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Equal access to health care

Report[1]
Committee on Social Affairs, Health and Sustainable Development
Rapporteur: Mr Jean-Louis LORRAIN, France, Group of the European People's Party

Summary

Access to care is a key aspect of the fundamental right to health. Inequalities in access to health care are growing in the Council of Europe member States due to financial, geographical and language barriers, corruption, socio-economic inequalities, certain migration and security policies and the economic crisis which had repercussions on health systems. These inequalities particularly affect vulnerable groups and lead to a phenomenon of non-recourse or delayed recourse to care, which could have disastrous implications for both individual and public health and lead in the long term to an increase in health expenditure.

With a view to reducing inequalities in access, States should, *inter alia*, reduce the proportion of health-care expenditure payable by the most disadvantaged patients, ensure that health professionals are accessible throughout the territory as well as access to information on the health system. They should dissociate their security and immigration policies from health policies. Having regard to the importance of continuing to protect the right to health enshrined in Article 11 of the revised European Social Charter, the Committee of Ministers should enhance the role of the European Committee of Social Rights.

1. Reference to committee: Doc. 12504 and 12512, Reference 3753 of 11 April 2011.

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A. Draft resolution[2]

1. The right to health is a fundamental human right. Protection of health is an essential condition for social cohesion and economic stability and represents one of the indispensable pillars of development. Access to care is a key aspect of the right to health.

2. The Parliamentary Assembly observes that inequalities in access to health care are growing in the Council of Europe member States. Various factors are at the root of this phenomenon, including financial, geographical and language barriers, corruption, socio-economic inequalities and certain migration and security policies which are unmindful of health needs. The economic crisis led to budget cuts in many countries, forced by austerity policies, thereby putting pressure on the health systems. Several countries have therefore introduced or increased charges payable by patients, particularly for essential health services.

3. The Assembly notes that inequalities in access to care particularly affect vulnerable groups, including people experiencing financial problems such as the unemployed, single parent families, children, the elderly, as well as Roma, migrants, especially those in an irregular situation, and homeless people. These inequalities lead to a phenomenon of non-recourse or delayed recourse to care, which could have disastrous implications for both individual and public health and lead in the long term to an increase in health expenditure.

4. Recalling its Resolution 1884 (2012) "Austerity measures – a danger for democracy and social rights", the Assembly once again draws attention to the negative impact of austerity measures on social rights and their effects on the most vulnerable categories. In this connection, it notes with concern the impact which the economic crisis and austerity measures have had on the accessibility of care in several member countries, including Greece, which is now faced with a health, and even humanitarian crisis and an increase in xenophobic and racist acts against refugees and migrants.

5. The Assembly believes that the crisis should be viewed as an opportunity to rethink health systems and be used to increase their efficiency and not as an excuse for taking retrograde measures.

6. The Assembly therefore calls on the Council of Europe member States to:

6.1. reduce, where appropriate, the proportion of health expenditure payable by the most disadvantaged patients and take all other necessary measures to ensure that the cost of care does not hinder access to care, including the promotion of increased use of generic drugs;

6.2. ensure the accessibility of health-care facilities and health professionals throughout the territory by taking appropriate measures, having recourse where appropriate to incentive measures;

6.3. ensure the accessibility of information on the health system, including vaccination and screening programmes, and set up health education programmes, while taking account of the specific needs of the different vulnerable groups and of the requirement to reduce language barriers to a minimum;

6.4. simplify the administrative procedures required to be able to receive health care;

6.5. introduce measures to combat corruption in the health sector, in close co-operation with the Group of States against Corruption (GRECO);

6.6. dissociate their security and immigration policies from health policy, where appropriate by abolishing the obligation on health professionals to report migrants in an irregular situation;

6.7. introduce training policies for health professionals stressing the need to combat arbitrary applications, discrimination and corruption in the health sector.

2. Draft resolution adopted unanimously by the committee on 3 June 2013.

B. Draft recommendation[3]

1. The Parliamentary Assembly refers to its Resolution … (2013) on equal access to health care.

2. The Assembly welcomes the recent work of the Committee of Ministers in the health field, resulting in particular in the adoption of Recommendation CM/Rec(2010)6 on good governance in health systems, Recommendation CM/Rec(2011)13 on mobility, migration and access to health care, the 2011 Committee of Ministers' Guidelines on child-friendly health care and Recommendation CM/Rec(2012)8 on the implementation of good governance principles in health systems.

