improved for informing them about existing programmes and services and how to reach them.

Health professionals should act as advocates for persons living in marginal situations who generally have a low access to health services. This role could include lobbying authorities, politicians, and international organisations for improving access to health services for these persons.

### Suggestions with regard to specific groups

With regard to specific population groups, the Council of Europe made the following comments:

- Women living in insecure conditions have a higher rate of premature birth and perinatal morbidity, so they should benefit from special social/health surveillance during pregnancy and the perinatal period;
- Children with social/family risk factors should receive special attention from social/health services;
- Families with economic and/or social difficulties should receive support in education their children, with an emphasis on measures directly benefiting the recipient children (educational vouchers, food stamps, etc.);
- Specific social/health services should be implemented at local level for young people having family/social risk factors with special emphasis on information on family planning, STD, HIV/AIDS, traffic accidents, suicide, drug abuse, alcohol, etc. Their general physical and psychosocial well-being should be regularly assessed;
- Social/health services should pay particular attention to the needs of disabled persons whatever the origins of the handicap;
- Special attention should be paid to the needs of persons living in marginal situations with chronic diseases as well as with metabolic or neurological pathologies;
- Occupational health should be developed in particularly exposed working places;
- People living in prison and their children living in collective institutions should benefit from health services of equally good quality as outside prison;
- For underprivileged groups of population including refugees, recent migrants, etc. special attention should be paid to the specific cultural dimension of health. Some key social/health services should include professionals coming from such populations;

- Health care for elderly persons living in insecure conditions should be developed within the community by specially trained social/health workers;
- Specialised services should be available for alcohol and drug abusers.

### I.3 Implications for the health sector's role

Having described the European policy context, what can be said about the potential contribution from the health care sector to the various objectives? More particularly, what could be the sector's role with regard to the fight against poverty and social exclusion?

One obvious answer can be found in addressing the various specific challenges with regard to access to and quality of services that are put forward in the common objectives and priorities. Through occupational health services, the health sector is contributing to employment opportunities and the prevention of social exclusion and poverty. However, the health care sector is also a major employer and therefore an 'instrument' in objectives calling for improvement of the labour market and opportunities for life-long learning. And last but not least, the sector can be a partner in more 'upstream', multisectoral efforts to break the cycle of ill health, poverty and social exclusion.

#### Improving access, affordability and responsiveness

As a provider of services, the health care sector can and clearly should play a key role in addressing the European policy objectives that directly appeal to the sector's core business by ensuring access to good quality services. Services should not only accessible and affordable, but also responsive. This implies services have to be tailored to the needs of people living in poverty and/or at risk of social exclusion.

This could be channelled through the improvement of mainstream services, but also through setting up special initiatives in support of people at risk of poverty and/or social exclusion, or groups already faced with specific disadvantages. Indeed, in the first round of National Action Plans (2001-2003), many Member States have included several measures to address the common policy objectives with regard to health access.

### Improving employment

Health services can also contribute to policy objectives related to facilitation of employment participation. More than 500 million work days are lost across the EU15 as a result of work-related health problems and accidents. The majority of work-related health problems are musculoskeletal, followed by stress, pulmonary and cardiovascular disorders<sup>12</sup>. Occupational health services are specifically designed to support healthy work conditions, help people stay in work, overcome work-related illness, and enable them to return to work.

On a more abstract level, it is widely recognised that health services contribute significantly to Europe's economy. To phrase it in the words of the former European Commissioner Byrne: 'Health equals wealth'<sup>13</sup>.

The health care sector itself is a major employer. Data from Eurostat Labour Force Survey (LFS)<sup>14</sup> indicate that the number of people employed in the area of health and social work in the EU grew steadily from 13 to 15 million between 1995 and 2000. Expressed as a proportion of

total employment, it grew from 9.0 % to 9.5% over the same period. These data underestimate employment in the sector as a whole: in many statistics some providers of health services (e.g. in productions, gross and retail sales of medical goods) are categorised as belonging to other business sectors. In the EU 15, people working in personal care and related services represent 24.6% of total employment in health and social care.

As an employer, the health sector may provide job opportunities to people from disadvantaged communities or to people in long-term unemployment. Accreditation of prior learning or of organisational and caring skills acquired in a domestic environment could help those who have been out of paid work for a long period of time due to unemployment, illness, caring or parenting to re-enter vocational training and employment<sup>15</sup>.

An example of how employment schemes can tackle social exclusion in more than one way can be found in the Netherlands. The 'Working and Caring' scheme recruited women from deprived communities with a history of unemployment, and trained them in a group setting to reach out to, visit and support older people suffering from loneliness. This project contributed to the quality of life of the older people involved as well as increasing the self-esteem and employability of the trainees<sup>16</sup>.

The health care sector should also ensure it has good policies in place with regard to equal opportunities, anti-discrimination and managing diversity. The North Western Health Board in Ireland can be mentioned as an example

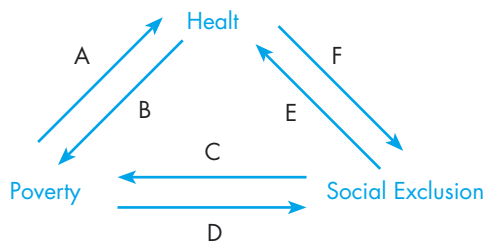
<sup>12</sup> Eurostat/European Commission. The Social Situation in the European Union. 2003.

<sup>13</sup> EU Commissioner David Byrne. Speech delivered at European Health Forum Gastein, 2003.

<sup>14</sup> Eurostat. Health statistics: key data on health 2002.

<sup>15</sup> Tamsma N and Kooij S. Workforce. In: Nies H and Berman PC. Integrating Services for Older People: A resource book for managers. Dublin, EHMA, 2004.

Fig. 1: Relations between health, poverty and social exclusion  
 From: Stegeman I and Costongs C. Health, Poverty and Social Inclusion in Europe: literature review on concepts, relations and solutions. Brussels, EuroHealthNet, September 2003.



here. It has developed an anti-racist code of practice, an equal opportunities policy based on all nine grounds of the Irish equality legislation, and a policy on anti-bullying, harassment and sexual harassment in the workplace<sup>17</sup>.

Pillinger<sup>18</sup> refers to the low level of employment of disabled people in health and social service organisations: between 1% and 3% of the total workforce. Employment is particularly low and senior levels. She stresses the importance of the development and implementation of policies relating to staff with disabilities within a broad diversity framework, and the need for better knowledge and awareness about the benefits of valuing and accommodating diversity in the area of disability.

#### The health care sector as partner in wider efforts breaking the cycle of poor health, poverty and social exclusion

Stegeman and Costongs' literature review on health, poverty and social exclusion<sup>19</sup> clarifies that there are many pathways via which poverty and social exclusion can lead to ill health and that ill health can lead to poverty and social exclusion, thus generating a cyclical relationship. The financial burden or physical constraints of ill health can, for example, lead to poverty and social exclusion. Similarly, the experience of being excluded can lead to ill health by way of a number of environmental, social and psychosocial mechanisms. This is illustrated in Fig. 1.

Breaking the cycle of poverty, social exclusion and health inequalities is an enormous and daunting task that requires creative alliances across sectors, governments and communities.

With reference to the Commission's emphasis on the importance of multi-stakeholder efforts across policy systems, the health care sector can -or maybe even should- function as a partner for others.

How crucial role of health may be in the cyclical relationship with poverty and social exclusion was highlighted by Jehoel-Gijsbers in her study on social exclusion in the Netherlands (2004). Based on interviews with people from 860 households, her study showed social exclusion to be primarily related to poor health and only in second instance to low income. There was also strong correlation with mental well-being, more so than with paid employment<sup>20</sup>. To combat social exclusion, improving both physical and mental health was put forward as the most urgent measure. For those whose health cannot be improved as such, e.g. in case of serious chronic illness, policies are recommended to ensure their situation does not lead to a deterioration of their living conditions.

<sup>16</sup>Tenhaeff C (2003). The Health Dimension of Comprehensive Action with Disadvantaged Women. Utrecht, NIZW/VHAI.

<sup>17</sup>Pillinger J. Managing diversity in public health and social care in the interest of all citizens. Report I: Race and Ethnicity. Dublin, ESN/EHMA, 2003.

<sup>18</sup>Pillinger J. Managing diversity in public health and social care in the interest of all citizens. Report II: Disability. Dublin, ESN/EHMA, 2003

<sup>19</sup>Stegeman I and Costongs C. Health, Poverty and Social Inclusion in Europe: literature review on concepts, relations and solutions. Brussels, EuroHealthNet, September 2003.

### An upstream role for the health sector?

Stegeman and Costongs highlighted the multi-dimensional nature of social exclusion: deprivation in one area may lead to deprivation in many areas. It is therefore important to find ways to break through these cycles of deprivation, which affect individuals as well as society as a whole. Addressing health status can be an important way to improve quality of life, thereby intervening in the cycle of social exclusion. Consequently, Stegeman and Costongs conclude the public health and health promotion sector can play a significant, 'upstream' role in this respect.

This is not to suggest that the health care sector does only have a 'downstream' role to play in the fight against poverty and social exclusion, by merely addressing symptoms of social exclusion or by drawing attention away from preventative actions. Instead, the sector can contribute proactively to other elements of the social inclusion agenda. The broad range of health care sector contributions may be illustrated by taking a closer look at the cyclical relations between health, poverty and social exclusion.

The health care sector could positively contribute to all six bipolar relations in Fig. 1 and thus have an overall impact on tackling poverty and social exclusion, and on reducing health inequalities. Examples of these contributions are:

#### A. Preventing poverty leading to poorer health:

- Ensuring access to and affordability of services, removing financial obstacles, particularly where they disproportionately affect disadvantaged populations.
- Locally, services should be equally available and accessible in areas or localities with a poorer and/or more socio-economically deprived or otherwise disadvantaged population.

- Guarding against regional inequalities in systems that rely on local authorities' spending power.

#### B. Preventing poor health leading to poverty:

- Ensuring the health system protects people in greater need of services, such as older people or people with chronic illness against income-related effects of service utility.
- Protection against adverse effects of out-of-pocket payments or other forms of co-payments, or of access to health insurance.
- Carers' allowances and other forms of financial support for informal carers can prevent carers falling in a poverty trap.
- Adequate health services for people in long-term unemployment and/or on long-term sick-leave, helping them to get back to work and a steady income.

#### C. Preventing poverty leading to social exclusion:

- Primary care sector support for community development projects; 'exercise on prescription'.
- Targeted service delivery, for instance aimed at children and young parents or at people with mental health problems, may help prevent people from getting caught in the downward spiral of poverty and social exclusion (see also D):

#### D. Preventing social exclusion leading to poverty:

- Ensuring there are no financial barriers to access targeted services for people in disadvantaged positions, such as drug users, sex workers or people with mental health problems.

<sup>20</sup>Jehoel-Gijsbers, G. Soc 2004/17, 2004.

- Employment schemes in the health care sector including accreditation of prior learning, flexible working arrangements, and opportunities to combine work and caring responsibilities.
- Equal opportunities and anti-discrimination policies for those applying to work and those already employed in the health care sector.

*E. Preventing social exclusion leading to poor health:*

- Responsive and culturally sensitive services for people living in poverty, people with special needs, people at risk of discrimination and social exclusion and/or people from disadvantaged communities.
- Supporting patient empowerment and participation, feedback panels.
- Children’s support services, support for young families.

*F. Preventing poor health leading to social exclusion:*

- Supporting people with mental health services against possible stigmatisation.
- Sensitive services for older people, chronically ill people and people with special needs.

Investment in health and health determinants are very powerful contributors to good health, to social inclusion and to an economically sustainable society. It is clear that health care services as such are by no means the principal determinants of health, yet they do absorb the bulk of attention of health policy makers<sup>21</sup>. Highlighting the health care sector’s potential to contribute to social inclusion objectives should not detract attention away from the important role of health promotion and health determinants. Instead, this overview seeks to inspire both health care and social pol-

icy sectors in their efforts to contribute to a more socially inclusive Europe by making clear the health care sector does have a role to play, and what this role could be.

[How can the health care sector take this on board: examples from Canada and the UK](#)

The following parts of this report will further explore issues with regard to improving access, affordability and responsiveness of services. The bulk of the literature reviewed is based on data from EU Member States. Sometimes, reports based on data from a wider range of countries such as the OECD member states have been incorporated.

Canada is an OECD-country with a relatively ‘European’ health system. By asking Canadian health sector employees to report initiatives taken to address poverty, Williamson (2001) took what he considers a ‘snapshot’ of health sector action at national, provincial/territorial and regional level<sup>22</sup>.

Almost two thirds of the 224 policies, programmes or projects measures identified focused on the consequences of poverty, aiming to decrease the negative health consequences of poverty, and to reduce the economic burden and/or barriers to health experienced by people living in poverty. Initiatives seeking to raise awareness about poverty, prevent people from becoming poor, enhance skills and education of people in poverty, or alter social and economic conditions contributing to poverty were less frequent. Types of intervention strategies could target individuals and families, organisations, communities, and policy makers.

<sup>21</sup> Hunter DJ. Public Health Policy. Cambridge, Polity Press, 2003.

At national level, strategies included national funding provided to community organisations and health regions to develop and/or implement programs that target individuals and families at risk of poverty (e.g. community action plan for children, prenatal nutrition programme, population health fund). Also, national government reported to work in partnership with other ministries and community organisations to examine barriers to social and economic inclusion, and to develop strategies for addressing poverty.

Types of provincial/territorial initiatives aimed at individual and families living in poverty included waiving health premiums; extended health benefits for children (e.g. optical, prescription education, dental); housing; income assistance; and childcare subsidies. At organisational level, initiatives focused on antenatal and postnatal programmes; early intervention; policy providing a framework for addressing socio-economic health determinants; suggesting objectives, measures and indicators associated with the reduction of poverty; examining barriers to social and economic inclusion, and possible strategies for addressing poverty. At community level, data were gathered providing information about poverty and health status, and recommendations about reducing poverty were drawn up. Political strategies focused on policies to improve income support programs and affordable housing; the development of a government-wide anti-poverty strategy; and a health status report.

Regionally, examples of initiatives aiming to reach individuals and families were: a 'nobody's perfect' childhood programme; community kitchens; free/low-cost dental services; milk coupons; provision of vitamins; assisting people

to find housing; employing new Canadians in the health region; provision of car seats; and food coupons.

At organisational level, collaboration with schools and other partners was set up to provide a stay-in-school program for teenage mothers, as well as a school snack programme. Also, additional community health nursing time was arranged in schools with high concentrations of families in poverty. Working with the business community and an anti-poverty group led to the provision of 24-hour childcare. Partnering with a community college resulted in training opportunities in the health region. Other examples included: incorporating broad social determinants into strategic, service and programme planning of health services; assessing income and poverty data for the health region; a workshop and report on negative health consequences of poverty; and an education programme for staff about working with people in poverty.

Two concrete examples from the UK further illustrate what the health sector could undertake to tackle access problems. One example shows how spatial and transport planning could help alleviate problems related to physical distance to health services. The other one demonstrates how health professionals may help identify effects of poverty that are often considered to be the responsibility of another sector –in this case housing-, and how they may point their patient the direction of further assistance.

