

2017 Observatory Report Executive Summary

FALLING THROUGH THE CRACKS:

The Failure of Universal Healthcare Coverage in Europe

EUROPEAN
NETWORK
TO REDUCE
VULNERABILITIES
IN HEALTH



UCL





EXECUTIVE SUMMARY

This European Observatory Report provides a snapshot of those who fall through the cracks in European healthcare systems, and calls upon stakeholders at global, European, and national level to achieve universal healthcare coverage as a priority.

Testimonies and data collected from 43,286 people attending programmes run by Doctors of the World/Médecins du Monde (MdM) and partner non-governmental organisations (NGOs) across Europe present a powerful and rare insight into those who cannot access healthcare services, how they are excluded, and their healthcare needs. They show what should be done to ensure everyone can access healthcare when they need it.

The global agenda is unequivocal. The World Health Organization (WHO) and United Nations (UN) urge all governments to provide universal coverage.¹⁻² Yet over half of the people surveyed told us they had no healthcare at all and almost one in five could only access care in an emergency.

People were often in desperate need of medical care. Some had acute and chronic conditions but had not been able to see a doctor, and over half of pregnant women were not accessing antenatal services. Many people said their psychological health was bad, and children had vaccination levels below recommended standards.

The programmes saw a wide range of people who were excluded from healthcare, nearly a quarter of which were children. Most were migrants from outside of the EU/EEA, with the largest number of people coming from Syria. The study also shows that nationals and EU/EEA migrants struggle to access European healthcare systems.

Many were living on the edge, in circumstances that have a detrimental impact on their health, wellbeing and access to healthcare. The overwhelming majority were living in poverty, and almost a quarter were street homeless or living in emergency shelters, camps, slums, squats, or hotels. Predictably, nearly two in five people told us they could not afford to pay for healthcare.

Social isolation was common. Over a third of people did not have someone they could always rely on to help them when needed, and half faced language barriers. It is not surprising that nearly a fifth were unable to navigate the bureaucracy to get the treatment they needed.

Many people were under incredible emotional strain. Some were fleeing war and conflict, other were escaping persecution because of their political opinions, religion, race/ethnicity, or sexual orientation. Nearly two thirds of patients were separated from their children (under 18 years) and half of people talked to us about their experiences of violence.

1. WHO. "Universal Health Coverage". Health systems, 2017 (accessed on September 22, 2017, www.who.int/healthsystems/universal_health_coverage/en/).
2. United Nations. "Sustainable Development Goal 3: Ensure Healthy Lives and Promote Well-Being For All at All Ages". Sustainable Development Knowledge Platform, 2017 (accessed on September 22, 2017, <https://sustainabledevelopment.un.org/sdgs>).

2016 IN FIGURES

WHO WE SAW

- 22.2% of people seen were children under 18 years (9,626/43,286), 8.3% were children under 5 years (3,578/43,286), and 2.3% were adults 70 years and over (988/43,286).
- 79.1% were non-EU/EEA migrants (34,227/43,286), 12.1% were nationals (5,227/43,286) and 7.5% were EU/EEA migrants (3,257/43,286).
- The highest proportion of migrants came from Syria, 13.0% (5,613/43,286), followed by 11.3% from Afghanistan (4,874/43,286).

VULNERABILITIES IN HEALTH AND HEALTH ACCESS

- The overwhelming majority of people, 89.0%, were living below the poverty threshold in the country they presented in (6,725/7,560).
- 23.8% (1,954/8,197) of people were living in precarious circumstances, this includes 11.9% (976/8,197) who were street homeless or living in emergency centres, 2.1% living in camps or slums (173/8,197), 1.7% in squats (141/8,197), and 7.1% in a charity, organisation or hotel (581/8,197). Higher levels of street homelessness were reported by EU/EEA migrants (26.7%).
- 38.9% reported the absence of a reliable social network (2,500/6,421) this included 12.0% (769/6,421) who reported that they did not have anyone to help, support or comfort them in their current town, or city.
- 61.7% (1,496/2,425) were separated from some or all their children aged under 18 (5.9%, 55.8% respectively).
- 56.2% of non-EU/EEA migrants talked about violence during their consultation (8,857/15,749).