3. The Assembly regrets, however, that since 2012 the Council of Europe has been without an intergovernmental committee specifically responsible for facilitating policy development and exchange of good practices in the health field.

4. Having regard to the Council of Europe's principles and values, it is of paramount importance to continue to protect the right to health enshrined in Article 11 of the European Social Charter (revised) (ETS No. 163) and to enhance the role of the European Committee of Social Rights so that it can perform this task as effectively as possible.

5. In the light of the foregoing, the Assembly recommends that the Committee of Ministers:

5.1. urge those member States which have not yet done so to sign and ratify the European Social Charter (revised) and the protocols thereto;

5.2. take measures to ensure rapid progress towards implementation of the Charter in line with the conclusions and decisions of the European Committee of Social Rights;

5.3. encourage other sectors of the Council of Europe to include health-related issues in their work, based on a cross-sectoral approach.

3. Draft recommendation adopted unanimously by the committee on 3 June 2013.

C. Explanatory memorandum by Mr Lorrain, rapporteur

1. Introduction

1. The right to health is a fundamental human right. Protection of health is an essential condition for social cohesion and economic stability[4] and represents one of the indispensable pillars of development.[5] Access to care is a key aspect of the right to health.

2. The principles of universality, equity and solidarity are among the key principles of good governance in health systems.[6] These principles, including that of equity, require that equal access to health care be guaranteed both in law and in practice. Unfortunately, inequalities in access to health care are growing in the Council of Europe member States. Various factors are at the root of this phenomenon, such as financial and geographical barriers, social and economic inequalities, corruption, and certain migration and security policies, to name just a few.

3. The economic crisis has had major repercussions in terms of household income, particularly for the most vulnerable groups, thus creating new inequalities, and has led to an increase in health needs. Furthermore, austerity policies have targeted public health systems in many countries and have resulted in increased user charges.

4. Consequently, while the well-off population still has relatively easy access to available resources, some vulnerable groups face increasing difficulties of access to the benefits provided by health systems. These groups include people experiencing financial problems such as the unemployed, single parent families, the elderly, as well as Roma and migrants, particularly those in an irregular situation.

5. The purpose of this report is to identify, on the basis of national examples, the factors that lead to inequalities in access to health care, in order to suggest strategies for reducing those inequalities. It is intended neither as an exhaustive analysis covering all problems of inequality in access to care nor as a comparative report on inequalities in access to the different types of care (primary care, psychiatric care, antenatal care, etc.) and according to inequalities experienced by the different vulnerable groups (migrants, persons with disabilities, Roma, women, the elderly, prisoners, etc.), given that this would require a much more in-depth study.

6. In this report, particular attention is paid to the impact of the economic crisis on health systems, and in particular on the accessibility of care, on the basis of the information gathered during the fact-finding visit to Athens (Greece) from 11 to 13 April 2013.

2. Access to health care: a key aspect of the right to health

7. According to the United Nations Committee of Economic, Cultural and Social Rights, access to health care is a key aspect of the right to health. The right to health also embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment. Equal access to health care requires States to guarantee access to health-care facilities to individuals without sufficient means, as well as to prevent any discrimination in health-care provision.[7]

8. The right to health is guaranteed by various international and regional human rights instruments, as well as by many national constitutions.[8] The Constitution of the World Health Organization (WHO), adopted in 1946, was the first document to proclaim that “[t]he enjoyment of the highest attainable standard of health is one of

4. Warsaw Declaration adopted at the Third Summit of Heads of State and Government of the Council of Europe (Warsaw, 16-17 May 2005).
5. Health appears in three of the eight Millennium Development Goals (reducing child mortality rates, improving maternal health, and combating HIV/AIDS, malaria and other diseases) and also plays a decisive role in the achievement of the other goals, in particular those concerning the eradication of extreme poverty and hunger, education and the promotion of gender equality.
6. Committee of Ministers Recommendation CM/Rec(2010)6 on good governance in health systems.
7. General Comment No. 14 (2000) of the United Nations Committee of Economic, Social and Cultural Rights.
8. According to a WHO survey (2008), 135 national constitutions out of 186 contain provisions relating to health or the right to health.

the fundamental rights of every human being". Two years later, the Universal Declaration of Human Rights stated in Article 25.1 that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family …". In 1966, the United Nations International Covenant on Economic, Social and Cultural Rights enshrined the right to health in a legally binding international instrument for the first time. According to Article 12.1, the States Parties recognise "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[9]

9. At Council of Europe level, the revised European Social Charter (ETS No. 163) recognises the right to protection of health (Article 11) and the right to social and medical assistance (Article 13).[10] Protection of the right to health as recognised by the Charter presupposes, *inter alia*, the establishment of accessible and effective care facilities for the entire population. Finally, Article 3 of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (ETS No. 164) calls on the Contracting Parties to provide "equitable access to health care of appropriate quality".