In Merseyside,<sup>23</sup> a pilot was set up to explore a range of methods for addressing accessibility problems. Within this framework, a mapping exercise was part of the option appraisal for the selection of a site for the redevelopment

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<sup>22</sup> Williamson D L. The Role of the Health Sector in Addressing Poverty. *Canadian Journal of Public Health*, 2001, vol. 92 (3), 178-183.

or rebuilding of a major hospital. The information led to a decision to redevelop on the existing site: alternative sites had poorer access to public transport. A hospital travel plan addressed access issues, such as poor signage from a nearby railway station, and negotiations with local bus operators to change services. The pilot also helped to inform decisions on the location of new primary care facilities.

Also in the UK, a guide for primary care organisations, and public health and primary care professionals was developed to help alleviate problems related to fuel poverty<sup>24</sup>. It recognised that health professionals see the effects of bad housing – and particularly the effects of cold, damp housing – reflected on the health of their patients. Health professionals also have contact with vulnerable people, and are often confidants and advisers of isolated, old people.

The guide assists NHS professionals to recognise which diseases and conditions are related to cold homes; recognise who may be particularly vulnerable (older people, young children, people with disabilities and people with a long-term medical condition); and point patients towards trustworthy agencies who can help them overcome their fuel problems. It includes a checklist for health professionals and provides list of potential actions that they can take. It also suggests options for broader action from the health sector, particularly with regard to partnership working.

## I.4 Conclusions from Part I

Within the context of the EU's common objectives in the fight against poverty and social exclusion, the health care sector has a substantial role to play. The most obvious role lies in responding to the direct appeal of the Commission and Council through the four common policy objectives. Thus, safeguarding equal access to quality services and improving the delivery of services are explicit challenges the health care sector should address.

Yet, other elements of the common objectives should also appeal to the health care sector's options to contribute to a more socially inclusive society with less poverty. Like any other major employer, the sector can offer opportunities for jobs and life-long learning. In addition, the sector may play a more 'upstream', preventative role in breaking the cycle of ill health, poverty and social exclusion. In partnership with others, the health care sector can positively impact on all six bipolar relations in this cycle. All in all, the health care sector not only has an obligation but also a tremendous potential to be a strong player in the fight against poverty and social exclusion.

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<sup>23</sup> Health Inequalities Unit UK Department of Health. Accessibility Planning: an introduction for the NHS. London, DoH, 2004.

<sup>24</sup> Press, Vivienne. Fuel Poverty and Health: a guide for primary care organisations, and public health and primary care professionals. London, National Health Forum, 2003.

# PART II

## PART II.

# ACCESS AND AFFORDABILITY OF MAINSTREAM SERVICES

### II. 1 Concepts

As highlighted in Part I, guaranteeing equal access to quality health services is a prominent objective within the European social inclusion agenda. Access may be hindered by a range of factors, including financial ones. Literature distinguishes two key concepts in this respect, one that is used to study equity in service access, the other to look at equity issues with regard to finance. Because this review is carried out within the scope of the European fight against poverty, both are relevant.

Horizontal equity is the extent to which individuals on equal incomes are treated equally and/or to which individuals in equal need are treated equally. Horizontal equity is particularly relevant with regard to access to health care delivery. The concept of vertical equity refers to the extent to which individuals on unequal incomes are treated unequally to achieve equity in health care finance. This is also perceived as the 'fairness' of health systems.

Dixon et al. (2003) make a distinction between access and utilisation. Equality in terms of access requires only that all individuals in need have the same opportunity to use the health service. Equality of utilisation requires that people actually use the service. The authors regard observed inequalities in utilisation as proxies for inequalities in access and therefore inequitable. According to their definition, 'an equitable health service is one where individuals' access to and utilisation of the service depends on their health state alone, and not upon their socio-economic status, except in so far as that affects their health state'<sup>25</sup>.

### II. 2 Barriers to equity

Access to services can be influenced by many factors. Anderson (2004) refers to four principles underlying access to quality health and social services: support, equity, affordability and universality<sup>26</sup>. He distinguishes four dimensions affecting access: distance, delay, waiting, and costs. The Council of Europe mentions geographical distance, means of transportation, price of services, opening hours, structural obstacles, acceptability and the adequacy of services to respond to real needs as factors determining accessibility<sup>27</sup>.

Dixon et al. (2003) tried to identify barriers to access and utilisation that could be of particular relevance to disadvantaged groups. These include distance and transport; voice; and health beliefs and health seeking behaviour. These factors are discussed below in more detail.

#### Distance

Evidence from the UK presented by Dixon et al. (2003) suggests that distance as such is unlikely to act as a barrier. However, longer travel time, greater travel costs and lower car ownership do appear to contribute to differential access to health services by socio-economic group, adjusted for need. For non-attenders of out of hours primary care service, not having a car available was the main reason for having to cancel their appointment.

<sup>25</sup> Dixon A, LeGrand J, Henderson, J, Murray, R and Poteliakhoff E. Is the NHS Equitable? A review of evidence. LSE Health and Social Care, Discussion Paper Number 11. London, LSE, 2003.

<sup>26</sup> vice quality and access. Paper presented

<sup>27</sup> Council of Europe. The Adaptation of Health Care Services to the Demand for Health Care and Health Care Services of People in Marginal Situations. CoE Recommendation Rec (2001) 12 and explanatory memorandum.

This is supported by findings from the UK's Social Exclusion Unit<sup>28</sup> that show that in 2003 three percent of all people have missed, turned down or not sought medical help in a hospital because of transport problems. Generally, 20% of people find it difficult to travel to hospital. Approximately 31 percent of people who do not own a car have difficulties travelling to their local hospital, compared to 17 percent of people with a car.

Of people using mental health services, 23% report that financial problems have restricted their ability to access these services. The majority of these problems were related to transport problems. The report concludes that the recent trend to move hospitals out of town centre locations has made it harder for people to access services and that this was particularly the care for people reliant on public transport.

### Voice

Whilst it is likely that differences in the ability of social groups to express their opinion (or 'voice') is a major factor affecting access, most evidence presented by Dixon et al. (2003) is indirect. However, the middle class' networks and their confidence and ability to articulate and express their views are clearly key factors affecting their ability to communicate with GPs and to promote onwards to secondary or tertiary care. Patients from lower socio-economic groups may have lower levels of health literacy skills, which may prevent them from understanding and interpreting information or may have lower levels of self efficacy, which means they are more reluctant to take part in shared decision making.

### Health beliefs and health seeking behaviour

Analysis by Dixon et al. (2003) suggests there are systematic differences in the health beliefs and consequent health seeking behaviour of lower socio-economic groups compared with higher socio-economic groups. Social differences in the lay construction of family histories may influence the efficiency of diagnosis. Operations and medical tests may not be revealed to doctors. Social difference may also affect delay of seeking care and denial of symptoms, and opting to self-manage symptoms. Fear of hospitals may lead to self-management of pain.

Lower social-economic groups also tend to have more misconceptions of acute problems or treatment possibilities. If lower socio-economic groups indeed systematically underestimate their health state or the likelihood that they will benefit from health care, this could also have implications for the use self-reported health as indicator for their health needs.

### Relevance throughout the health care process

Dixon et al. (2003) distinguish two types of disadvantage that lower socio-economic groups experience when using the health service: those that relate to the problems of making first contact with the services, and those that concern the problems they experience once contact has been established. Most of the factors causing disadvantage affect both types, but health beliefs and behaviour are more likely to affect first contact while voice difficulties are more likely to impact on second stage.

<sup>28</sup> UK Social Exclusion Unit. Making the Connections. London, 2003.

### II. 3 Cross-national and national evidence on socio-economic status and equity: horizontal equity

Having briefly discussed the range of barriers that may affect health service access, we will now turn to the question of horizontal equity: are people in equal need indeed treated equally? Evidence gathered through cross-national studies as well as national ones suggests that this may not be the case in many countries across Europe.

#### Evidence from international studies

Looking at horizontal equity in 14 OECD countries, Van Doorslaer et al. (2002) found that even in countries which have long achieved rather universal and comprehensive degrees of health insurance coverage, persons in equal need do not receive equal treatment at all income levels. A consistent pattern emerges where higher income individuals are more likely receive specialist services whereas lower income individuals are more inclined to use general practitioner care<sup>29</sup>.

Van Doorslaer et al. provided estimates of equality of access to GPs, specialists, and all physicians combined. While those on low incomes use all services more intensively, once standardised for need a fairly consistent pattern emerged across most countries. Total physician contacts were generally distributed according to need, as were GP visits, although in some countries there was some tendency to be pro-poor. Contacts with specialists were more often pro-rich. Overall, there was a tendency for those on low incomes to

use GP services and those on high incomes to use specialist services relative to need. This is consistent with earlier findings<sup>30</sup> that indicated the rich tend to be more intensive users of medical specialist services than one would expect on the basis of need for care.

In a 2004 study in 21 OECD countries updating earlier work on equity in physician utilisation, Van Doorslaer et al. found significant horizontal inequity favouring the higher socio-economic groups on approximately half of the countries<sup>31</sup>. The study looked at utilisation of the services of general practitioners, medical specialists, inpatient care, dental care and coverage of private health insurance.

No overall evidence of inequity across income groups were found in utilisation of GP services, but where it appears to exist it is often indicating a pro-poor distribution. In all countries, the rich are significantly more likely to take up medical specialist services and sometimes uptake is also more frequently. No clear pattern for inequity with regard to inpatient care was found. For dental care, however, in all countries showed a pro-rich distribution of the probability as well as the frequency of dentist visits, but wide variation was found in the degree to which this occurs. With regard to private health insurance coverage income-related differences were found in seven countries, including France, Germany, Ireland and the UK. Van Doorslaer et al. also concluded that regional differences in medical care utilisation often mirror underlying socio-economic differences between regions.

<sup>29</sup> Van Doorslaer E, Koolman, X, Puffer F. Equality in the use of physician visits in OECD countries: has equal treatment for equal need been achieved? In: OECD, editor. *Measuring Up: Improving health systems performance in OECD countries*. Paris, 2002, p. 225-248.

<sup>30</sup> Van Doorslaer E, Wagstaff A, Van der Burg H, Christiansen T, De Graeve D, Duchesene I, Gerdtham U-G, Gerfin M, Geurts J, Gross I, Häkkinen U, John J, Klavus J, Leu R, Nolan B, O'Donnell O, Propper C, Puffer F, Schellhorn M, Sundberg G, Winkelhke O. Equity in the delivery of health care in Europe and the US. *Journal of Health Economics*, 2000, Vol 19, No 5, p 553-583.

<sup>31</sup> Van Doorslaer E, et al. *Equity in the delivery of health care in Europe and the US*. Paris, OECD, Health Working Papers 14, 2004.

In 2003, the European Quality of Life Survey was carried out in all 28 countries of the enlarged EU and the three Candidate Countries. Drawing on those data, Anderson (2004) points out that income inequalities show a pattern of advantage for people in the highest income quartile in access to services across all four dimensions (see par II.3) of distance, delay, waiting and costs. This pattern is evident in all countries, but to the least extent in the EU 15.

Income levels do influence access to health services: across all 28 countries those in the highest income brackets generally have fewer difficulties with access. Affordability was a real barrier for many people, especially those on low incomes in the Mediterranean Member States and the three candidate countries (Bulgaria, Romania and Turkey). Differences by income are most clear in relation to the proportion of people reporting that on their last visit the costs of seeing the doctor made it 'very difficult' to do so.

Also, there is substantial evidence of social inequalities in access to medical services, particularly for people on lower incomes and for older people. While there was no consistent evidence that older people had more difficulty making an appointment or that their age has much influence on waiting times, older people do seem to have more difficulty in relation to distance. In assessment of health services, there was no consistent lower rating of health services by unemployed people, nor were marked general differences found with regard to gender.

#### Studies with a national focus

In their reflections on the equity of the NHS, Dixon et al. (2003) conclude that the NHS is inequitable in key areas of health care provision.

The studies they cite include evidence on:

- Cardiac care: admissions, rates of investigation and revascularisation do not match the higher levels of need experienced by the most disadvantaged groups compared with more affluent groups;
- Coronary care: 'affluent achievers' had 40% higher CABG and angioplasty rates than the 'have-nots', despite far higher mortality from CHD in the deprived group.
- Cancer care: coverage of screening programmes is poorer for lower socio-economic groups. Poorer outcomes may be explained by late presentation or by inappropriate access (emergency rather than elective admission).
- Oral health: patients using elective inpatient oral surgery were generally from higher socio-economic groups, while the opposite was true for emergency oral surgery.
- Antenatal care: the risk of maternal death among women from the most disadvantaged groups is up to 20 times greater than those women in the two highest social classes.

People from socio-economically deprived backgrounds are disproportionately using emergency access as a route into the UK health service, and lower socio-economic groups tend to present with more advanced and/or more severe disease. If poorer populations would indeed present their problems and questions at a later stage and tend to have more emergency admissions, then they may show up in health statistics as utilising more health services. However, that utilisation would be less effective in terms of delivering health benefits compared to the path followed by better off groups with similar needs. This latter group contacts the health service earlier and subsequently has access to elective –rather than emergency- treatment.

Based on data from the Living in Ireland Survey for 2000,

Layte and Nolan concluded that levels of health service utilisation favoured the more affluent groups in Irish society. Relative to the less well off they the use significantly more health services than would be expected given their level of need<sup>32</sup>. High income groups use show relatively more dentist and optician visits, GP care, inpatient care and prescriptions are relatively more concentrated among lower income groups.

#### II.4 A closer look at equity in health care finance: vertical equity

In a review that focuses on the interrelatedness of health care services and poverty, it is inevitable to look at how the costs of services and arrangements for health system finance may affect access. How fair are our health systems, in other words: are our systems treating individuals on unequal incomes unequally in order to achieve equity in health care finance?

The work of Van Doorslaer et al. on horizontal equity that was discussed in II.3 has been carried out within the context of the ECuity project. This project has been running since the early '90 and has also been the framework of various studies on equity in health care finance, or 'vertical equity'.

##### Vertical equity: concept and measurement

Vertical equity is concerned with the extent to which system finance is progressive, proportional or regressive. In progressive systems affluent people spend a greater proportion of their income on health care than the poor. In proportional systems affluent and poor people pay equal

proportions relative to their income. Regressive systems cause the poor to spend proportionately more of their income on health care compared to the rich.

The most common index to measure vertical equity is *the so called Kakwani Progressivity Index*<sup>33</sup>. It measures the extent to which funding systems, including those set up to finance health care, depart from proportionality. A positive value of this index indicates progressivity, when the index is negative the funding is less fair to those on a low income.

##### International evidence

In Wagstaff and Van Doorslaer's earlier work (1992), three OECD countries with a national tax-based health service were reported to have positive Kakwani indices: the UK, Ireland and Portugal. Two countries (USA and Switzerland) with a predominantly private health system had a negative index. France, Spain and The Netherlands had a low negative index because their state health insurance produced a more equitable share compared to their private insurance compartment.