When asked why they left their country of origin, 18.0% of responses from non-EU/EEA migrants reported discrimination due to their political opinion, religion, race/ethnicity, or sexual orientation (799/4,441). 14.1% of responses reported escaping war or conflict (628/4,441), and 5.6% reported escaping family conflicts (248/4,441).

49.7% had permission to reside in the country they were living in (4,882/9,832).

- 49.7%; of non-EU/EEA migrants with irregular immigration status limited their movements in public for fear of being arrested (684/1,377).

HEALTHCARE ACCESS

- The majority of people, 55.2%, reported having no healthcare coverage (5,582/10,120). A further 18.3% (1,847/10,120) had coverage for emergency care only.
- When asked about barriers to accessing healthcare, 18.9% of responses reported the person did not try to access healthcare services (1,734/9,184), 17.0% reported administrative barriers (1,558/9,184), 16.3% reported economic barriers (1,493/9,184) and 2.2% (205/9,184) of responses reported that they did not access healthcare services for fear of being arrested.

HEALTH CONDITIONS AND STATUS

- The most common chronic pathologies were cardiovascular (19.9%; 1,945/9,774), followed by musculoskeletal (13.2%; 1,293/9,774), digestive (12.2%; 1,191/9,774), endocrine, metabolic and nutritional (11.6%; 1,133/9,774), and psychological (10.0%; 975/9,774). Higher levels of chronic pathologies were observed in nationals (71.0%).
- The most common acute pathologies were respiratory (19.4%; 1,639/8,435) followed by digestive (16.0%; 1,347/8,435), musculoskeletal (13.5%; 1,137/8,435), and skin (13.4%; 1,128/8,435).
- The majority of pregnant women had not accessed antenatal care prior to visiting the programmes (58.4%; 215/368).
- 42.3% of acute pregnancy pathologies were reported by EU/EEA migrants (161/381).
- 14.9% said their psychological health was 'bad' (1,122/7,515) and 5.8% said they were 'very bad' (433/7,515). Nationals reported higher levels of 'very bad' psychological health at 11.2% (101/906).

22.2%

of people seen were children under 18 years (9,626/43,286), 8.3% were children under 5 years (3,578/43,286).

89%

The overwhelming majority of people, 89.0%, were living below the poverty threshold in the country they presented in (6,725/7,560).

55.2%

The majority of people, 55.2%, reported having no healthcare coverage (5,582/10,120). A further 18.3% (1,847/10,120) had coverage for emergency care only.

RECOMMENDATIONS

Everyone must have equitable access to healthcare coverage, regardless of their immigration status or economic resources.

To achieve universal coverage, healthcare services must be available, accessible, acceptable, and of adequate quality. This principle is in line with the UN International Covenant on Economic, Social and Cultural Rights of 1966 (ICESCR, 1966)³ and the ambitions of the UN Sustainable Development Goals (SDGs)⁴ and WHO.⁵

ON THE RIGHT TO HEALTH AND UNIVERSAL HEALTH COVERAGE

Member states must ensure universal healthcare coverage for everyone residing within their state, regardless of their immigration status.

To the EU institutions

- Promote the European Pillar of Social Rights⁶ by engaging in new legislative initiatives that ensure access to social protection in particular to “affordable, preventive, and curative healthcare of good quality” as proclaimed in the EU Commission recommendations.⁷

To national governments

- Implement international commitments to the “full realisation of the right to health for all” (UN International Covenant on Economic, Social and Cultural Rights of 1966)⁸ and the UN Convention on the Rights of the Child including the right to “the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health” including “appropriate pre-natal and postnatal healthcare for mothers”.⁹

- Commit resolutely to achieving universal healthcare coverage as per SDG 3 and WHO’s top priority.

- Adopt the recommendations made by the UN Committee on Economic, Social and Cultural Rights in its ‘Concluding Observations’ on their country.¹⁰

ON ACCESS TO HEALTHCARE

National public health policies should be progressive, equitable, evidence-based, and include accessible, affordable, and quality primary antenatal, and postnatal care, vaccines, medicines, and health promotion.