3. Factors leading to inequalities in access to health care

10. Despite the diversity of methods of funding and organising health systems in Europe, two broad trends can be identified: compulsory sickness insurance systems funded by social insurance contributions shared between employers and employees (for example Czech Republic, France, Germany, Hungary, Poland, Romania) and national health systems funded by the State on the basis of public revenues, especially taxes (for example Denmark, Ireland, Italy, Spain, Sweden). In all these systems, patients pay user charges, which vary in the amounts payable. Lastly, private insurance schemes (whether voluntary or compulsory)[11] play an additional role, especially with regard to medical expenses not or only partly covered by the public health system.

11. Equal access to health care presupposes the availability of care to everyone, both in law and in fact. This means removing any obstacles or barriers which might hinder certain individuals or groups from gaining access to the benefits provided for under the health system. These include financial barriers (cost of care), the limited scope of benefits, geographical barriers (problems regarding the accessibility of care over the entire territory, particularly in rural areas), language barriers or information barriers (poor knowledge of the health system), as well as corruption. These are factors associated mainly with health systems.

12. Inequalities in access to health care are also the result of other factors such as discrimination (which will not be considered in this report),[12] socio-economic factors and certain migration and security policies. One, several, or all of these factors may be at the root of inequalities in access and it is not always easy to identify the particular factor(s) involved. For example, the very limited use of a particular type of care in a given region might indicate the existence of geographical obstacles hindering access to that type of care, whereas its very limited use in a given population group would rather tend to suggest that its cost is too high (financial barrier).

13. Similarly, delayed recourse to care in a given group could be an indicator that the group is unable to afford the care (financial barrier) as well as being unaware of its right to receive the care in question (information barrier). In certain circumstances, exceptionally heavy use of a particular type of care (such as emergency care) may also indicate unequal access to it, simply because its root cause may be an impossibility to access the appropriate care at the right time. In this context, the collection of data on the state of health and the use of health services, with a breakdown by sex, age, region and group, is essential in order to identify inequalities in health and access to health care as well as the factors underlying them.

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9. Additional guarantees designed to protect the right to health of vulnerable groups were subsequently adopted, in particular under the International Convention on the Elimination of All Forms of Racial Discrimination (Article 5.*e*.iv), the Convention on the Elimination of All Forms of Discrimination against Women (Article 11.1.*f* and Article 12) and the Convention on the Rights of the Child (Article 24).

10. The other regional instruments that enshrine the right to health are the African Charter on Human and Peoples' Rights (Article 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Social, Economic and Cultural Rights (Article 10). With regard to the development of the right to health in the European Union, see paragraph 34 of the explanatory memorandum to Resolution 1824 (2011) on the role of parliaments in the consolidation and development of social rights in Europe.

11. In the case of compulsory private insurance, the law obliges private insurers to participate in a system based on social solidarity, and risk selection policies are strictly regulated by the State.

12. For a detailed analysis of discrimination in access to health care, see the report by the European Union Fundamental Rights Agency on "Inequalities and multiple discrimination in access to and quality of healthcare", 2013.

14. Unequal access often leads to a situation of non-recourse or delayed recourse to care, which has implications for both individual and public health.

3.1. Factors associated with health systems

15. In its World Health Report (2010), WHO emphasises the move to universal coverage, which it regards as an essential means of promoting and protecting health.[13] WHO defines universal coverage as access for everyone to the health services they need without suffering financial difficulties in paying for them. Today, the provision of health systems that guarantee universal coverage, particularly for those with the lowest incomes, remains an objective for European countries, in view of the various factors described below. In this connection, it should be noted that major economic and/or political events (such as an economic crisis, a change of regime or a war) often lead to the collapse of the existing health system, thus having a disastrous impact on the accessibility of care. Similarly, the concerns aroused by dwindling resources and the crisis in health expenditure (see below) have significantly changed the way in which health is organised, funded and administered and have led in some countries to a rationing of health care, which also has major implications for the accessibility of care.