Most health care systems in EU Member States are funded from a mixture of sources, such as taxation, social health insurance, private health insurance, or out-of-pocket payments. Most health care systems draw to some extent on most of these. The relative importance of these sources will affect the overall impact on equity.

In their extensive review of health care funding in Europe, Mossialos and Dixon (2002) conclude that 'the available evidence on how different revenue sources affect equity shows that taxation and social health insurance are more progressive than private health insurance and out-of-pocket payments,

<sup>32</sup> Layte R and Nolan B. Equity in the Utilization of Health Care in Ireland. Dublin, ESRI Working Paper 2, no year stated.

<sup>33</sup> Kakwani, N. C. Measurement of tax progressivity: an international comparison. *Economic Journal*, 87 (March), 1977, p 71 – 80.

which are both highly regressive. Equity of access is greater when health care is funded through taxation of social health insurance than when funded through private health insurance or out-of-pocket payments. User charges are a blunt policy instrument deterring both necessary and 'frivolous' utilization and disproportionately affect poor people<sup>34</sup>.

In their 2004 report on health systems performance, the OECD pointed out that multi-payer systems -i.e. systems that allow for publicly as well as privately financed options- can make it difficult to maintain equity in access and financing compared to systems that feature just a single payer<sup>35</sup>.

### Taxation

Wagstaff et al.<sup>36</sup> reported that in most high-income countries tax liability is mildly progressive to proportional. Thus, people with more income contribute a larger or similar share of their income to health care financing compared to people with a lower income. Tax-funded health care financing is predominant in northern Europe, Ireland, the UK and southern European countries such as Italy, Spain and Portugal. Local taxes are generally less progressive than national taxes.

Evans<sup>37</sup> notes that the extent of reliance on tax financing for health care in a country seems to be inversely related to the progressivity of the tax system in that country. This would suggest a political compromise in the conflict of economic interest between the healthy and wealthy on the one hand, and the unhealthy and unwealthy on the other.

### Social insurance systems

Social insurance systems, such as exist in Germany, France and The Netherlands, may be either progressive or regressive, depending on their structure and policies. Most tax-financed systems tend to be relatively more progressive than most social insurance systems. Wagstaff et al. (1999) found social health insurance to be regressive in Germany and The Netherlands. In both countries, part of the population -determined by their income level- can opt out of the statutory system and purchase private health insurance instead.

In the case of The Netherlands this 'opt out' is mandatory. Consequently, about 30 percent of the Dutch population is covered through private health insurance leaving the statutory schemes to cover a relatively large group of low-income people. The Dutch have tried to compensate for this by placing a levy on private insurance to subsidize statutory funds and by a slightly progressive system for universal coverage for long-term care.

Mossialos and Dixon (2002) conclude that upper-income ceilings tend to make social health insurance schemes more regressive, whereas minimum thresholds or exemptions for low-income groups increase progressivity. When there is no income ceiling or opportunity to opt out of the system, as is the case in France, the progressivity of social health insurance does not appear to differ systematically from that of systems based on taxation.

<sup>34</sup> Mossialos E and Dixon A. Funding health care: options for Europe. Buckingham, Open University Press, European Observatory on Health Care Systems Series, 2002.

<sup>35</sup> OECD Health Project. Towards High-Performing Health Systems. OECD, 2004.

<sup>36</sup> Wagstaff A, van Doorslaer E, van den Burg H, et al. Equity in the finance of health care: some further international comparisons. *Journal of Health Economics*, 18 (3), 1999, p. 263 – 290.

<sup>37</sup> Evans R G. Financing health care: taxation and the alternatives. In: Mossialos E, Dixon A, Figueras J and Kutzin J. Funding health care: options for Europe. Buckingham, Open University Press, European Observatory on Health Care Systems Series, 2002.

### Private health insurance

Private health insurance premiums are a regressive source of financing compared with income-based taxes or social insurance contributions (OECD, 2004). Government efforts to promote access to private health insurance -for instance through restrictions on risk selection or targeted subsidies- can improve equity in access as well as financing. This is particularly relevant to people with low income levels, people with chronic conditions and people with high risk for disease.

Private health insurance can be substitutive, supplementary or complementary. In the first case, it functions as an alternative to statutory cover. This type of insurance can be purchased in countries such as Germany and the Netherlands by people that have either opted out or have been forced out of the statutory system. Complementary insurance offers partial or full coverage for services that are not included in the package covered by the statutory insurance. Supplementary insurance increases choice and access and is sometimes referred to as 'double cover' and is a particularly common phenomenon in countries with a national health service<sup>38</sup>.

According to Mossialos and Thomson (2002) there is a lack of research on the equity implications of expanding voluntary health insurance in the EU. Most subscribers are high earners which would suggest that tax incentives to encourage the take-up of voluntary health insurance are likely to subsidise those who are already well off and will therefore be regressive in terms of funding health care.

Even though evidence is limited, Mossialos and Thomson conclude that risk selection -or 'cream-skimming'- does appear to be a feature of the voluntary health insurance market in some EU member states. Risk selection implies that insurers encourage individuals with below-average risk to take up insurance with them and discourage or even refuse individuals with above-average risk. This may lead to gaps in coverage for those who are most likely to be vulnerable, such as elderly or chronically ill people. In those cases where voluntary health insurance gives rise to faster access, it is likely to increase inequality in the provision of health care. Also, there is some evidence to suggest that the existence of voluntary health insurance increases health inequity in some EU member states.

Analysing the redistributive effect of health care funding among individuals with equal incomes, Van Doorslaer et al. (1999) found that voluntary health insurance caused income inequality in France and Ireland, had no distributive effect in Denmark, and had a very small redistributive effect in Germany and the Netherlands. Based on their work within the Spanish health care system Borrás et al<sup>39</sup>. suggest the existence of voluntary health insurance may increase health inequity, resulting in negative consequences for the health of poorer people.

<sup>38</sup> Mossialos E and Thomson S. Voluntary health insurance in the European Union. In: Mossialos E, Dixon A, Figueras J and Kutzin J. Funding health care: options for Europe. European Observatory on Health Care Systems Series. Buckingham, Open University Press, 2002.

<sup>39</sup> Borrás J, Guillen M, Sanches V, Junca S, and Vincente R. Educational level, voluntary private health insurance and opportunistic cancer screening among women in Catalonia (Spain). European Journal of Cancer Prevention, 1999, 8, p. 427 – 434.

## Cost-sharing

While, to some extent, private health insurance is a feature in all countries across the EU, out-of-pocket payments –or ‘user charges’- make up the bulk of private expenditure on health care in all EU member states<sup>40</sup>. User charges are a way for governments to shift part of the health care costs to the people using the services. They can appear in all types of health systems. To counteract the adverse impact of cost-sharing on vulnerable groups, most countries offer full or partial exemptions to young and elderly groups, people with certain chronic diseases and low-income households.

User charges can take different forms. Direct forms would include:

- Co-payment (flat fee or charge per service);
- Co-insurance (percentage of the total charge);
- Deductible (a payment covering the first x Euro’s before insurance coverage begins);
- Balance billing (additional fee the provider levies in addition to the payment received from the third-party payer).

Payments that would have to be made as a result of policies that only provide statutory cover for generic pharmaceuticals would be an example of a more indirect form<sup>41</sup>.

Governments often look at user charges not only as a way to reduce their public costs, but also as a means to make potential service users more aware of costs, and to reduce unnecessary utilisation of services. Dawson<sup>42</sup> argues that this latter purpose could be achieved more effectively by

countering the moral hazard of physicians who recommend excessive treatment for patients with insurance coverage. She would perceive excessive utilization as a supply-side rather than a demand-side problem.

Rubin and Mendelsen<sup>43</sup> (1995): reviewed 19 studies that examined the effect of different types of cost-sharing on health services utilization and health status. They found evidence that cost-sharing adversely affected the health of unemployed and homeless people.

Robinson’s own investigations confirm this pattern. He cites unpublished data from Sweden: surveys in Stockholm carried out between 1993 and 1996 indicate that 20 - 25 percent of the population refrained from seeking care at least once during a given twelve month period because of financial reasons. The same studies showed that individuals on low incomes (such as unemployed people, students and immigrants) tended to be affected more strongly than other groups.

A study of out-of-pocket payments in Croatia showed that the lowest income quartile paid 5 percent of income in co-payments versus 0.6 percent of income for the highest income quartile. Combined with other direct payments, including informal payments, the financing becomes even more regressive. Those on a low income pay 17.3 percent of income versus 2.9 percent of income for the highest income group<sup>44</sup>.

<sup>40</sup> OEDC Health Data 2003.

<sup>41</sup> Robinson, R. User charge vatory on Health Care Systems Series. Buckingham, Open University Press, 2002.

<sup>42</sup> Dawson D. Why charge patients if there are better ways to contain costs, encourage efficiency and reach for equity? *Eurohealth*, 5 (3), p. 29-31.

<sup>43</sup> Rubin R and Me y Perspective.

Basle: Pharmaceutical Partners for Better Health.

<sup>44</sup> Mastilica M and Bozиков J. Out-of-pocket payments for health care in Croatia: implications for equity. *Croatian Medical Journal*, 40 (2), 152-159.

Following increase of the level of co-payments in home care service provision in The Netherlands, Vernhoud and Dragt<sup>45</sup> looked into the effects on the uptake of services. Within the first few months of receiving their new co-payment invoice, 1.6 % of all clients of a sample of 54 home service providers had cancelled the uptake of all services. Another 0.3 % had cancelled the uptake of at least part of all the services they received prior to the implementation of the new financial arrangement.

### Options to tackle vertical inequity

Findings from the OECD health project point toward possible approaches that could help to bridge gaps in vertical equity and may foster more adequate and equitable access<sup>46</sup>. Financial barriers to access may be eliminated or reduced by providing or subsidising health coverage for the poor, exempting poor persons from patient cost-sharing requirements, and allowing complementary private health insurance to cover a portion of user fees.

In some systems, private health insurance may be required to access certain types of care. In those cases, interventions such as targeted regulation, subsidies or fiscal incentives may support access to affordable private health insurance by high-risk persons, including older people and those with chronic or costly medical conditions. Policy interventions such as provider reimbursement limits or the employment of common waiting lists may help to avoid unintended inequities in access by persons with different sources of health coverage.

## II. 5 Conclusions from Part II

There are many barriers that may hinder health service access and service affordability. Some -such as distance and transport, voice, and health beliefs- disproportionately affect people from lower social-economic groups. Horizontal and vertical inequity is a feature across EU health systems, in spite of the fact that most countries have long achieved rather universal and comprehensive degrees of health insurance coverage.

Social inequalities in access to medical services do exist, particularly for people on lower incomes and for older people. Richer, better educated people find their way to medical specialists and dentists more easily and more frequent, while people with less income tend to use more GP and emergency services. Late presentation of people from lower socio-economic groups may also affect their perspective for receiving adequate services, their prognosis for recovery and ultimately their overall health.

Health care finance is an important factor in overall access to health care services. Funding for health care systems may come from a variety of sources. Each tends to have a different effect on vertical equity: out-of-pocket payments being the most regressive method of payment. There are a range of options for policy makers to eliminate financial barriers to access. In light of the differences in health system finance across the EU, countries could be encouraged to embrace these options in a way that is appropriate to their particular system.

<sup>45</sup> Vernhout G and Dragt W. Results assessment of the number of home care services. Organisatieadviseurs, 2004.

<sup>46</sup> OECD Health Project. Towards High-Performing Health Systems. OECD, 2004.

# PART III

## PART III.

# SPECIFIC ISSUES WITH REGARD TO PEOPLE AT RISK OF POVERTY OR SOCIAL EXCLUSION

### III. 1 Introduction

Ever since the publication of the Black Report in the UK, it has been well documented that poverty or social exclusion do not cause specific diseases or pathologies, rather that a social gradient exists for all causes of mortality<sup>47</sup>. In other words: people living under conditions of disadvantage suffer from the same diseases, but in a disproportionate way. Timely and adequate provision of health services that are tailored to their needs is thus of relatively high importance to them, as is the prevention of ill-health.

This chapter focuses on several population groups that have received specific mention as deserving particular attention within EU-wide social policy frameworks: people from minority ethnic groups, Roma, women, older people, and people with mental health problems. Of course this list is not inclusive and should by no means suggest that improving responsiveness of health care systems is less important with regard to other groups. Rather, many of the lessons that can be learned from efforts to improve service responsiveness for the abovementioned groups can or even should be taken on board when addressing the needs of other groups at risk of social exclusion.

Providing responsive health services to people from disenfranchised or disadvantaged groups should focus on the improvement mainstream access as well as on exploring options for specialised services. As the Council of Europe pointed out, the best policy for improving the health of people living in marginal situations is to ensure equal access to

social and health systems for everybody whatever his/her economic and legal status.

Additional outreach services or specific services addressing the needs of particular groups may help to tackle access and responsiveness problems within the mainstream system. However, the Council recommends these services should be presented as an alternative only. People in marginal situations should never be forced to use these special services only and second-class health care for people in marginalised situations should be avoided<sup>48</sup>.

### III. 2 Ethnic minorities and immigrants

The population of Europe is becoming increasingly diverse in terms of its ethnic background. Meeting the needs of the contemporary multi-ethnic society is a major challenge for health professionals. As was pointed out in Part I of this report, the European Commission asked Member States to acknowledge the special difficulties facing immigrants as regards their social inclusion.

In her report on race equality in health and social services, Pillingier (2003) points out that countries may differ in the way they consider the provision of specific services to be a 'desirable' instrument to achieve equality. While Sweden would stress the moral appropriateness of treating everyone equally according to their needs – and thus of finding solutions within mainstream services only-, the UK has seen many specific equity initiatives in health and social servic-

<sup>47</sup> Inequalities in Health. The Black report (1980). London, Penguin Books, 1990 (reprint).

<sup>48</sup> Council of Europe. The Adaptation of Health Care Services to the Demand for Health Care and Health Care Services of People in Marginal Situations. CoE Recommendation Rec (2001) 12 and explanatory memorandum.

es<sup>49</sup>. Pillinger quotes the UK Commission for Racial Equality on this matter: 'In order to promote integration whilst respecting diversity, it is now recognised that all services should be delivered in ways that are culturally appropriate for all users, whilst leaving scope for services specifically for members of certain ethnic minority groups'.

#### Health care services utilisation

Data from Denmark, Germany, and the Netherlands<sup>50</sup> suggest that there are differences in the utilisation of health care services between migrant groups and non-migrants, and between different migrant groups. Dyrh, Andersen and Engholm looked at general practitioner and A&E contacts of all Copenhagen inhabitants during 1998. Compared to non-immigrants, overall service contact level of immigrants was 13% lower. Immigrant children also had lower contact rates. However, particular immigrant subgroups had higher contact rates compared to the indigenous Danish population: male refugees aged 20-59 had higher overall rates and so called 'guest workers' and refugees aged 19 – 59 had higher A&E contact rates. In contrast, guest workers and refugees older than 60 had much lower overall contact rates.

