UNIVERSAL HEALTH COVERAGE IN THE EU: WHAT DO WE KNOW (AND NOT KNOW) ABOUT GAPS IN ACCESS?

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Summary: Universal Health Coverage (UHC) is a key priority for many European Union (EU) health policymakers. Common descriptions of UHC include the dimensions of population coverage, service coverage, and cost coverage. Yet a formal entitlement to coverage does not always result in real access as individuals face barriers in accessing health services. This article describes the EU’s progress towards UHC and points to several areas where we lack data to fully understand gaps in coverage and access. By improving data availability, health policymakers would be able to take more targeted policy actions, supporting the goals of both UHC and a European Health Union.

Keywords: Universal Health Coverage, population coverage, cost-sharing, health benefits

Introduction

Countries around the world seek to progress towards Universal Health Coverage (UHC), envisioned by UN Sustainable Development Goal 3.8 as, “including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”. The Office of the High Commissioner for Human Rights identifies health as a human right, with essential elements of availability, accessibility, acceptability, and quality. Similarly, the European Union (EU) includes the principle in the European Pillar of Social Rights that everyone has the right to timely access to affordable, preventive and curative health care of good quality. However, even in the EU, gaps in coverage and access to health care persist. UHC is commonly depicted as a coverage cube with three dimensions: population coverage, service coverage, and cost coverage (see Figure 1). Yet, formal entitlements to coverage do not always translate into real access to health services. Adding a fourth dimension, service access, which captures whether individuals are in practice able to access the health services for which they are entitled, should be considered to help overcome this limitation. A case in point is the large backlogs of care that have arisen in virtually all European countries as a result of the COVID-19 pandemic, which are mostly due to lacking access, not coverage.
Changing the policies: Towards a true European Health Union

While countries in Europe generally have high population coverage, certain groups such as undocumented migrants are at times excluded. Service coverage, cost coverage, and service access vary across European nations, and the lack of granular, standardized data makes cross-country comparisons difficult. This article will consider the existing gaps in coverage across the various dimensions, describe available indicators to assess coverage, and identify opportunities to increase monitoring of coverage gaps.

Figure 1: The UHC coverage cube

Coverage has three dimensions:
- Breadth: the proportion of the population covered
- Scope: the range of benefits covered
- Depth: the proportion of the benefit cost covered

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Population coverage in the EU is generally high, but some countries exclude certain groups

Most EU countries provide high levels of population coverage. Yet as of 2019, seven EU countries had more than 5% of their populations without statutory health coverage, including Estonia (5%), Slovakia (5.4%), Hungary (6%), Poland (6.6%), Bulgaria (10.2%, 2017), and Romania (11%, 2017), and Cyprus (17%). In some cases, the relatively high percentage of uninsured may be due to reporting discrepancies (e.g., counting citizens living abroad as uninsured) or inconsistencies in the survey methodology across countries. However, in other instances, the lack of population coverage can point to excluded groups. For example, Bulgaria and Romania both require a valid identity card to register for insurance, which in practice makes it very difficult for certain population groups to obtain coverage, such as Roma individuals and homeless people. More positively, a 2020 reform in Cyprus has dramatically improved population coverage, and the new General Healthcare System (GeSY) has integrated the separate public and private health systems. Cyprus now provides universal population coverage, including to refugees and asylum seekers.

Several EU countries exclude some groups of migrants from statutory health coverage. In Germany, for example, EU citizens who are unable to provide for their own living costs are excluded from entering into statutory health coverage and – after four weeks of so-called “bridging services” – do not have any alternative healthcare coverage. In addition, asylum seekers, refugees and undocumented migrants in many countries are covered by a separate funding mechanism. To access these alternative schemes, many countries require undocumented migrants to apply for coverage, and some migrants fear they will be reported to the authorities. In Germany, social service departments responsible for providing cost coverage for asylum seekers and undocumented migrants have the duty to immediately report undocumented migrants to the immigration department or the police. This leaves undocumented migrants de facto without coverage.