3.1.1. Eligibility criteria and limited scope of benefits

16. Many health-care systems make benefiting from health care dependent on eligibility criteria, such as lawful residence or the possession of an employment contract. However, unemployed people, Roma and migrants often encounter difficulties in accessing the job market and are therefore at a disadvantage with regard to accessing health care. In Bulgaria, for example, 46% of Roma are reported to have no health insurance as they do not meet the eligibility criteria.[14] In Spain, a new law brought into force by royal decree in April 2012 now makes access to health care more difficult for unemployed people. This is also the case in Greece, although it should be noted that coverage continues for a year after becoming unemployed. As a consequence, hundreds of thousands of unemployed people and undocumented migrants have virtually no access to health care.

17. The limited scope of benefits is another obstacle to access to care. The typical example is dental care, which is excluded from lump-sum repayments in some countries (for example Belgium, Denmark, Greece, Portugal and Switzerland). The exclusion of certain benefits means that patients are obliged to cover the cost themselves, and this accordingly hinders access to care for low-income groups.

3.1.2. Financial barriers

18. As mentioned above, all health systems have charges payable by patients, sometimes referred to as “user charges”. These are sums which patients must pay in order to be able to make use of the service in question (consultation, medication), the remainder being covered by the health system. While the level of this contribution varies from one country to another, the lack of financial protection to make up the amounts not covered by the health-care system may considerably limit access to care for vulnerable categories, such as pensioners of limited means, the chronically ill etc. According to a survey published in July 2010 by the French social research institute *Centre de recherche pour l'étude et l'observation des conditions de vie*, one French person in seven, or around 14% of the population, is forced to restrict spending on medical care owing to the costs involved. In Georgia, user charges payable by patients reportedly account for 74.7% of total health expenditure. These inequalities may lead to extremely high health expenditure in excess of 40% of household income.

19. In this connection, it should be stressed that, according to the European Committee of Social Rights, the right to access to health care presupposes that the cost of care should not place an excessive burden on individual patients. The Committee therefore recommends the introduction of measures to alleviate the effects of user charges in disadvantaged population groups.[15]

13. In this report, WHO outlines the changes which countries can make to their funding systems in order to move more quickly towards universal coverage and subsequently maintain those achievements.

14. “Addressing inequalities in access to health care for vulnerable groups in countries of Europe and Central Asia”, Xenia Scheil-Adlung and Catharina Kuhl, Social Security Department, International Labour Office, 2011.

15. Conclusions XVII-2, Portugal.

3.1.3. Geographical barriers

20. Geographical disparities in terms of accessibility of services represent another obstacle to access to care. These disparities may be due to the lack of a health-care facility close to the patient's home, the lack of transport between the patient's home and the nearest health-care facility, and the time and cost involved in making the journey. In this connection, there is a clear dividing line between urban and rural areas. In the European Union, the number of people who report problems of access to medical care because of the distance to the nearest hospital is twice as great in rural areas as in urban areas. In Ukraine in 2009, 30% of rural households said they did not have access to primary health services, medical centres, clinics and pharmacies.[16] Poor distribution of available doctors is another problem which should be stressed in this context. In France, for example, there are 458 doctors per 100 000 people in urban areas, but only 122 per 100 000 in rural areas.[17]

3.1.4. Language barriers

21. The impossibility of, or difficulty in, communicating with medical personnel is a major obstacle to access to health care, especially for migrants who do not have an adequate command of the host country's language, but also for persons suffering from sensory disabilities. Contrary to what might be thought, this applies not only to "recent" migrants or non-working migrant women who live under particularly isolated conditions in the host country, but also to elderly persons of immigrant origin and migrants suffering from an intellectual disability.[18]

22. Language barriers disrupt the entire process of medical consultation from beginning to end, including the establishment of a relationship of trust between the patient and the doctor. In addition to the difficulties this creates for patients in giving free and informed consent to any treatments they may be offered, the difficulty or impossibility of understanding the patient's problem often leads medical staff to perform multiple tests – which are not necessarily appropriate or essential – in order to identify the problem. In some cases, language barriers may go so far as to cause a public danger, for example where a patient suffering from tuberculosis does not understand that she/he must continue her/his treatment for several months.