In Germany, Zeeb, Baune and Kramer interviewed 565 adults, 276 of which were migrants. With regard to self-reported health care utilisation, indigenous Germans appeared to utilise health care facilities and preventative programmes more frequently than migrants. Migrants were somewhat less satisfied with the care received and felt less well informed about major diseases and health promotion.

Comparing 1995 - 2001 hospital admission data in The

Netherlands, Verweij and De Bruin found admission rates for people of Turkish, Moroccan and Surinamese descent to be somewhat higher than those of indigenous Dutch. Of the three minority ethnic groups, inpatient admissions and day treatment were highest among the Turkish group, while average length of admission was highest for the Surinamese group.

With regard to outpatient clinic visits at the Rotterdam University Hospital in the same country Lanting et al. found that female and first generation migrants from Turkey and Morocco make significantly more use of outpatient care compared to other groups. Differences for Surinamese and Antillean groups are less pronounced. Differences are smaller for second generation migrants.

#### Specific needs

People from black and minority ethnic communities may encounter a range of problems that can impede on service access and quality. These include language; communication; information about health issues, health services, and complaints procedures; religion; discrimination; and lack of knowledge amongst staff. (Pillinger, 2003, 1).

Pillinger notes that older and disabled minority ethnic people may encounter particular disadvantages. Shah and Priestley's work on the health experiences of black and minority ethnic disabled people in Leeds (UK) confirms this<sup>51</sup>. They recommend more effective monitoring and auditing of services for this group of people; improved staff

<sup>49</sup> Pillinger J. Managing diversity in public health and social care in the interest of all citizens. Report I: Race and Ethnicity. Dublin, EHMA/European Social Network, 2003.

<sup>50</sup> Brujnzeels M. Migrant Health in Europe: international conference on differences in health and health care provision Rotterdam, the Netherlands. *Ethnicity & Health*, vol 9 (2004), June, Supplement 1.

training; improved access of public services; more action to combat isolation in local communities; and improved information and health promotion.

Lyons and Clarke (in Bruijnzeels, 2004) explored the experiences of Irish maternity service providers working with migrant women. Problems emerged with regard to communication differences; knowledge and use of services; cultural differences, and negative issues in relation to caring for migrant women. Findings suggest that migrant women are expected to adapt to the Irish services rather than the service adapt or be responsive to the needs of the growing multicultural population. Lyons and Clarke identified a need to address the communication deficiencies between service providers and migrant women, as well as the negative perceptions, feelings and racism expressed by maternity service providers.

Also in Ireland, Pierce (2003) reports a range of barriers faced by minority ethnic people with disabilities. Again, lack of knowledge about services and poor access to information are mentioned, as are language and communication barriers. Inadequate accommodation hindering access to aids and equipment was also found to be very relevant. People from Travellers communities reported institutional racism. Pierce suggests more work need to be done in the area of improving cultural competency: 'the understanding that culture profoundly influences an individual's health beliefs, practices, behaviours and the outcomes of health care; responding respectively and effectively to people of all cultures; affirming the worth and dignity of individuals, families and communities'<sup>52</sup>.

### Culturally sensitive methods and instruments

Various studies have pointed towards the need for cultural sensitivity in the delivery of services. Similarly, there is a need for various methods supporting service delivery and research, such as interview instruments and questionnaires to measure client satisfaction or health beliefs. Quality of interpreting services would benefit from recognised guidelines or accuracy criteria (Bruijnzeels, 2004).

At the same time, the growing acceptance of standard guidelines in quality assurance of clinical care may actually be at odds with the growing ethnic diversity in many western countries. Guidelines should mention ethnic differences and could be counterproductive when they do not take ethnic diversity into account. Guidelines disregarding important ethnical differences between patients may even be harmful (Manna and Bruijnzeels, in Bruijnzeels, 2004).

Between migrant and ethnic groups important variations may exist in the pattern and causal basis of certain types of disease. One way to explore these variations is through cohort studies. Ranganathan and Bhopal (in Bruijnzeels, 2004) looked at whether ethnic minority populations were included in cardiovascular cohort studies in Europe and North America. They found that publications rarely provide details on the racial or ethnic composition of the population under study. Sometimes, ethnic minority groups were explicitly or implicitly –for instance by using language or birthplace criteria- excluded from cohort studies. The authors conclude that exclusion of ethnic minority groups, particularly in Europe, has created inequity.

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<sup>51</sup> Shah S and Priestley M. Better Services, Better Health: the healthcare experiences of black and minority ethnic disabled people. Leeds, Leeds Involvement Project, 2001.

<sup>52</sup> Pierce M. Minority Ethnic People with Disabilities in Ireland. Dublin, The Equality Authority, 2003.

### Improving services: examples of what can be done

Many initiatives are taken across Europe to address the problems faced by people from black and minority ethnic communities in accessing good quality and responsive services. Answers are being found by setting up specific services or specialised teams, but also by improving mainstream service provision.

Foets, Van Vree and Van der Kemp (in Bruijnzeels, 2004) drew up an inventory of intercultural interventions carried out in the Dutch health care sector between 1995 and 2002. They identified 130 interventions, only 10% of which had a permanent character. Two-thirds of all interventions were concerned with measures to improve cultural sensitivity (e.g. training, leaflets). Measures concerning the actual care process (such as mediation, translation) were less common. Most (60%) interventions were aimed at professionals rather than at ethnic minority patients. Collaboration with migrant organisations was exceptional.

### Developing national policy

The Swiss Federal Strategy 'Migration and Public Health 2002-2006' was developed by the Swiss Federal Office of Public Health, in cooperation with the Federal Office for Refugees, the Federal Office of Immigration, Integration and Emigration and the Federal Commission for Foreigners. The longer-term objective of the Strategy is the creation of a healthcare system that addresses the needs of a society and clientele that have changed as a result of migration.

In order to improve access to the healthcare system and to provide specific services, the strategy calls for the im-

plementation of measures in five areas<sup>53</sup>. The first of these is education, including training migrants as interpreters, and trans-cultural education of health workers and professionals. The Swiss aim to establish national standards for interpreting services. Information, prevention and health promotion, including dissemination of health-related information for specific groups within the migrant population form the second area.

In the area of health care provision, the focus is on three packages of measures:

- removing barriers to access by promoting easily accessible services in areas with a relatively high migrant population;
- targeted mediation and coordination to improve allocation of services as well as communication between service providers and the migrant population;
- more availability of professional interpreters in the health care sector.

Improving treatment options for traumatised refugees is the fourth area: existing services are to be improved, accessible decentralised services are to be established, and standards of care will be defined. Finally, the Swiss will establish a health monitoring system for migrant populations and increase basic research focusing on their health.

### Integrated approaches

The 'Migrant-Friendly Hospital' project brought together hospitals from 12 EU countries. Running from 2002 – 2004, the project addressed differences in health care access and effectiveness by identifying, implementing and evaluating models of good practice to improve quality of care in hospital services<sup>54</sup>. In spite of the great diversity

<sup>53</sup> Swiss Federal Office of Public Health. Migration and Public Health: the Confederation's strategic orientation 2002 – 2006. Berne, 2002.

<sup>54</sup> See: [www.mft-reu.int](http://www.mft-reu.int)

of migrant groups living in the respective EU Member States and seeking care in of these each countries, the hospitals collaborating in this project identified three joint problem areas in providing quality care: language and communication barriers; lack of culturally adequate patient information and education; and lack of cultural competencies among hospital staff. In response to these problem areas, three sub-projects were set up: interpreting in clinical communication; culturally and linguistically adequate information and education on post-partal issues for pregnant women; training towards cultural competence for hospital staff.

### *Improving cultural awareness*

Based on its extensive work on measuring patient experiences, the Picker Institute has presented UK health care professionals with several suggestions as to how cultural gaps and barriers in health service provision could be addressed. Language and literacy skills are often the most obvious of barriers. Providing information in different languages, making it available on video and audio tapes as well as in written form, using pictures instead of words, using a phonetic phrase book, or providing interpreting services can all be helpful here. It can be very reassuring and respectful to patients if health care professionals have mastered at least some words in common 'immigrant' languages. Within health care settings such as hospitals, using colour coding rather than written signs and directions can help navigation.

Patients' religious and cultural beliefs may influence the way they will seek help and express their needs or health complaints. They may also influence lifestyle, making the understanding of religion a very important element of good diagnostic skills. In residential settings, religion needs to be

taken into account with respect to food, clothing, washing and physical examination. Also, religion may require patients to carry out certain duties with regard to worship or bereavement. Some cultures may emphasise personal modesty and do not allow sexes to mix. This can have consequences for examination as well as for inpatient treatment<sup>55</sup>.

### *Staff training*

Swiss research indicates that people with immigrant backgrounds are often late in accessing counselling facilities for substance abuse, and are proportionally underrepresented as clients of these services. Brönnimann, Castra and Bern (in Bruijnzeels, 2004) report on concrete measures taken to tackle the problem. These included creating a specialised team of staff and improving intercultural skills of staff through education, intervision and case conferences. Existing models, concepts and job descriptions were adapted to make them more responsive to specific needs of immigrant clients and the theoretical basis for the services was further developed. Also, the services organisation improved contact with immigrant communities, building trust and increasing cooperation with them.

### *Community involvement*

Liaising and working with black and minority ethnic communities is a strategy that has proven to be effective as well as appreciated by the communities concerned. It can be achieved by appropriate research methods for the identification of needs, by consulting the groups concerned in the planning process for new services, by feedback panels, and by making use of specific community resources. Recruiting health workers from ethnic minorities eases communication problems and enhances accessibility<sup>56</sup>.

<sup>55</sup> Picker Institute. Improving Cultural Awareness in the Healthcare Environment. Patients' Experience Newsletter 5 (March), 2003.

<sup>56</sup> Council of Europe. The Adaptation of Health Care Services to the Demand for Health Care and Health Care Services of People in Marginal Situations. CoE Recommendation Rec (2001) 12 and explanatory memorandum.

To improve services for people in marginal situations, the Council of Europe recommends a range of measures that involve some form of community participation and are also relevant to black and minority ethnic communities. These include a more prominent role for NGO's and volunteers in protecting the health of persons living in marginal situations. NGO structures are usually more flexible, can react more quickly to emerging new needs and are able to create services that are more adapted to specific needs. They may be more acceptable and attractive to socially underprivileged groups.

Other measures the Council strongly supports are professional medical undergraduate and postgraduate courses and in-service training to add new subjects to their programmes: training in partnership skills, advocacy skills, negotiation and communication skills, and social and management training. Setting up self-help groups and other activities aimed at empowering people should be encouraged.

Peer-based models provide lay members of the community with training and some form of supervision and support to enable them to provide information, counselling and advice to people from their own community. Peer-based services and programmes have been developed and implemented in different European countries. Often, they have been set up as a way to improve health information and deliver culturally sensitive health promotion. They also play a role in preventative health services, in bridging gaps in acute health care settings, in mental health, and in services for drug users. Peer-based approaches have not only been implemented to improve services for black and

minority ethnic communities, but also for other groups that may encounter specific barriers with regard to health services, such as women, gay men and lesbians, and older people<sup>57</sup>.

### III. 3 Roma and travellers

Roma have suffered from severe poverty and exclusion throughout European history. The situation of Roma communities in Europe has been put in the spotlight within the framework of the 2004 EU accession of ten new countries and the candidate status of others<sup>58</sup>. Roma are the most prominent poverty risk group in many of these countries and suffer from very high rates of unemployment. Their poverty situation has multiple and interrelated causes which reinforce each other. The improvement of their situation calls for sector-wide policies as well as for specific interventions. Access to public services, including health services is compounded by the geographic isolation of some of their settlements<sup>59</sup>.

#### Recommendations for new EU Member States and Candidate Countries

In 2004, the World Bank and Open Society Institute joined forces to discuss opportunities to improve the health of Roma in countries of Central and Eastern Europe. This led to a range of recommendations<sup>60</sup> :

- combating discrimination in access to health services needs to be an integral part of the national Roma health strategies;

<sup>57</sup> Voorham AJJ. Gezondheidsbevordering vooreen-door de doelgroep (peer-led health promotion). Rotterdam, GGD, 2003.

<sup>58</sup> Zoon I. On the Margins: Roma and Public Services in Romania, Bulgaria and Macedonia. New York, Open Society Institute, 2001.

<sup>59</sup> Ringold D, Orenstein MA and Wilkens E. Roma in an Expanding Europe: Breaking the Poverty Cycle. Washington, World Bank, 2003.

<sup>60</sup> Summary report Roma Health Workshop World Bank/OSI. Budapest, 2004.

- services should be mainstreamed and comprehensive, and strategies should be long-term;
- investments should be made in building the capacity of the Roma population;
- networking is crucial;
- a gender perspective should be maintained in the development and implementation of all programs;
- an independent investigative body should be established within the government in order to investigate reports of discrimination;
- informational and educational programs for the community and medical staff should be provided;
- in service training for health care workers is needed in order to sensitise them to special needs of vulnerable populations.

#### Reports and actions from within other EU countries

Roma live in nearly all countries of Europe, where they may also be identified as 'travellers'. Parry et al. carried out an in-depth study of 293 Gypsy Travellers in England<sup>61</sup>. They found Gypsy Travellers to have a significantly poorer health status and significantly more self-reported symptoms of ill-health compared to other UK residents, English speaking ethnic minorities and economically disadvantaged UK residents.

Parry et al. found an inverse relationship between health needs and the use of health services. Travellers' health beliefs and attitudes demonstrated a cultural pride in self-reliance, a stoicism and tolerance of ill-health, nihilistic attitudes to illness, and a deep-rooted fear of cancer or other

diagnoses perceived as terminal leading to an avoidance of screening. Self-reported anxiety, chest pain, respiratory problems and arthritis were more prevalent, and there was an excess prevalence of miscarriages, stillbirths, neonatal deaths and premature death of older offspring. Poor housing accommodation was identified as the overriding factor in the context of health effects. Widespread communication difficulties were reported between health workers and Gypsy Travellers, as was a reluctance of general practitioners to register Travellers or to visit sites.

In Ireland, the poor health status, high infant mortality and low life expectancy of travellers, coupled with disconcerting data on services access, led to the development of a national Travellers Health Strategy<sup>62</sup>. The strategy stresses the right of travellers to have their culture recognised in the planning and provision of services. The involvement of Travellers in the delivery of services is considered crucial in bridging the gap between the Traveller community and access to health services.

The strategy proposes as many as 122 actions, which can broadly be summarised as follows:

- Establishment of active partnership between Travellers, their representative organisation and health service personnel in the provision of services;
- Awareness training for health personnel in relation to Traveller culture, including Traveller perspectives on health and illness;
- Strengthening of Traveller Health Units comprising Health Board staff and Traveller representatives, with re-

<sup>61</sup> Parry G, Van Cleemput P, Peters J, Moore J, Walters S, Thomas K and Cooper C. The Health Status of Gypsies & Travellers in England: a report to the Department of Health. Sheffield, University of Sheffield, 2004.

<sup>62</sup> Irish Ministry of Health and Children. Traveller Health – a National Strategy 2002 to 2005. Dublin, MHC, 2002.

sponsibility for planning and implementing the strategy locally.