To the EU institutions

- Continue to fund member states cooperation and research into public health, health inequalities, and healthcare systems to enable European-wide solutions, informed by evidence, to assist policy making.

To national governments

- Take positive steps to end administrative barriers and discrimination within healthcare services, and to raise awareness of rights and entitlement amongst patients and healthcare workers. These steps could include information campaigns and training frontline staff.
- Develop outreach policies to increase coverage at community level in order to access excluded people, including cultural mediators within health services.
- Reinforce the first line of care with an integrated medical, social, and psychological approach.

ON SOCIAL PROTECTION AND ECONOMIC CONDITIONS

Better social protection and economic conditions are key to ending poverty, promote wellbeing and reduce inequalities.

To the EU institutions

- Promote the European Pillar of Social Rights by engaging in new legislative initiatives that ensure access to social protection. The EU Parliament should vote new directives aiming at asking the Member states to translate into national law the recommendations of the Communication COM (2017)¹¹ 2600 on the social pillar, especially the recommendation number 16 on health care “Everyone has the right to timely access to affordable, preventive and curative health care of good quality”.
- Propose an implementation and monitoring strategy involving all relevant agencies for the achievements of SDG 1, 10, and 11 by the EU member states.

To national governments

- Endorse and proclaim in the next European Social Summit the European Pillar of Social Rights especially social protection and inclusion.
- End reductions to social security benefits and provide a basic level of financial support to all to meet obligations under SDG 1 and 10 to end poverty in all its forms everywhere.
- Provide safe and adequate housing to all in order to meet obligations under SDG 11.
- Tackle social exclusion, discrimination, and inequalities through the provision of services and partnerships with NGOs and community organisations.

3. OHCHR. “International Covenant on Economic, Social and Cultural Rights.” 1996 (accessed on September 29, 2017, www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx).

4. United Nations. “Sustainable Development Goal 3: Ensure Healthy Lives and Promote Well-Being For All at All Ages.” Sustainable Development Knowledge Platform, 2017 (accessed on September 22, 2017, <https://sustainabledevelopment.un.org/sdgs>).

5. WHO. “Universal Health Coverage.” Health systems, 2017 (accessed on September 22, 2017, www.who.int/healthsystems/universal_health_coverage/en/).

6. European Commission. “The European Pillar of Social Rights in 20 principles.” 2017 (accessed on September 29, 2017, https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en).

7. European Commission. “Proposal for a Interinstitutional Proclamation on the European Pillar of Social Rights.” COM(2017) 251 final, 2017 (accessed on September 29, 2017, <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=COM:2017:251:FIN>).

8. OHCHR. “International Covenant on Economic, Social and Cultural Rights.” 1996 (accessed on September 29, 2017, www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx).

9. OHCHR. “International Convention on the Rights of the Child.” 1989 (accessed on October 10, 2017, www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx).

10. Committee on Economic, Social and Cultural Rights. “Concluding Observations.” OHCHR, 2017 (accessed on September 29, 2017, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=5).

11. European Commission. “COMMISSION RECOMMENDATION of 26.4.2017 on the European Pillar of Social Rights” 2017 (accessed September 10, 2017, <http://ec.europa.eu/social/BlobServlet?docId=17625&langId=en>).



ON REFUGEES AND MIGRANTS

The principle of universal and equitable health coverage should be applied to all persons residing de facto in a country, regardless of their legal status.

To the EU institutions

- The future reform of the Common European Asylum System¹² should make provision for the regularisation of seriously ill third country nationals and their protection from expulsion when effective access to adequate healthcare cannot be ensured in the country to which they are expelled.

To the Council of Europe

- Take a clear and renewed stance on the protection of medical confidentiality and the doctor-patient relationship confidentiality. Healthcare staff, services, and medical records must not be compromised by immigration policy objectives.