3.1.5. Corruption

23. Corruption in the public health sector is another important aspect to be taken into consideration when studying inequalities in access to health care. It takes various forms, including unofficial payments to health professionals, in other words the payment of bribes in order, for example, to avoid being placed on a long waiting list (for a consultation or an operation) or, worse still, simply to receive treatment. Whatever the purpose, and leaving aside the other nefarious effects of corruption in general, the practice of bribes creates an inequality in access to health care, to the detriment of those who lack sufficient means. On this latter point, it is interesting to note that, according to studies which have been brought to the attention of the Group of States against Corruption (GRECO), access to health care is one of the areas in which corruption could have a potentially differentiated impact on men and women. GRECO has therefore supported the inclusion of a gender perspective in national surveys of corruption as an obstacle to equality in access to care.

24. The Office of the United Nations High Commissioner for Human Rights has noted that the low salaries of health professionals combined with a lack of ethics training, a non-transparent system of financing by the national health system and underfunded clinics create fertile ground for bribery.[19] While the prevalence of corruption varies from one member State to another, the statistics for the European Union member States are not gratifying. According to a recent report by the European Health Care Fraud and Corruption Network, of the thousand billion euros spent in health services in the European Union, 56 billion euros are lost to fraud and corruption.

16. See footnote 14.
17. However, in France, this "medical deserts" phenomenon also affects urban areas since it is very difficult in some parts of Paris or in some big cities to find a GP who charges the statutory rate (the rate reimbursed by the health insurance scheme).
18. See footnote 12.
19. Good governance practices for the protection of human rights, Office of the United Nations High Commissioner for Human Rights, New York and Geneva, 2007.

3.1.6. Other barriers

25. Ignorance of one's rights and of the rules by which health systems operate is another factor making for inequalities in access to health care. In this connection, *Médecins du Monde* note that 60% of all patients who attend their clinics do not know where to go to get vaccinations.[20]

26. Unduly complex administrative procedures and excessive red tape before being able to receive treatment (for example production of valid identity documents, proof of residence, proof of insufficient income, home visits, etc.) tend to create additional obstacles to access to health care, especially in the case of vulnerable groups.

3.2. Socio-economic factors

27. A study carried out in developing countries[21] shows that access to health services depends to a significant extent on the socio-economic characteristics of a household, especially the mother's education. According to the study's authors, a policy to provide universal education for girls could therefore contribute to significantly improving access to health for poor people.

28. Socio-economic factors also play an important part in health inequalities. Statistics on the mortality rate and state of health of Europeans reveal substantial inequalities both between countries and between socio-economic groups in the same country. For example, in 2009, life expectancy at birth was 82 in Switzerland (80 for men and 84 for women), whereas it was only 68 in Russia (62 for men and 74 for women).[22] Life expectancy at birth for men was 54 in Calton, a poor area of Glasgow (Scotland), whereas in Lenzie, only a few kilometres away, it was 82.[23]

29. This situation cannot be explained solely by inequalities in access to health care. Such disparities are due in particular to socio-economic factors such as income, employment, education and living and working conditions, and their unequal distribution among the population. According to WHO experts, disadvantaged communities are handicapped in many different ways: "poor education, lack of amenities, unemployment and job insecurity, poor working conditions, and unsafe neighbourhoods, with their consequent impact on family life" and they add that "[t]his unequal distribution is not in any sense a 'natural' phenomenon but is the result of policies that prize the interests of some over those of others – all too often of a rich and powerful minority over the interests of a disempowered majority".[24]

3.3. Migration and security policies

30. The trend in Europe towards increasingly stringent migration and security policies aimed at deterring, in particular, Roma and undocumented migrants is also a factor that leads to inequalities in access to care. In this context, the repeated expulsions of Roma in France have made it nearly impossible for some members of this group to access health care. Similarly, the requirement for health professionals and/or public servants to report irregular migrants discourages many of the latter from making themselves known to the health authorities, for fear of being reported and sent back to their countries of origin.

31. These policies also have an impact on health policies. In Spain, for example, since 1 September 2012, undocumented migrants have been excluded from most of the public health system,[25] whereas the law previously provided for all residents to have access to health care, whatever their status.