- Development of initiatives to increase Travellers' awareness of mainstream services and make these more accessible;
- Provision of designated public health nurses to work specifically with Traveller communities;
- A Traveller Needs Assessment and Health Status study, the results of which are to inform future actions;
- Establishment of a liaison arrangement between relevant government ministries, local government and Travellers organisations;
- Replication of Primary Health Care for Travellers project (see also below).

Across Ireland, specific 'Primary Health Care for Travellers' projects have been set up since 1994. The recruitment and training of 'community health workers' drawn from the Traveller community itself are key features of these projects, as is a good balance between the support from community development and health professionals. The community health workers collaborate with public health nurses, dentists and other health professionals in providing community-based primary health care<sup>63</sup>.

### III. 4 Women

#### Poverty risks

Women are generally at greater risk of living in a poor household: in 2001, 16% of adult women (aged 16 years or more) had an income below the poverty threshold, against 13% of men in the same age group<sup>64</sup>. This pattern is consistent across all Member States, with the widest differences being recorded in Austria, Finland and the United Kingdom. Austria and Finland, together with Ireland, also display the largest gender gaps in terms of persistent poverty risk.

The risk of poverty is comparatively greater for women aged 65 years and over: 21% as compared to 16% for men in the same age group for the EU as a whole<sup>65</sup>. Across the EU, around a quarter of women are now over the age of 60 compared with only about 18% of men and this predominance is especially marked among those in the over 80 group. Since many women appear to be especially disadvantaged in old age this raises important questions with regard to access, quality and affordability of health and social care services for older people<sup>66</sup>.

By household type, the risk of poverty is highest among single parent households (35% for the EU average), most of which are headed by women. In the United Kingdom, the exposure to the poverty risk for single parent households, which represent a relatively high proportion of all households, is particularly high (50%). Also those living in large households with three or more dependent children are particularly exposed to income poverty risk, with Ireland, Italy,

<sup>63</sup> Quirke B and Fay R. Mainstreaming Equality Case Study: Travellers' Access to the Health Service. Dublin, Pavee Point, 2000.

<sup>64</sup> Except for single person households, gender gaps in poverty risk need to be interpreted with caution, since they rely on the assumption of equal sharing of income within the household.

<sup>65</sup> Eurostat, 2001.

<sup>66</sup> Tamsma N. Advancing Integrated Care for Older People through EU Policy. Dublin, EHMA, 2004.

Spain and Portugal displaying the highest risk (between 34% and 49%, against a EU average of 27%).

### Gender differences

Because women are more at risk of poverty and social exclusion compared to men their specific needs with regard to health care access and responsiveness are discussed here. This is not to suggest that men do not have specific health needs, not that these needs are not important to be addressed. Gender affects health status of men and women differently. Also, men are more vulnerable to ill health from an earlier age, and tend to take more risk with their health. Overall, they are also more reluctant to contact the health system<sup>67</sup>.

There are no societies in which women are treated equally to men, and these social inequalities resonate in women's health<sup>68</sup>. Many of the health problems women face are not related in any direct way to their specific biological characteristics; depression and the consequences of domestic violence being two striking examples. Although men are more likely than women to die prematurely, women experience more chronic ill health, distress and disability compared to men, especially in old age<sup>69</sup>. This is particularly relevant given older women's higher risk of poverty in this phase of their life (see above).

Self-reported illness and disability do show marked gender differences. At all ages, and across EU Member States, women are more likely than men to perceive their health as bad or even very bad (Eurostat, 2001).

### Women's health problems

Health issues of particular relevance to women include eating disorders, HIV/AIDS –to which women are more vulnerable than men-, heart disease, and osteoporosis. Reproductive health, and violence to women are also important women's health issues<sup>70</sup>. Migrant women are more likely to have reproductive and mental health problems and to have experienced domestic violence. Factors that could play a role here are poverty, geographical and cultural mobility, cultural and language problems limiting access to services, and racism<sup>71</sup>.

### Access to health services

Gender inequalities may affect women's use of health care and the quality of the services they receive. While women may be offered equal access to health care, their actual use of health services may be hindered by a number of gender related factors which are likely to affect poor women in particular. These include lack of culturally appropriate care, lack of transport and lack of substitute care for dependents. When women do get access to care there is evidence that they may receive treatment which is technically inferior to that received by men and/or that services to women may be delivered in less respectful ways<sup>72</sup>.

Quality of services may be influenced by the fact that biomedical research and practice often ignores the fact that men and women are biologically different. Doyal discusses the impact of this phenomenon on the treatment of coronary health disease, where many epidemiological studies

<sup>67</sup> Center for Health, Ethics and Society. Gender and Health: a call for action for EU policy mainstreaming. Draft report, October 2004.

<sup>68</sup> United Nations Development Programme. Human development report 1995. New York, UNDP, 1995

<sup>69</sup> World Health Organisation. Gender and Health; a technical document. Geneva, WHO, 1998.

<sup>70</sup> European Commission. The state of women's health in the European Community. Brussels, DG Employment and Social Affairs, 1997.

<sup>71</sup> Carballo M, Divino J and Zeric D. Migration and Health in the European Union. Tropical Medicine and International health, 13 (12), 1998, p 936 – 944.

<sup>72</sup> World Health Organisation. Gender and Health: a technical document. Geneva, WHO, 1998.

<sup>73</sup> Doyal L. Gender Equity  
University of Bristol, 2000.

and clinical trials continue to be done on all-male samples. This results in major gaps in the knowledge about the differences between disease processes in males and females. Also, preventive and curative strategies are too often applied on women when they have only been tested on men<sup>73</sup>.

Doyal (2000) suggests the European Commission could play an important role in tackling the gender bias in the production of medical knowledge, for instance by including a requirement in EU funding criteria that all applicants take sex/gender concerns seriously in their research design. The expanded role of the EU in the regulation of pharmaceutical products would offer an additional opportunity to achieve the same objective.

#### How to improve services:

According to the World Health Organisation (WHO), addressing women's poverty and addressing discrimination against women are prerequisites for improving women's health in the European region<sup>74</sup>. According to WHO all health care services should increase their sensitivity to women's health needs. Strategic action planning could support a range of measures to improve health care practice and provision for in this respect.

Health care reforms, and more specifically those reforms that focus on increasing privatisation or reducing standard packages of publicly funded care, should ensure essential women's health services such as preventative care and maternity care are sufficiently available to all women. Health care systems should undertake health promoting strategies that should include the empowerment of women and avoid medicalisation.

Measuring quality outcome of services should include the degree to which women have been provided with appropriate information to allow them to make meaningful decisions. Qualitative research evidence is needed with regard to access to and utilisation of health services and health-care-seeking behaviour of women.

WHO also stresses that health care services have an important role to play in caring for battered women and collecting evidence on the level of damage. Health care professionals require training to ensure they identify and respond appropriately to abuse. Strategies to address violence should be incorporated into health policy and integrated into models of health care. Migrant and refugee women require special attention because of their relative distance from their normal environmental social protection.

Initiatives to improve women's health, their access to health services and the quality of the services they receive can take many different shapes, forms, and approaches. One example is Transact, the Dutch centre for gender issues in health care and the prevention of sexual violence<sup>75</sup>. The centre has a national remit and builds on the knowledge and experience of a range of specific services in the area of women's health and domestic violence. As such, it was set up to mainstream this expertise into health and social services across the country. Mainly funded with government money, the centre offers advice, education and training, and information for service providers and professionals, service providers and policy makers.

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<sup>74</sup> World Health Organisation. Strategic Action Plan for the Health of Women in Europe. Copenhagen, WHO Office for Europe, 2001.

<sup>75</sup> see [www.transact.nl](http://www.transact.nl)

### III. 5 Older people

#### Demographic developments

The EU population is ageing and old age dependency rates will increase. In 2003, people older than 65 represented 16% of the EU15 population while those younger than 15 represented 17%. As the baby-boom generation reaches retirement age, life expectancy continues to grow, and fertility rates continue to stay well below 'replacement level' these ratios will shift to 18% for people over 65 and to 16% for people younger than 15. The number of people over 80 will increase by almost 50% over the next 15 years.

The population in the new EU10 countries has a younger age structure – their population aged 65 and over amounts to 13%, the population under 15's to 19%. However, in the medium and long-term its effect on the total EU population is expected to be small and temporary<sup>76</sup>. It is important to reiterate here that the majority of old and very old citizens of the EU are women<sup>77</sup>.

#### Health care and long term care for older people within the EU social agenda

The ageing of European society does present a challenge to the current health and social care sector across Member States. Consequently, health care and long-term care for older people has been identified as a fourth key theme to be tackled jointly by Member States through the Open

Method of Coordination within the framework of the Lisbon Agenda<sup>78</sup>. Social inclusion, social protection and pensions, and employment are the other three key themes. The European Commission has been presenting specific plans to streamline work on all four themes, aiming to start implementation of this streamlining process by 2006<sup>79</sup>.

Building on the results of the CARMEN project<sup>80</sup>, Tamsa pointed out that this streamlining process provides a unique opportunity to support mutually reinforcing policy frameworks with respect to social protection, social inclusion, employment, and health and social care for older people across EU Member States. It was noted that, within the broader EU social policy agenda, social inclusion and health care agenda objectives are in many ways interconnected<sup>81</sup>.

Policy instruments reducing public health care expenditure but increasing costs borne by individual citizens themselves could impact negatively on access for people with less socio-economic resources. Such policy measures also pose a danger to social inclusion objectives, as older people in need of long-term support or care may have to spend a disproportionate amount of their resources on care. In addition, older people may also be forced to sell their house or move away from their own neighbourhood, putting them at risk of social isolation. This would call for measures to prevent that poorer health will lead to impoverishment and

<sup>76</sup> Eurostat and European Commission. The social situation in the European Union 2003. Brussels, European Communities, 2003.

<sup>77</sup> Eurostat. Health statistics: key data on health 2002.

<sup>78</sup> COM (2004) 304 final. Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the 'open method of coordination'. Brussels, European Commission, 2004.

<sup>79</sup> Social Protection Committee. Work Programme 2004. Brussels, European Commission DG Employment and Social Affairs, 2004.

<sup>80</sup> The 'Care and Management of Services for Older People in Europe Network' CARMEN was managed by the European Health Management Association and funded by the EU's Vth Fr

<sup>81</sup> Tamsa N. Advancing Integrated Care for Older People through EU Policy. Dublin, EHMA, 2004.

low income, and that lack of income will then restricting access to care.

Compared to men, the need for health care and long-term care services of women is higher. At the same time, women's financial resources are often less than those of men. The financial position of older women may therefore negatively influence their access to good quality services. Older people in long-term care situations could be at risk of social exclusion, as could their informal carers. EU programmes aimed at tackling social exclusion should facilitate projects that prevent this from happening and that encourage social participation and independence.

In many European countries, health and social care system reforms lead to the retraction of many services that do not necessarily carry a 'medical flavour', such as domestic services, or leisure and social activities. Theobald perceives this as a threat to social exclusion as it takes away at least some of older people's opportunities for social participation and also may affect their feeling of competence and self-worth<sup>82</sup>.

#### Access issues at national level

Based on a cross-national comparison of community care, Tester<sup>83</sup> emphasised that establishing social rights as well as setting up national assessment procedures are a decisive factor in preventing inequality of service access based on social-economic, gender or ethnicity. The advantages of earlier life are passed on into older age and become

an important factor for gaining access to –including buying into– long-term of social care services. Tester attributes differences in access partly to the fact that –compared to health care services– there seem to be fewer social rights to community care, and in particular to housing and social care services.

Reviewing evidence of age discrimination in public policy in Britain, Grattan et al. identified several problem areas with regard to health and social services. In health care, upper age limits blocking access to services such as breast cancer screening, coronary care and cardiac rehabilitation units, and a range of medical specialist operations were found to be widespread. Also, older people have been excluded from participation in clinical trials. People in residential care were found to be at risk of exclusion from primary care services. In hospital Accident & Emergency departments, patients over 60 years old may have to wait longer and are less likely to receive appropriate treatment. Depression and other forms of physical and mental illness may be misdiagnosed as symptoms of dementia, while dementia itself may go unrecognised<sup>84</sup>.

In Sweden, the strengthening of local responsibility for elderly care that allows municipalities the freedom to make decisions on the scope and volume of services has increased unequal access to care. This had led to central government intervention, introducing upper fee limits that municipalities can charge for their care services.<sup>85</sup>

<sup>82</sup> Theobald H. *Social Exclusion and Care for the Elderly*. Research Report: EU project CARMA. Berlin, 2003.

<sup>83</sup> Tester S. *Community Care for Older People: a comparative perspective*. Basingstoke, Macmillan, 1996.

<sup>84</sup> Grattan P, Groombridge B, Harding T, Henwood M, Howard M, Metz D, Roberts E, Soulsby J. *Age Discrimination in Public Policy: a review of evidence*. London, Help the Aged, 2002.

<sup>85</sup> Trydegard G-B. *Swedish elderly care in transition*. Paper presented at the 2003 ESPAnet Conference. Copenhagen, 2003.

### What can be done

The CARMEN project was concerned with integrated care, looking at the whole spectrum of health and social services and their contribution to client-centred provision. At policy level, the results emphasised the importance of a broad focus on services for older people including perspectives on empowerment, prevention, social values such as equity and solidarity, and the role of informal carers. Older people should be seen as assets and not just as a 'burden'<sup>86</sup>.

Policies should be set within a broader positive context which promotes health, active life and independence, combats age discrimination, and sees older people as individuals and not as a uniform group. National policies should also reinforce active ageing, citizenship and inclusive and non-discriminatory approaches. Older people should be directly involved in the development of policies at local, national and European levels .

Policies aimed at empowering older people in their role as 'clients' of health and social services tend to focus on developing instruments that seem better suited for clients with more social, intellectual and physical resources befitting the role of critical consumer. A disproportionate percentage of services, however, are needed by frail, very old people with multiple needs. Tamsma (2004) pointed out that solutions should therefore focus on establishing a client-centred system with a range of attractive and suitable

options for all older people, including vulnerable people with multiple needs, regardless of socio-economic status, ethnicity, gender or lifestyle.

Policies that seek to increase choice by encouraging older people to become purchasers need to go hand in hand with mechanisms that provide them with the necessary information and support to take on this role. If this does not happen these policies may lead to increased inequalities in access. People with less education, verbal skills, assertiveness, or socio-economic resources may be particularly vulnerable in this respect.

In the UK, the National Service Framework for Older People<sup>88</sup> includes the obligation for all NHS organisations to review any age-related policies and to justify them on clinical grounds. The framework rejects any explicit exclusion of older people from effective treatments. It contains a wide range of policy recommendations and also forms the backbone of many good practices aimed at improving services for older people, including arrangements to ensure services are more equitable, accessible and responsive.

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<sup>86</sup> Commission DG Employment and Social Affairs. Guidelines to Call for proposals VP/2004/006.

<sup>87</sup> Banks P. A Policy Framework for Integrated Care for Older People. London, King's Fund, 2004.

<sup>88</sup> Department of Health. National Service Framework for Older People. London, DoH, 2001.