Cost sharing for health services is common in the EU, and in some cases leads to catastrophic spending

Most European health systems have some level of cost sharing, and several cost sharing methods exist. These include co-payments, most commonly applied for physician visits; co-insurance, most used for prescription medicines; and deductibles, a defined amount that must be paid before insurance will reimburse costs, which are prevalent in the Netherlands and Switzerland. Many countries have exemptions or caps on out-of-pocket (OOP) spending in an attempt to increase financial protection. Exemptions are most common for children, low-income individuals, and those with a chronic condition or disability. Austria and Germany set the cap for OOP spending based on household income.
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Catastrophic health spending refers to health spending that exceeds a predefined percentage or threshold of a household’s ability to pay for health care. The WHO Regional Office for Europe has found a link between OOP payments and both catastrophic spending and unmet needs (see Figure 2). It therefore recommends designing coverage policy to minimize access barriers and reduce OOP payments to less than 15% of current spending on health. Bulgaria (2018), Hungary (2015), Latvia (2016), and Lithuania (2016) all have more than 10% of households with catastrophic spending.

Health systems in Europe typically cover a wide range of services

A country’s benefits basket describes the service coverage available to the population covered by the statutory health system. The most commonly excluded services from statutory coverage include optical treatments, dental care for adults, physiotherapy, and assistive devices. In several countries, these services are commonly covered by voluntary health insurance. The coverage of novel pharmaceutical products also varies across countries, which can particularly affect cancer patients and patients with rare diseases. This has prompted some countries, such as Belgium and Latvia, to introduce exceptional reimbursement funds to pay for expensive medical treatments that are not included in the statutory system.

While a service may be considered as covered, there may be conditions (e.g., age, medical indication) for receiving the service. Further, when comparing country coverage at a more granular level, additional distinctions appear. For example, while all EU countries may cover ‘reproductive services’, this could mean in practice 3 or 30 doctor’s visits, certain genetic screenings but not others, fertility treatments or not (or only up to a certain age), abortion services, and more. Indeed, detailed patient vignettes on stroke, depression and dental care revealed important gaps in coverage in 12 EU countries that would have stayed under the radar when only looking at available services in the benefit basket of a country. Examples are the lack of rehabilitation care and low thrombolysis and thrombectomy rates, which mean that patients in some countries do not receive recommended care even where formal coverage for such services exist. Several countries limit the scope of services for certain population groups, such as asylum seekers, refugees, undocumented migrants or citizens from other countries, often depending on the length of their stay in the country. Germany, Sweden and Belgium, for instance, limit the range of services to some extent. In Germany, asylum seekers are entitled only to services for acute illness and pain, prenatal, obstetric and postnatal care as well as vaccinations during the first 18 months of their stay in the country. Other services – including for mental health or chronic illnesses – are dependent on individual case decisions. Similar restrictions exist in Sweden. Individuals in some countries also may fall behind in paying their health insurance premiums, which may limit the available scope of services (as for example in Germany) and/or lead to loss of insurance. In the Netherlands and Switzerland, new arrangements and bodies had to be put in place to administer the rising numbers of uninsured due to defaulting.

Discussions about UHC must consider the service access dimension

Even when an individual has statutory health coverage, with their service covered...
in the benefit basket at no cost, other access barriers are still possible. These can relate to problems of physical availability within the statutory health system (e.g., waiting times, transport cost), problems of functional capacity (e.g., inability to provide consent for care, language barriers), and problems with provider attitudes (e.g., discrimination).

The EU-SILC survey collects data from EU citizens on a wide range of indicators, including on whether they have unmet medical or dental needs. The causes for unmet needs are then categorised into several reasons, such as “too expensive”, “too far to travel”, “waiting list”, and “fear of doctor, hospital, examination or treatment”. The OECD assesses the share of publicly covered services by calculating the percentage of expenditure covered by statutory health schemes. Generally, EU countries in 2018 had high statutory coverage of hospital care (88%) and outpatient medical care (74%), medium coverage of pharmaceuticals (56%), and low coverage of dental care (31%).

The UN SDG 3.8 tracks two indicators, with 3.8.1 related to service coverage and 3.8.2 capturing catastrophic health spending. The coverage of essential services indicator collects data on 14 tracer indicators grouped into the categories of reproductive, maternal, newborn and child health; infectious diseases; non-communicable diseases; and service capacity and access. Then, an index on a scale of 0 to 100 is calculated to assess service coverage (with 100 representing complete UHC). In 2019, the UHC service coverage index globally was 67 while in Europe it was 80. According to the 3.8.2 indicator data, in 2017 6.7% of Europeans allocated more than 10% of their household income to health, compared with 13.2% around the world.