32. As the HUMA (Health for Undocumented Migrants and Asylum seekers) network observes, "the debate concerning undocumented migrants continues to be rooted in the fight against 'illegal migration', and no debate has yet been opened, if only for public health concerns, about the need to protect the health of these people".[26]

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20. "Access to healthcare in Europe in times of crisis and rising xenophobia", Médecins du Monde, April 2013.
21. Jean-Claude Berthélemy and Juliette Seban, "Dépenses de santé et équité dans l'accès aux services de santé dans les pays en développement", Université Paris 1, Centre d'Economie de la Sorbonne, 2009.
22. World Health Statistics, WHO, 2012.
23. WHO, Closing the gap in a generation. Health equity through action on the social determinants of health. 2008 report.
24. Ibid.
25. For adult migrants in an irregular situation, universal assistance is now limited to medical or accident emergencies and maternity care, whereas health care for under 18-year-olds will continue to be provided free of charge.
26. Are undocumented migrants and asylum seekers entitled to access health care in the European Union? Synthesis of the study concerning the legislation of 16 countries. Health for Undocumented Migrants and Asylum seekers (HUMA) Network, November 2010.

The migration and security policies in question not only put the lives of those concerned at risk and stigmatise these individuals even more, but also constitute a real public health problem in the case of communicable diseases, as the inability to access care or a delay in doing so exposes the entire population to possible infection.

4. European health systems faced with the economic crisis

33. Nowadays, longer life expectancy, due in particular to medical advances, is accompanied by a sharp rise in chronic diseases (cardiovascular and respiratory diseases, diabetes, cancer, etc.) and neurodegenerative conditions (Alzheimer's and other forms of dementia), as well as the emergence of new diseases. Although medical advances enable increasingly specialised treatments to be developed in order to meet these challenges, it is still extremely costly to fund them. As a consequence, care needs have risen dramatically in the last few decades. In the face of this mounting financial pressure, the viability of European health systems has been put to the test and many States have embarked on reforms to increase the efficiency of their health systems.

34. The situation has recently been exacerbated by the economic crisis, which is having a dual impact on health-care systems. On the one hand, the austerity measures adopted by governments are leading to cutbacks in public expenditure, including on health care. On the other, the crisis is having a significant effect on the socio-economic determinants of health, such as access to employment or housing, especially for vulnerable groups, which could be reflected in a rise in care needs. This eventuality is confirmed by an article published recently in *The Lancet,* which analyses the effects of the crisis on the basis of national surveys and statistics. In the case of the United Kingdom, the study notes that the rise in the suicide rate between 2008 and 2010 can be linked to rising unemployment, which resulted in 1 000 additional deaths. In Spain, cases of mental illness increased substantially between 2006 and 2010 and it is estimated that at least half of these cases are due to unemployment and difficulty in paying mortgages.[27]

35. A study recently published by WHO[28] points out that, in order to adapt their health-care systems to the exigencies of the crisis, States have pursued very different policies, which may be divided into three types: policies aimed at changing the level of contributions to fund health services, especially by making budget cuts and increasing or introducing user charges for patients; policies aimed at changing the range and quality of services; and policies aimed at influencing the cost of care, especially by lowering the price of medical goods or lowering or freezing the salaries of health professionals, and by promoting the rational use of medicines. In most countries, the breadth of coverage and the population covered have not radically changed. However, several countries[29] have introduced or increased user charges for essential health services. There is a risk that this will disproportionately affect access to care for vulnerable categories such as low-income groups, the unemployed, migrants and regular users of these services such as those suffering from chronic diseases. The authors of the study note that, in the long term, measures of this type might lead to an increase in health expenditure owing to the costs arising from delayed recourse to treatment (aggravated clinical state requiring more expensive treatment).

36. As already pointed out above (see paragraph 32), problems of access to care and delayed recourse to treatment could have another consequence, not of an economic nature, but no doubt far more disastrous, namely the public health risk associated with possible exposure of the population to communicable diseases or the use of counterfeit medicines.

27. "Financial crisis, austerity, and health in Europe", *The Lancet*, Early online publication, 27 March 2013, Marina Karanikolos, Philipa Mladowsky, Jonathan Cyclus, Sarah Thompson, Sanjay Basu, David Stuckler, Johan Mackenbach and Martin McKee.

28. WHO, Health policy responses to the financial crisis in Europe, Policy Summary 5, 2012.

29. The countries concerned are: Armenia, the Czech Republic, Denmark, Estonia, France, Greece, Ireland, Italy, Latvia, the Netherlands, Portugal, Romania, the Russian Federation, Slovenia, Switzerland and Turkey.