<sup>89</sup> Lavikainen J. Future Mental Health Challenges in Europe: the Impact of Other Policies on Mental Health. Report of the consultative meeting, Brussels, 3-4 September 2001. Helsinki/Brussels, Stakes/DG SANCO, 2001.

### III.6 People with mental health problems

#### Cross-national appeals to advance social inclusion

Mental health experts from various EU Member States expressed the urgent need for EU policies –and also the EU social policy agenda- to not only focus on social exclusion but explicitly move towards a more integrated policy approach in order to foster the social inclusion of people with mental health problems<sup>89</sup>. Two paradoxes were recognised. Firstly, social exclusion can be a determinant of mental disability, yet mental disability can itself be a determinant of social exclusion. Secondly, economic downturn may lead to increased mental disability, but a high level of economic progress may give rise to work stress and work pressure which in turn may lead to mental disability.

Social welfare policies should accommodate for the prevention of stigmatisation and improvement of social inclusion of people with mental health problems. They should take other challenges into account, for instance with regard to employment, housing, and welfare. Opportunities for upgrading work skills, for life long learning, and increasing knowledge may all enhance opportunities for people with mental health problems. The availability of appropriate housing for people with mental health problems demands a cohesive society with strategies for combating public stigmatisation, discrimination and ignorance. Benefits and welfare payments have to be provided in an equitable manner without discrimination by reason of mental health problems.

#### Addressing the issues: an example from the UK

In the UK, the government has been trying to clarify what can be done to reduce social exclusion among adults with mental health problems. More particularly, questions were asked as to how this group of people could enter and retain work, and how equal opportunities for social participation and access to services can be ensured for them<sup>90</sup>.

It was acknowledged that mental health problems often lead to and reinforce social exclusion. Stigma and discrimination impact on employment opportunities. At the same time, health and social care professionals have low expectations of what their clients with mental health problems can achieve. With regard to this mechanism, it was recognised that many professionals do not see employment as a key objective for people with mental health problems. There is only limited recognition in the NHS that retuning to work and overcoming social isolation is associated with better health outcomes.

Within the statutory sector there is lack of clear responsibility for promoting vocational and social outcomes for adults with mental health problems. There is also insufficient ongoing support to enable people with mental health problems to work. At the same time, they may encounter barriers to engaging in the community, for instance in participating in education, sports, art or leisure activities, or even with accessing basic need such as housing and transport.

Ethnic minorities, young men, -single- parents, and adults with complex needs were identified as facing particular barriers to getting their mental health and social needs addressed. The UK report stressed the role of health and

social care in tackling social exclusion and the importance of early access to mental health services regardless of age, ethnicity, gender or social status.

More action was suggested through health and social services. This would require vocational services to be modernised, providing everyone with mental health problems with access to an employment adviser and to social support. Day services provided by mental health services should for make more effort to promote social inclusion, and primary care services should facilitate access to vocational and social support. The report also called for measures to tackle inequalities in access to health services and for training health and social care professionals.

### III.7 Conclusions from part III

People at living under conditions of poverty or social disadvantage may come from very different backgrounds, but have in common that they are disproportionately more at risk of ill health. In itself, this would be sufficient reason for the health system to ensure the needs of these groups in terms of access and responsiveness are being met. Recognising that many excellent efforts are indeed being made, much work still remains to be done to safeguard steady and sustainable improvement of service access, responsiveness and quality.

The population groups discussed within the framework of this chapter each face their own particular challenges with regard to their health and the health care system. Measures to tackle these challenges have to accommodate for

this diversity. Yet, on a more abstract level, it is possible to distinguish common themes that would feature in a more responsive health system for all. Awareness of the current socio-economic bias within health care provision and research, respect for diversity, efforts to improve communication, linking with communities, a client focus, and staff training are all examples of this.

The interconnectedness of health and social policy agendas at national and EU level has again emerged as a key issue. While the importance of intersectoral collaboration in achieving health improvement objectives has long been recognised, interlinking national and EU policy objectives could help overcome the negative health consequences of poverty and social exclusion. Similarly, the health sector can contribute significantly to achieving objectives aimed at reducing poverty and social exclusion.

# PART IV

## PART IV.

# ANALYSIS OF NATIONAL ACTION PLANS AND EC JOINT REPORTS ON SOCIAL EXCLUSION

### IV. 1 Introduction

In Part I of this report, it was suggested that the health care sector could contribute positively to all six bipolar relationships between health, poverty and social exclusion, as illustrated by Stegeman and Costongs<sup>91</sup>:

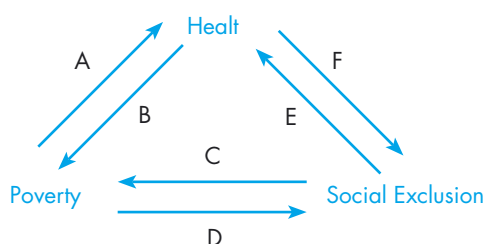


Fig. 1: Relations between health, poverty and social exclusion

In analysing the National Action Plans, this report will use these six bipolar relationships, particularly to address the following key questions:

#### A: Preventing poverty leading to poorer health:

- » To what extent do the NAPS address access to and affordability of services, removing financial obstacles, particularly where they disproportionately affect disadvantaged populations?
- » To what extent do the NAPS address equal availability and accessibility of services in areas/localities with a poorer and/or more socio-economically deprived or otherwise disadvantaged population?
- » To what extent do the NAPS guard against regional inequalities in systems that rely on local authorities' spending power?

#### B: Preventing poor health leading to poverty:

- » To what extent do the NAPS ensure that the health system protects people in greater need of services, such as older people or people with chronic illness against income-related effects of service utility?
- » To what extent do the NAPS protect against adverse effects of out-of-pocket payments or other forms of co-payments, or of access to health insurance?
- » To what extent do the NAPS ensure that carers' allowances and other forms of financial support for informal carers can prevent carers falling in a poverty trap?
- » To what extent do the NAPS ensure adequate health services for people in long-term unemployment and/or on long-term sick-leave, helping them to get back to work and a steady income?

#### C: Preventing poverty leading to social exclusion:

- » To what extent do the NAPS ensure that the primary care sector provides support for community development projects; 'exercise on prescription'?
- » To what extent do the NAPS ensure that targeted service delivery, for instance aimed at children and young parents, or at people with mental health problems, help prevent people from getting caught in the downward spiral of poverty and social exclusion? (see also D):

<sup>91</sup> Stegeman I and Costongs C. Health, Poverty and Social Inclusion in Europe: literature review on concepts, relations and solutions. Brussels, EuroHealthNet, September 2003.

#### D: Preventing social exclusion leading to poverty:

- » To what extent do the NAPS ensure that there are no financial barriers to access targeted services for people in disadvantaged positions, such as drug users, sex workers or people with mental health problems?
- » To what extent do the NAPS ensure that employment schemes in the health care sector include accreditation of prior learning, flexible working arrangements, and opportunities to combine work and caring responsibilities?
- » To what extent do the NAPS ensure that equal opportunity and anti-discrimination policies exist for those applying to work and those already employed in the health care sector?

#### E: Preventing social exclusion leading to poor health:

- » To what extent do the NAPS ensure that services are responsive and culturally sensitive to people living in poverty, people with special needs, people at risk of discrimination and social exclusion and/or people from disadvantaged communities?
- » To what extent do the NAPS support patient empowerment and participation, feedback panels?
- » To what extent do the NAPS ensure the provision of children's support services, support for young families?

#### F: Preventing poor health leading to social exclusion:

- » To what extent do the NAPS ensure support for people with mental health problems against possible stigmatisation?
- » To what extent do the NAPS ensure the existence of sensitive services for older people, chronically ill people and people with special needs?

i. **Affordability:** To what extent do the NAPS address affordability of health care services, removing financial obstacles, particularly where they disproportionately affect disadvantaged populations (adverse effects of out-of-pocket payments, other forms of co-payments, access to health insurance)?

ii. **Accessibility:** To what extent do the NAPS address accessibility of health care services (socially-deprived areas, rural remote areas, disadvantaged communities, ethnic minorities, regional inequalities)? It should be noted that, in this report, accessibility refers to physical access rather than financial access, which is considered under "affordability".

iii. **Responsiveness:** To what extent do the NAPS address and target the specific health care needs of particular groups of poor or socially excluded people (homeless, addicts, women and children, disabled people, older people, travellers, migrants and ethnic minorities, chronically sick and/or unemployed people, people with mental health problems, carers)?

iv. **Quality:** To what extent do the NAPS ensure that health care services meet the needs of poor or socially excluded people to the same quality levels that apply to other sectors of society?

This section of the report will analyse each of five NAPS (Ireland, Spain, Sweden, Poland and the Netherlands) in relation to these four key measures and will then conclude with some general recommendations linked to the EC Joint Reports on Social Inclusion.

These questions can be condensed into the following four key measures to analyse the extent to which the NAPS address inequalities in access to health care services:

## IV. 2 Ireland

### Affordability

The Irish NAP for 2003-2005 has relatively few references to affordability of healthcare, except to state (paragraph 1.8.2) that:

“Residents on low incomes in Ireland are entitled to receive the full range of health services free of charge. Just under 30 % of the population are currently in this category. The remainder of the population has access to public hospital services subject to modest statutory charges. Approximately 47% of the population have private health insurance.”

While, at first glance, it would appear that Ireland ensures that the health care costs of poor people are fully met, it should be noted that the statement does not define “low incomes” and, in particular, does not indicate any relationship between the income level, poverty levels or inflation. Furthermore, if “just under 30% of the population” are currently entitled to receive the full range of health services free of charge and a further 47% of the population have private health insurance, this begs the question whether the other 23% of the population have inadequate health care coverage and, if so, whether some of these people are falling into a health care poverty trap.

The report goes on (para 3.3.1) to state that “the strategy on access to services being pursued over the period to 2007 includes the development of more formal expressions of entitlement across the range of public services...”. Such a development would be welcome, particularly if it ensures that socially excluded groups, who often lack knowledge of their entitlements, will become better informed. In paragraph 4.3.5, the development of more formal expressions of entitlements is elaborated in relation to primary medical care:

“Issues such as barriers to uptake, information deficits and transparency in relation to income guidelines, are being addressed in relation to eligibility for health and personal social services as well as a review of all existing eligibility legislation. Proposals will be drafted to clarify legislation on eligibility and entitlements in line with the goals and objectives of the National Health Strategy.”

The only reference in this report to any major new funding initiative in respect of health care is the statement (para 4.5.3) that “consideration is being given to the findings of a study to examine the future financing of long-term care in Ireland, which has recently been published.”

### Accessibility

Accessibility issues are clearly identified as a major issue in the Irish NAP. The core objective of the strategy, as set out in *Sustaining Progress* is “to build a fair and inclusive society and ensure that people have the resources and opportunities to live life with dignity and have access to the quality public services that underpin life chances and experiences.” (para 3.1.1)

Paragraph 1.8.2 explores the problem of acute hospital waiting times. While indicating that waiting times have fallen, the report acknowledges that there is “considerable ‘catching up’ to do in terms of health infrastructure” and establishes the policy task “to improve access to services for the less well off”. The National Health Strategy set a target for the reduction, by the end of 2004, of waiting times to three months for treatment following referral from outpatient appointments. While this target is encouraging, it does not address the problem of waiting times between initial referral from the GP and outpatient appointment.

Later in the report (para 4.3.5) the statement that “greater surveillance and monitoring of the public/private mix is being undertaken to protect access by public patients to acute hospitals” implicitly recognises that problems of access to acute hospitals by public patients currently exist. There is, though, no indication of how this surveillance and monitoring will be done, or how access by public patients will be protected. In Annex 2 (Review of progress during the 2001/3 NAPs), paragraph A2.3.3 states that:

“Management of the public/private mix in acute hospitals is important to ensure that those who depend on the public system are not disadvantaged. Closer monitoring of the mix of elective activity at hospital level is the key to ensuring equity for public patients. Current bed designations show that the ratio between public and private beds stands at 80/20. In general the ratio between public and private patients is operating reasonably well in the case of emergency admissions. The position regarding elective or planned admissions is less satisfactory. In 2001, 30% of the elective admissions to public hospitals were private while 70% were public patients.”

The acknowledgement of the problem in relation to elective or planned admissions is welcome, although an explicit target to adjust the ratio from 70/30 to 80/20 would be desirable.

In Section 3.3.1 – Access to Services – the strategy over the period to 2007 includes

- » Monitoring, by means of indicators, access to services of a given standard and working to improve performance over time;
- » Continuing to pursue a much greater focus on effective outcomes and on indicators to monitor outcomes, particularly in relation to the drive for integrated approaches

- to the problems of disadvantage at local level; and
- » Driving forward, in a comprehensive way, the range of proofing mechanisms (poverty, equality and others) necessary to ensure that policies and programmes are developed in such a way as to achieve the maximum impact in reducing and eliminating poverty and social exclusion.

While these are laudable objectives, it is very noticeable that, unlike most of the other sections in this chapter on the strategic approach, this section does not contain key targets. It will therefore be difficult to measure the extent to which the strategy has succeeded.

While the National Action Plan addresses the needs of urban disadvantage, rural decline, migrants and ethnic minorities, the relationship between these issues and access to health care is not made in any specific manner, and nor is there any reference to regional inequalities within Ireland. While a key target in relation to urban areas (para 3.5.7) is to “ensure that the basic needs of all families, especially young parents, lone parents, older people, and ethnic minorities are met through enhanced and better coordinated State support services” once again the connection with health services is not explicit. However, the key target in relation to rural areas is rather more explicit: “improve access to employment, health, education and housing services for rural dwellers” although there is no clear indication as to how this might be achieved.

Clearly, Ireland’s smaller towns and especially its rural communities face physical access problems in relation to health services but, while the NAP identifies accessible transport in both urban and rural areas as a policy task, the crucial connection with health care accessibility is not made, except that a transport action plan is being pre-

pared for the further development and implementation of accessible transport services for people with disabilities.

### Responsiveness

Ireland's NAP targets the specific health care needs of some groups while ignoring others.

The needs of both lone parents, older people and carers are well addressed, although this comes under heading of "care" rather than "health" – a boundary that is difficult to define. Paragraph 1.8.3 states that:

"The increase in female participation in the workforce, in particular, has given rise to significant problems in the provision of care. This affects both the carers and those receiving the care. The availability of high quality and affordable childcare greatly influences employment participation rates especially of lone parents and may also influence birth rates. The ageing of the population, including increasing longevity, also leads to greater demands for care for older people."

The plan goes on to identify the policy task of developing "an infrastructure of care services that seeks to achieve a proper balance between the respective roles of families, the State, the private sector and voluntary organisations". However, once again, the specific and crucial connection with health care is not explicitly made.

Similarly, while the plan addresses the needs of homelessness, alcohol and drug abuse, migrants and ethnic minorities, their specific health care needs are not considered. This is an extraordinary omission from the Irish NAP. The only specific reference to the health needs of refugees and asylum seekers is that (para 4.5.8) "A three year Health Research Board Fellowship has been awarded to explore the health and social care needs of refugees and asylum seekers in Ireland and to gather information about the per-

ceptions and needs of primary health care providers to deliver care to this community in a culturally sensitive manner". While, of course, the primary health care needs of refugees and asylum seekers in Ireland are very important, their specific needs (and those of other ethnic and minority groups) for acute, secondary care are also important, but these have not been identified in the NAP.