To the United Nations

- The Global Compact on Refugees¹³ and the Global Compact on Migration¹⁴ must both include universal access to healthcare in their principles, and contain commitments for UN member states to provide access to health coverage for refugees and migrants, and that the provision of public service including healthcare should not be limited as a deterrent for people to migrate or seek asylum.
- The Global Compact on Refugees and the Global Compact on Migration should both guide member states to engage in concrete action to create safe migration route free of violence and legal pathways to destination countries and make provision for each member state to ensure compliance to human rights standards when cooperating with third countries on return policies and asylum proceedings.

To national governments

- Engage in the implementation of the Commission Communication on the protection of children in migration of April 12 2017.¹⁵ Especially ensure that all children have timely access to healthcare and psychosocial support, and to strengthen child protection systems along the migratory routes, end unreliable, and intrusive medical age assessments.
- Establish a firewall between health, welfare and protection services, and immigration agencies. Reporting patients to immigration authorities by healthcare workers or social services should be explicitly prohibited, and this should be robustly enforced and clearly communicated to healthcare workers and patients.

ON EU/EEA CITIZENS

The principle of free movement and residence of EU citizens should be extended to a right to health.

To the EU institutions

- Engage in a new EU legal framework that will ensure access to healthcare for all EU/EEA migrants irrespective of their resident or social security status.
- Prioritise access to healthcare coverage for both EU citizens living in the UK and UK citizens living in Europe in Brexit negotiations.

12. EuropeanParliament. "Reform of the Common European Asylum System." Legislative Train Schedule Towards a New Policy on Migration, 2017 (accessed on October 01, 2017, www.europarl.europa.eu/legislative-train/theme-towards-a-new-policy-on-migration/file-reform-of-the-common-european-asylum-system).

13. UnitedNations. "Global Compact on Refugees." Refugees and Migrants, 2017 (accessed on October 01, 2017, <http://refugeemigrants.un.org/refugees-compact>).

14. UnitedNations. "Global Compact for Migration." Refugees and Migrants, 2017 (accessed on October 01, 2017, <http://refugeemigrants.un.org/migration-compact>).

15. EuropeanCommission. "Communication from the Commission to the European Parliament and the Council: The Protection of Children in Migration." COM(2017) 211 final, 2017 (accessed on October 01, 2017, https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/policies/european-agenda-migration/20170412_communication_on_the_protection_of_children_in_migration_en.pdf).



2017 OBSERVATORY REPORT

The annual Observatory Report is produced by the European Network to Reduce Vulnerabilities in Health, which brings together MdM programmes, partner NGOs' and academics who seek to reduce EU-wide health inequalities. It is an observational study of people who are excluded from mainstream healthcare services.

The purpose of the report is to present data, analysed and validated by a leading epidemiologist, on people who are excluded from mainstream healthcare services, alongside testimonies and photos collected in programmes run by MdM and partner NGOs. It is aimed at policy makers at local, regional, national and EU level, providing them with the evidence base on reducing vulnerabilities in health and identifying ways that health systems could become more responsive and adapted. It is also valuable for academics to acquire greater understanding about how vulnerabilities contribute to health inequalities, and vice versa.

Since 2006, the seven observatory reports have seen a gradual expansion in the geographical coverage of the data collection, as well as in the focus – from irregular migrants to all patients who attended programmes run by MdM and partners. Previous reports are available at: www.mdmeuroblog.wordpress.com

This 2017 Observatory Report includes data, testimonies and photographs collected from thirteen programmes from January to December in 2016. The programmes are both medical and non-medical, collecting the social and medical data. There was a total of 110,277 medical and social consultations.

The report was produced in partnership with the Institute of Global Health, University College London. With over 160 staff and access to expertise of over 200 staff from across UCL, the Institute collaborates across disciplines to find solutions to global health problems with cross-disciplinary approach at the heart of its research and teaching.

Contact

Anna Miller, UK Policy & Advocacy Manager Doctors of the World UK
AMiller@doctorsoftheworld.org.uk / Tel.: +44 (0) 20 71675789 (ext. 7024)



All the reports of the Doctors of the World International Network and other documents and information about the European programme can be found at:
www.mdmeuroblog.wordpress.com