Cross-country indicators related to UHC and access to health care have been developed

Several international organisations collect cross-country data on indicators related to UHC and access to health care. These include the EU, which features questions on the European Union Statistics on Income and Living Conditions Survey (EU-SILC) and European Health Interview Survey (EHIS) about the prevalence and causes of unmet medical needs and which publishes Mutual Information System on Social Protection (MISSOC) tables containing detailed information on social protection (e.g. benefits); the OECD, which reports the share of services financed by public coverage systems; and the WHO, which tracks two indicators related to UHC and SDG 3.8.

Available indicators fail to capture progress towards UHC or the root cause of unmet health needs

Despite the availability of the indicators described in the previous section, all have limitations that fail to illuminate the underlying reasons for coverage gaps and therefore allow for a more targeted policy response. For example, the statistical population for the indicator “self-reported unmet need for medical care” in the EU-SILC is comprised of people living in private households above 16 years of age. This excludes people living in communal housing or in institutions (e.g. nursing homes, psychiatric hospitals or prisons), undocumented migrants and all homeless people. A report from Médecins du Monde (MdM) shows that by limiting the population base, the EU-SILC does not gauge the existing unmet need for healthcare. Data from 25,355 patients coming to the MdM clinics in seven European countries in 2019 and 2020 show that 82.3% of patients did not live in private households and 8.5% were under 16 years. While actually experiencing problems in accessing healthcare, they were not represented in the EU-SILC survey and thus in the results on unmet need for medical care. Furthermore, the EU-SILC survey does not collect data on health condition or social and legal status, which would further clarify the reasons for unmet needs. Additionally, there are differences in the survey question itself across countries. Most countries ask about both a medical examination and treatment, but the Czech Republic, Slovenia and Spain only ask about a medical examination or a doctor’s consultation, resulting in lower rates of unmet needs.

With regards to financial indicators, countries often cannot disaggregate OOP spending and to determine what share is absorbed by direct payments (due to lacking population or service coverage) or cost sharing (due to lacking cost coverage). Additionally, reporting the share of cost coverage covered by public funding sources does not necessarily relate to whether a service is covered in the benefit basket. In other words, a country with relatively low population coverage but relatively high service coverage may have a lower percentage than a country with universal population coverage but relatively limited service coverage. Similarly, the category of unmet need due to financial reasons in the EU-SILC survey also does not provide insights into whether this unmet need resulted from lacking statutory coverage, service coverage, or cost coverage.
Historically, and still today with the SDG 3.8.2 tracking, the indicators used to describe catastrophic health spending are the proportion of the population with household expenditures on health greater than 10% or 25% of total household expenditure or income. However, using this method overestimates financial hardship among rich households and underestimates it among poor households. Instead, using normative spending on food, housing, and utilities is a more effective way to capture catastrophic health spending.

Assessment (2021) provides concrete suggestions to adapt existing tools and provide comparable data at the European level. Experience from organisations such as Médecins du Monde and PICUM could be utilised to improve insights for policymakers. The existing efforts underway could coalesce around a larger EU data project to understand access and coverage in the EU, and should include governments, international organizations (including patient organizations), academia, and statistical bodies. Having the right data would be a key prerequisite to meet the goals and promises of a European Health Union.

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Enhancing solidarity and equity of health coverage in the EU requires ongoing monitoring and EU-wide coordination

European countries have come a long way in improving data availability and comparability on access and coverage in the EU. International organizations like the European Union and Eurostat have played a crucial role in this development. However, as described in the previous section, current indicators to measure progress towards UHC are often insufficient to design targeted policy responses. This is due to both the inability to capture all population groups residing in EU countries, particularly those most vulnerable, and methodological challenges. Ongoing monitoring and coordination at the EU level is needed to improve these indicators to ensure that the data available to policymakers reflects the situation on the ground and that countries can learn from each other. In fact, the European Commission’s Expert Group on Health System Performance