In contrast, the health care needs of young children, older people and their carers, people with disabilities, travelers and some particular illnesses are specifically addressed, as follows:

- » **Young children** (para 3.5.2): "Better medical and health services within the community for young children and their parents."
- » **Older people** (para 3.5.3): "By 2003, national guidelines will be put in place for the provision of respite care services to carers of older people. Access to orthopaedic services will be improved so that no one is waiting longer than 12 months for a hip replacement. This is an initial short-term action to improve quality of life for older people and it will be reviewed in 2003." The NAP also (para 2.4.1) refers to improved financial and leave arrangements for carers.
- » **People with disabilities** (para 3.5.4): "The Department of Health and Children is to ensure that, within each Health Board, there is sufficient rehabilitative training provision, both numerically and qualitatively, to meet the demand for training which focuses on the development of an individual's core personal capacities (i.e. life skills, social skills etc.) to each individual's level of capacity. A rehabilitative training policy document will be produced and circulated as part of the Department's 2003 Business Plan. One of the specific targets is to improve access to planned respite care for carers of disabled people by 2003."

Paragraph 4.5.4 indicates that “The Department of Health and Children will carry out a strategic review of existing service provision, with a view to enhancing health and personal social services to meet the needs of people with disabilities”.

- » **Travellers** (para 3.5.5): “The overall objective in relation to Travellers is to improve the life experience of Travellers through the provision of appropriate education, health and housing services and to remove any remaining barriers to the full participation of members of the Traveller Community in the work and social life of the country. One of the key targets in relation to Travellers is that the gap in life expectancy between the Traveller Community and the whole population will be reduced by at least 10 % by 2007.”

Paragraph 4.5.5 indicates that a Study Group has been established to progress an All-Ireland Traveller Needs Assessment and Health Status Study that it is expected will commence in early 2004. It will involve both quantitative and qualitative research methods. Two key elements include measurement of the health status of Travellers and an evaluation of health needs, as identified by Travellers and service providers.

- » **Key targets – circulatory diseases, cancer, injuries and poisoning, and low birth weights** (para 4.3.5): “The Cardiovascular Health Work Programme aims to ensure equity of access for poor and socially excluded groups, in particular in relation to health promotion, secondary prevention programmes in general practice and access to hospital and rehabilitation services. A new National Cancer Strategy is being developed in the light of service and clinical developments since 1996. Deadline for completion is early 2004 and it will set key priorities for the coming years. The national breast screening programme BreastCheck (currently operating in three health board areas) is being extended nation-

wide and approximately 150,000 women in the target population 50 to 64 years of age will be eligible for screening. Development of an Injury Prevention Strategy has also commenced. To reduce the difference in low birth weight between highest and lowest socio-economic groups action will be co-coordinated in relation to a) health promotion on nutrition, smoking and alcohol use during pregnancy, b) reducing teenage pregnancy and c) encouraging early attendance for ante-natal care.”

It should be noted that there are significant variations in the detail of the targets set for the above groups. While some are merely aspirational, others are detailed and specific.

#### Quality

In November 2001, the Irish Government published a major national health strategy focusing on quality issues titled “Quality and Fairness: A Health System for You”. The key principles underpinning the strategy are equity, quality, accountability and people centredness. Key objectives under the Health Strategy include “placing the health of the population at the centre of public policy, and reducing health inequalities.” Key targets to reduce health inequalities are as follows:

- » Reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10% for circulatory diseases, cancers and injuries and poisoning by 2007.
- » Reduce the gap in low birth weight rates between children from the lowest and highest socioeconomic groups by 10 % from the 2001 level, by 2007.

The NAP (para 2.5.6) also indicates that “A series of performance indicators has been developed in the Health Sector. These are now in use in association with the annual

Service Plan, which is a legislative requirement for all regional health boards. Performance indicators for services for a wide range of vulnerable groups are included e.g. for Travellers, the homeless, people with disabilities, asylum seekers, drug users, children and the elderly. Refinement and improvement of these indicators will continue in 2003–2005.”

Paragraph 4.3.5 also identifies that, under the health strategy “Health impact assessment (HIA) will be developed to ensure that relevant policies, strategies and legislation undergo a comprehensive process of health proofing so that their impact on the physical, mental and social well being of the population is positive.”

## Conclusions

While this detailed analysis of the Irish National Action Plan demonstrates that the health care sector is contributing to the reduction of health inequalities and to tackling social exclusion, it is also clear that the NAP does not adequately consider how health care services might reduce health inequalities by responding in a coherent manner to the needs of either poor people or socially excluded groups.

## IV. 3 The Netherlands

### Affordability

The Dutch National Action Plan for 2003-2005 places a strong emphasis on employment policies as a means of addressing financial poverty. Their argument is that by gaining access to the labour market (“reintegration”), poverty diminishes and – in health care terms – people will be able to afford sickness insurance.

The NAP specifically addresses “affordability of provisions” under “Main objective 3 – promoting the accessibility of provision in the fields of.....care....”. Here it is stated that:

“All residents in the Netherlands, irrespective of income, are legally insured against ‘uninsurable’ health risks and long-term nursing and care. For the provision of specific services a contribution is requested which is often income-dependent. Various forms of insurance currently exist for curative care, both via private care insurers and through health insurance funds. People with a (below) average income – which includes those entitled to benefits – are ‘automatically’ insured through a health insurance fund.

From January 1st 2006 a mandatory standard insurance for curative care is to be introduced. Every adult will pay a nominal premium, with an obligatory excess, or ‘own-risk’. A care surcharge will provide ongoing compensation for health costs which are too high in relation to family income (premium costs plus own payments). In an effort to limit the increase in health cost premiums, a decision was made to limit the insurance package in the so-called Algemene Wet Bijzondere Ziektekosten (AWBZ – General Act on Exceptional Medical Expenses) and health insurance fund to 1 billion euros. Furthermore in anticipation of the intended system change, an excess or ‘own-risk’ has been introduced into the Ziekenfondswet (ZFW – Health Insurance Act). In the income policy the cabinet will take account of the consequences of these measures for the chronically ill, the disabled and other vulnerable groups, partly because within the tax estimate more room exists for the fixed deduction of exceptional costs by the chronically ill and disabled persons.”

It is not clear, from this description, whether the mandatory standard insurance for curative care which is to be introduced from January 2006 will provide the same automatic entitlement to benefits for people below average income as currently exists or whether the 1 billion limit to the AWBZ

will have negative consequences for people either in poverty or those who are socially excluded.

Nevertheless, the point is made that:

“Most vulnerable are those with an accumulation of poverty risks (for example a combination of poor labour market status, problematic debts, low educational level, homelessness and health problems). These are people with multiple problems which often have a non-financial background, of which the exclusion situation and the lack of resources are the result. Merely providing financial support for such groups with complex problems is not sufficient.”

### Accessibility

Unlike the Irish NAP, accessibility to health care is only occasionally mentioned in the Dutch NAP, perhaps because the major focus is on reintegrating people into the labour market. However, the report does recognise that availability of services (including health care) is a problem for at-risk groups:

“For certain risk groups the non-availability or lack of timely availability of provisions (for example ..... long waiting-lists) produces an increased risk of poverty. Those involved are the illiterate, clients of the mental health care sector, addicts, ethnic minorities (newcomers and the longer-established), the homeless and women needing shelter.

The poverty policy aims at ensuring that the abovementioned risk groups can make use of the provisions necessary for them to a sufficient degree and on time, in order to prevent them running high(er) risks of poverty.”

Appendix I “Common objectives in the fight against poverty and social exclusion” states (para 1.2 (c)) that it is necessary:

“to put in place policies which aim to provide access to all to healthcare appropriate to their situation, including situations of dependency.”

Unfortunately, the Dutch NAP does not elaborate on this aspiration.

The waiting list problem is mentioned on several occasions in the NAP as a pressure point which can lead to exclusion from the basic provisions, thereby creating risks of poverty:

“The Netherlands has a wide and variegated offer of provisions for preventive and curative physical and mental health care and care for the disabled. In principle these are accessible to everyone who needs care. Because demand is greater than supply, there are waiting times for access. In order to prevent poverty and social exclusion it is particularly important to counter the waiting-lists for mental health care (GGZ) and care for the disabled. With GGZ clients non-timely attention and treatment can lead to further marginalization. For the disabled the absence of care would mean a serious impediment to function independently.”

However, when it comes to specific waiting list targets, while there is a target (table 2.5) to reduce mental health care waiting-lists (but with no specific figures) and for disabled people (with figures), no attention is paid to those in financial poverty.

There is also no mention of access improvements for rural communities – but this may well be a reflection of the high population densities in the Netherlands and the existence of an effective transport infrastructure. This contrasts markedly with the Polish NAP which focuses strongly on the needs of deprived rural communities.

## Responsiveness

The Dutch NAP identifies specific risk groups for the 2003 NAP – ethnic minorities, older people (55 plus) and, to a lesser degree, one-parent families and single households. The point is also emphasized that an accumulation of poverty risks occur more frequently among women such as single, older women from ethnic minorities. The report goes on to elaborate the categories of people with accumulated risks:

“The most vulnerable are those people with an accumulation of poverty risks. Broadly speaking these are: the homeless, addicts, people with a mental disability, people with chronic psycho-social problems and people with (chronic) poor health. These multiple problems are particularly relevant in the field of social relief, debt problems, socio-economic health differences and reintegration policy. A coherent linked approach is important here, whereby the various provisions of care and reintegration are interlocked.”

Improving the position of the most vulnerable by providing an integrated service (customised approach) is the focus of Main Objective 4, with specific targets to encourage municipalities and/or executive bodies to offer target groups with complex multiple problems an integrated, interlinked package of care and reintegration, aimed at achieving paid employment or independent participation. A further target is to improve the health situation of those with low socio-economic status by extending their life expectancy by three years (from around 53 to 56 years) in 2020. Regrettably, these targets are short on specifics. How such an integrated service is to be achieved is not stated, nor is it clear how the extended life expectancy will be realized. Clearly, health services have a major role to play in both these targets, but the connection with health care is inadequately made in the NAP. The report rightly states that “the health situation can be both the cause and result of poverty and social exclusion, and it indicates that:

“an interdepartmental implementation programme has been drawn up with concrete measures and investments aimed at improving the health condition of people with a low socio-economic status (SES). Its publication will take place simultaneously with the Prevention Policy paper 2003-2006. The target in this programme is the extension of the life expectancy of people with a low SES from around 53 years (in 2000) to 56 years (in 2020). This will be achieved by diminishing differences in education, income and other socio-economic factors (see elsewhere in this NAP), combating the negative effects on health of low education and income, and improving the accessibility and effectiveness of health care of and for people with a low SES. There is the matter of differences between men and women in the target group (people with a low SES), whereby women (still) score more positively in terms of health conditions and life expectancy.”

However, while improving the accessibility and effectiveness of health care of and for people with a low SES is part of the policy, there is no indication of how this policy will be implemented. Apart from mental health care and care for the disabled (see 3.2 above) the report does not respond to the specific health needs of ethnic minorities, the homeless, older people or any other socially excluded group.

## Quality

The Dutch NAP makes no reference to the need to ensure that health care services meet the needs of poor or socially excluded people to the same quality levels that apply to other sectors of society.

## Conclusions

The approach taken in the Dutch NAP focuses primarily on increasing social participation in the form of paid work, guaranteeing a minimum income for people who cannot support themselves independently, promoting accessibility of provisions, providing an integrated service for the most vulnerable, and encouraging active input and collaboration between all stakeholders. It is also made clear that the NAP has set itself limited targets because choices have to be made. Nevertheless, given that the Plan calls for a linked approach with regard to risk groups with multiple problems, specifically stating that “it is essential to devote attention to the entire chain of services/provisions from (different) executive organisations”, it is remarkable that the NAP pays scant attention to health care. It certainly gives the impression – perhaps falsely - that policy makers do not recognise the key role that health care can play in combating poverty and social exclusion.

## IV. 4 Poland

The Polish health care system is in the midst of major reform. According to the Polish NAP for 2004-2006:

“In 2004 – 2006 the health care contribution will be increasing which means that the financial abilities of the system will also increase. At the same time financial and organisational restructuring of the health care institutions will be carried out and the principles of operation of public health care institutions will be changed. The draft law on public aid and restructuring of public health care institutions regulates the principles of: financial restructuring, developing and implementing restructuring programmes, change of the organisational structure, personnel and property management. Thanks to the transformation of the independent public health care institutions into public utility corporations the ownership supervision of the institutions will improve, which

should result in increased efficiency and better financial management as well as improved quality of the health care services offered by these institutions.”

While it is clear that major changes are currently under way, it might perhaps be optimistic to assume such a strong connection between cause and effect, particularly in such a short period. Nevertheless, these structural changes may have some impact on affordability, accessibility, responsiveness and quality.

### Affordability

The NAP demonstrates that there is a clear shift from the public to the private sector (para 1.7):

“The falling number of public health care facilities (in 2001 by 20%) and employment in health care is counterbalanced by the creation of non-public health care facilities (in 2001 an increase of 95%).”

The conclusion is drawn that:

“The health status of the poor population may be lower owing to lack of financial resources to obtain quality health treatment. In 2002, 30% of people refrained from purchasing drugs due to insufficient means.”

This is a remarkably clear demonstration that health care in Poland is failing to address the needs of the poor population and that, inevitably their health is suffering, thus diminishing their opportunities to overcome their poverty.

The National Social Inclusion Strategy (NSIS) includes “promoting health insurance” among its goals (Chapter 2) but it is not clear whether the needs of poor people, who might not be able to afford health insurance, are addressed within this goal. However, under the chapter on social policy instruments, Action 1.3 states that:

“Ensuring universal access to health care will first of all require changes in the legislation.....The existing law...breaks the rules of...the citizens’ constitutional right of equal access to health care financed by public means due to the fact that the people who do not pay the health care contribution are not entitled to the health care.”

#### Para 1.3.1 “General access to health care” argues that:

“The systematic solutions adopted in the Law on health care services financed from the public funds will give access to health care benefits not only to people covered by mandatory health insurance (as it has been so far) but also to people not covered by it (on obligatory or voluntary basis). The law provides that persons fulfilling the income criteria ...will be entitled to health care benefits financed from the earmarked subsidy. The law also provides solutions aimed at the improvement of the accessibility and efficiency of basic health care, i.e., through adjusting the number of health care institutions to the number of inhabitants and their health care needs.”

While this law will clearly improve affordability of health care in the public sector, it should also be noted that the 20% diminution in the public health care sector (see above) will mean that there are fewer facilities available for poor people.

#### Accessibility

Accessibility of health care receives considerable attention in the Polish NAP, partly in relation to waiting lists but more particularly in the context of rural populations.

Throughout the NAP, regional differences – and relative deprivation – are highlighted, in marked contrast to the Swedish NAP. Poor rural and regional health care provision should be set in the context of higher level unemployment and poorer quality education:

“There are regions of Poland with a difficult situation (regions round post-State farms and with collapsing heavy industry) and specific enclaves of dynamically developed labour markets (mainly big towns)...but the labour market situation in small towns is difficult (the unemployment rate ca. 25%).” (para 1.1.3)

“There are strong differences between urban and rural areas. In 2003 ca. 18% rural areas inhabitants lived in extreme poverty (in small cities 11%)”

The report goes on to emphasise the strong correlation between income poverty and other types of deprivation in spheres such as accommodation, access to health care, education or culture. However, like the Dutch NAP, the Polish report emphasises that choices have to be made (under the difficult situation with Polish public finances), and the Polish NAP suggests that “particular attention should be focused on preventive measures targeted at children and youth as well as activities eliminating extreme poverty”. (Para 1.3.2)

Despite the “significant regional differences in population health, which persist and sometimes rise” (para 1.7), there are no proposals – and certainly no targets - in the NAP to address these marked regional variances, except to state that “there are actions in the Integrated Regional Operational Programme, aiming at the improvement of the infrastructure of health care services” and that “the challenge for the future is support for the access to the specialised health care for the poorest and rural areas inhabitants through, inter alia, rationalisation of the network of health care facilities as well as shortening of the waiting times for appointments”. While the NAP addresses the legal situation in relation to health care, it appears that the practicalities of delivering and implementing health policy lies with the regions:

"Actions in the field of health care policy ....are derived from the National Health Programme. Moreover, local governments will be obliged to prepare commune, district and voivodship health programmes. These will be the basis for preparing the voivodship health programmes".

Although the deterioration of the transport infrastructure and its increasing costs are seen as a cause of concern in relation to labour force mobility, the need for effective transport to enable people to access health care is not identified.

Thus, while considerable attention is given the problems of rural health, the national action plan has few specific actions or plans to address the problems.

The same might also be said for the waiting list issue. While the problem is clearly acknowledged:

"In spite of an increase in the number of doctors employed in health care facilities, long waiting times for medical treatment, especially for an appointment to see a specialist, remains a serious problem"

the solution is seen merely to lie with regulation:

"Provisions relating to waiting for medical procedures (i.e. management of the queue system, informing the public about waiting times) are a new regulation, which makes the system of awarding public health benefits more transparent and may lead to the elimination of existing abuses."

The relationship between the growth in the private sector, at the expense of the public sector, and the waiting list problem is not made. If Poland is similar to some other European countries, those with sufficient income will overcome the waiting list problem by availing of private health care, leaving the poorer sections of the community to rely on the public sector, with its longer waiting lists. It should be noted that there are no specific targets in the NAP to address Poland's waiting list problem.

### Responsiveness

The NAP highlights the needs of specific risks groups – the difficult situation for women, arising from increasing competitiveness in the labour market combined with insufficient access to affordable childcare of good quality, single parents and families with many children, elderly people, particularly those on pensions which are "insufficient to meet the specific needs of seniors in a poor health condition (in 2003 every 20th person aged over 65 lived in the extreme poverty)", families with disabled-headed households or with at least one disabled child, refugees, and the Roma population.

However, apart from the development of community support for the elderly, monitoring the health situation of mothers with young children and health insurance for refugees, the only group that receives a specific mention in relation to health care is the Roma population. The Programme for the Roma Community in Poland includes "health condition improvement [mainly through health promotion, encouraging women to monitor pregnancy, employment of environmental nurses of Roma origin]. Yet the report is very specific about the health problems of the Roma (para 1.8.2):

"As a result of such factors as ....limited access to health care services, and lack of prevention and tradition in pregnancy monitoring, the Roma very often suffer from diseases – including tuberculosis, congenital abnormalities and their average life expectancy is shorter."

The Programme for the Roma Community in Poland hardly seems to be an adequate response to such specific health problems.

## Quality

The Polish NAP makes no reference to the need to ensure that poorer or socially deprived people should have the right to services of the same quality levels as the rest of the population.

## IV. 5 Sweden

The Swedish NAP boldly asserts (para 1.3) that

“health inequalities are a major challenge to public health and social cohesion. There are substantial social differences which do not appear to have diminished during the last 20 years. White-collar workers live longer than blue-collar workers, who generally run a greater risk of falling sick.....The risk of premature death is smaller...the higher the level of education. The differences between conditions for both men and women as regards work, family situation, social relationships and financial assets result in different patterns of sickness between the sexes. Women live longer than men but show more symptoms of ill-health. Disabled people are ill more frequently than the population as a whole.”

The NAP goes on to state (para 4.4) that:

“The overall objective of the health service is good health and health care on equal terms for the whole population. Its priorities are based on an ethical platform consisting of three principles: the human dignity principle, the needs/solidarity principle and the cost effectiveness principle”.

## Affordability

There is little mention of affordability in the Swedish NAP, perhaps because the entire population has the right to health care (para 3.4):

“The aim of the Health and Medical Services Act – good health and health care on equal terms for the whole population – applies equally to children and adults when they are treated as patients in the health service.”

Strengthening primary health care within the national action plan for the development of health and medical services “so that it provides a good foundation for health care services will strengthen the right to regular and close contacts with the health service, while ensuring that all patients are treated with respect and consideration when they are in need of health care”. To this end SEK 9 billion is allocated in the period 2001-2004 to strengthen primary care.

## Accessibility

Under Section 4 “Political measures”, objective 1.2 c) is “To put in place policies which aim to provide access for all to health care appropriate to their situation”. However, there is no elaboration of this objective and thus it is difficult to determine what shortcomings this objective is seeking to rectify.

Paragraph 4.4 “Good health and health care on equal terms”, however, implies that a waiting time problem does exist, and indicates that SEK 3.75 billion will be allocated during 2002-2004 to improve access to health care by introducing a national health care guarantee. This extended guarantee, which was expected to be introduced in January 2004, would ensure treatment within 90 days of a decision on treatment. This was part of a ‘0-7-90’ rule which is to be introduced – the waiting time for coming into contact with the community health sector is 0 days, patients will meet their doctor within 7 days, and they will be offered treatment within 90 days.

In the section entitled “The knowledge society offers new opportunities” (Section 4.8) access to the IT infrastructure is seen as a means to guarantee the welfare of the individual, making IT a tool for improving quality of life of vulnerable groups. The support given in 2002 included a free medical inquiry service for text telephony users.

### Responsiveness

The Swedish NAP places considerable emphasis on a number of disadvantaged groups:

- Children with allergies
- Children with mental health problems
- Children of immigrant parents, of mentally ill parents, of intellectually disabled persons, of battered women, of substance abusers
- Children at risk of physical and mental violence, sexual abuse
- Disabled people
- Older people

However, of these groups, the NAP only addresses the health care needs of some of these categories. Major efforts will be made (para 4.4) to improve the care of children, adolescents and elderly persons suffering from mental disorders and persons with mental disabilities. In order to promote gender equality in health care, the National Board of Health and Welfare, together with health authorities, has been instructed to monitor, analyse and report on gender differences in the health care sector, including a children's perspective, and to propose measures if necessary to promote gender equality. Care of the elderly is also to be reviewed to establish whether care is organised in the best interests of the elderly. It is unclear whether "care" in this context includes health care or merely social care. Indeed the boundaries between the two are often difficult to discern.

As far as disabled people are concerned, the NAP focuses on access to public services in general, without making any specific mention to health care, though it must be assumed that health services are included.

Strengthened collaboration between a range of public services – including the health service – is sought in order to prevent and deal with child battering, but there are no specifics as to how health services should improve their services.

Collaboration, coordination and partnership between public services are strong features of the Swedish NAP. In order to overcome obstacles to collaboration, the Government has produced a Act to enable local authorities and county councils to collaborate in joint committees for the purposes of delivering health and care services, based on the fact that many of those in need of care depend on the health services provided by the county councils and the care services provided by the local authorities.

### Quality

The NAP makes no reference to the need to ensure that poorer or socially deprived people should have the right to services of the same quality levels as the rest of the population.

## IV. 6 Spain

The Spanish NAP for 2003-2005 is highly aspirational, although it should be noted that these aspirations are not matched by specific targets. The need for integrated services and health care policies is, however, emphasised (para 1.2.5.1), particularly in terms of:

*"co-ordination protocols between social services for primary attention and health services in the Autonomous Regions and Municipalities, while promoting integrated, ongoing attention programmes for dependent persons and people with long-term needs."*

Of the five NAPS considered in this report, only the Spanish NAP refers to “the principle of solidarity and that of contribution and equity” which are key elements of the European Social Model but, disappointingly, these principles are not then specifically related to health care (see 6.1 Affordability).

### Affordability

The Spanish NAP for 2003-2005 has little to say about affordability of healthcare, other than to state in Objective 1.2 “Promotion of access to all resources, rights, goods and services” that

“In terms of health care, the necessary measures concluded in the Law on Cohesion and Quality of the National Health System approved in May 2003, whereby the social health care was defined and guaranteed for the whole population, were taken”.

However, it then adds (1.2.5 Access to Health Care) that

“The general Law on Public Health provides health care to all people, though there is a portion of the population which, due to its characteristics, has difficulty gaining access to public health coverage, for which purpose action will be taken”.

In describing the actions which will be taken, nothing is said about resolving financial difficulties – issues of affordability – while the focus is on the provision of specific services for vulnerable or specific groups. There are, therefore, no specific measures in the NAP to address the health needs of those in financial poverty or to address the fact that the growth of private sector health care, or co-payments may have adverse effects on the access to services for those on very low incomes.

### Accessibility

Given the decentralised nature of health care in Spain, with autonomous regions and municipalities, it is interesting that the NAP has almost nothing to say about health care in socially-deprived areas, remote rural areas, and disadvantaged communities. It would be remarkable if there were not regional inequities, particularly in a country with such large, scattered rural populations, but this is not an issue that is addressed in the report. Equally, no mention is made of the impact of waiting times.

### Responsiveness

The NAP states that special emphasis is placed on immigrants, children, women and ethnic minorities, but in terms of health care there is almost no specific mention of these groups, with the exception of the gypsy population (paras 3.6.1, 3.6.5 and 3.6.10):

“To improve the standard of living of the Gypsy population in a situation or at risk of exclusion, by ensuring access to and use of social protection systems and....through the development of integrated social intervention programmes which include...health”;

“To carry out training courses for inter-cultural mediators in the fields of.....health”.

and

“To promote complementary action by primary health care services and NGOs, by starting up health promotion programmes and pilot programmes to improve access to and the proper use of health care services, with special attention to paediatric check-ups for monors, perinatal check-ups, oral health and gynaecological care.”

While the NAP devotes attention to actions for women, young people, children, immigrants, returning emigrants, the homeless, senior citizens, disabled persons, and the prison population, health care is only mentioned in relation to only the last three. For senior citizens, “social health programmes and educational initiatives such as tele-medicine” are mentioned (para 3.1.1) together with “the plan to attend to patients of Alzheimer’s disease and other dementias) (para 3.1.2). Paragraph 3.2.2 seeks social health care for people with serious disabilities (but without any specific proposals), while paragraph 3.10 indicates a plan to “normalise health care in the prisoner population through its inclusion within the National Health System”.

### Quality

The Spanish NAP makes no reference to the need to ensure that poorer or socially deprived people should have the right to services of the same quality levels as the rest of the population.

## IV. 7 Conclusions in the context of the 2nd Joint Report on Social Exclusion

This analysis of the contribution that the health care sector could make to the alleviation of poverty and social exclusion in the context of the 2003-2005 NAPS has demonstrated some similarities and some differences in the approaches of the five countries selected for this analysis.

None of the countries paid adequate attention to issues concerning affordability – in particular the problems associated with the various forms of co-payments, which place a disproportionately heavy burden on people of low income. There seems to be some complacency that the existence of laws which state that all citizens are entitled to

health care on equal terms - or that provision is made for low-income earners - means that their needs are met in reality. But if coverage levels do not take account of inflation in those countries which only guarantee services to those at risk of poverty, then there is a real risk that increasing numbers will become exposed to a health care poverty trap. Equally, co-payments may be sufficiently high to prevent those at risk of poverty from visiting their GP or from buying necessary pharmaceuticals. It is recommended that future NAPs might specifically explore whether these issues might be of relevance.

There is a wide divergence in the approaches of the five countries both to accessibility and responsiveness issues. Some countries appear to have a considerable awareness that waiting times may have a disproportionate impact on those in poverty or social exclusion, while others – which do have waiting lists – ignore the issue. Equally, some countries address the consequences of the public/private mix in health care provision while others do not do so.

The 2nd Joint Report by the European Commission and Council (para 5.8) acknowledges that limited access to transport can increase social exclusion by limiting access to key services such as health, but few of the NAPs explore this problem. Again, we would argue that the member states should more systematically explore these accessibility issues.

Responsiveness clearly depends on circumstances which are particular to each country, although each country identified the specific needs of older people, and most addressed the needs of younger people and people with disabilities. Three of the five countries explored the health-care needs of travellers/Roma/gypsies but there were surprisingly few references to the requirement to respond to the specific healthcare needs of immigrants, ethnic minori-

ties, refugees, drug addicts or the homeless. The 2nd Joint Report particularly highlights (para 6.3) the serious consequences of homelessness on health, particularly mental health. In general, the NAPs were much stronger in terms of their recognition of the need to respond to the social care needs of those in social exclusion than to their health care needs.

With the exception of the Irish NAP, none of the other NAPs paid any attention to quality of health care. In the 2nd Joint report there are several references to the need to develop quality services for the most vulnerable, but the relative absence of references to quality of health care implies that Member States do not regard this to be a priority – perhaps a matter for concern.

The 2003-2005 NAPs examined in this report do not, in general, give the attention to the role that health services can play in alleviating poverty and social exclusion.

In analysing the EU situation with regard to social insurance, the 2nd Joint report uses life expectancy as an indicator not only of the health of individuals but also of access to and utilization of health services and acknowledges that poor health is both a cause and a consequence of wider socio-economic difficulties. The overall health status of the population is therefore recognised to be weaker in the lower income groups.

The Joint report states that “ensuring the provision of quality services which are adequate, accessible, and affordable for all citizens is still a major challenge for some Member States. In particular the challenge of increasing access to health services and care services especially for the elderly and the mentally ill ...are given a new prominence in many NAPs”

It should be noted that the 2nd Joint Report argues that “if they are to be effective in the fight against poverty and social exclusion, social transfers in cash must be accompanied by adequate health care” but that “EU commonly agreed indicators of poverty and social exclusion agreed to date...do not cover other important aspects like adequacy of housing, mortality and access to health care by socio-economic status and social participation”.

In Section 5.3 of the 2nd Joint Report, access to health care is specifically addressed. The adverse effects of cost-containment plans for persons on low or modest incomes are recognised and it notes –as this report also does – that these cost-containment measures are not addressed in the 2003-2005 NAPs.

Based on the arguments developed throughout this document, future NAPs should explore health care as a more significant component in their plans to alleviate poverty and social exclusion.

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