5. The impact of the economic crisis on access to health care: the example of Greece[30]

37. Greece is one the countries worst hit by the current economic crisis in Europe. In exchange for "financial rescue plans", the government has adopted drastic austerity measures demanded by the Troika consisting of the European Commission, the Central European Bank and the International Monetary Fund. These measures have affected all sectors, but especially the health sector, where significant budget cuts have been made. There is now talk of a health, and even humanitarian crisis affecting more and more people, principally the unemployed, migrants, refugees, Roma, women and children.

38. The Greek public medical insurance system is based on employment. Consequently, with some exceptions, only those who have a job and those who have been unemployed for less than a year are entitled to medical coverage. In a country where the unemployment rate has climbed to 27% in the population as a whole (youth unemployment stands at over 60%), the effect of an employment-based system is therefore to exclude a very large proportion of the population from access to health care. People with insurance coverage still have to pay €5 for each visit to hospital, and charges are made for any tests that have to be performed during the consultation.

39. The budget cuts have particularly affected public hospitals, where some basic supplies, such as syringes, compresses, latex gloves or suture thread, are out of stock and medical personnel are sometimes forced to ask patients to purchase these supplies themselves. The difficulties related to Greece's geography (its territory includes hundreds of islands) have grown worse with the crisis. The islands suffer in particular from staff shortages: many small islands have no doctor at all and others "share" a doctor with other islands. The larger islands, for their part, suffer from a shortage of specialists. A significant increase can be seen in the number of HIV carriers, and cases of tuberculosis are reappearing (although they remain isolated). Vaccines are no longer free, and children are not accepted in schools unless they are vaccinated.

40. The situation facing migrants is growing steadily worse. With the crisis, many have lost their jobs and fallen into an irregular situation and, as a result, no longer have access to health care. The problem of irregular mixed migration flows to Greece poses a real challenge to the government. In 2012, it spent 120 million euros on improving access to health care for irregular migrants, whose number is currently estimated at over a million. Special centres have been set up to cater for these migrants. At these centres, an initial medical examination is carried out for each new arrival. Where necessary, patients are referred to a public hospital to receive the proper care. Access to basic care is guaranteed throughout their stay in these centres.

41. Under current regulations, everyone has access to free emergency care. In practice, however, this requirement is not always met. In this connection, the situation of pregnant women who have no medical coverage is particularly worrying. If they are admitted to emergency services to give birth, they are subsequently required to pay the relevant charges, which vary between 800 and 1200 euros. Cases were mentioned of hospitals which refused to issue a birth certificate or even to let the newborns leave the hospital until the charges had been paid.

42. NGOs report an alarming increase in the number of people who come to them for help, including Greek citizens, most of whom are people suffering from chronic illnesses. Because of salary cuts and the increased charges for medicines (25% of the total cost), even people with medical coverage are unable to afford their medicines. Faced with growing demand, *Médecins du Monde* now issue medicines on presentation of a prescription, whereas a prior consultation was previously required.

43. Greek citizens have set up what is effectively a parallel health system based entirely on solidarity and voluntary work. An example of this is the free clinic in Hellenikon, where dozens of doctors work on a voluntary basis. Set up in 2011, the clinic caters in particular for patients who have no medical coverage and collects medicines which it subsequently distributes to its patients.

44. The Ministry of Health has embarked on some fundamental reforms aimed at improving management of the health system and making it more viable, and guaranteeing universal access to primary health care. In this context, there are also plans to strengthen the social security safety net in order to guarantee access to health

30. The information in this section was collected during the fact-finding visit to Athens (Greece) on 12-13 April 2013. In the absence of the rapporteur for health reasons, the visit was undertaken by the Chair of the Committee on Social Affairs, Health and Sustainable Development, Ms Liliane Maury Pasquier (Switzerland, SOC), who met with representatives of the national authorities, civil society and non-governmental organisations.

care for the most vulnerable groups. The plans include the introduction, in 2013-2014, of a “health ticket” to guarantee access to care for 200 000 people (not covered by sickness insurance). This project is funded by the European Union.

45. Lastly, xenophobic and racist acts against refugees and migrants have increased alarmingly. Also, asylum-seekers and refugees from certain countries who enjoy limited medical coverage by virtue of their status say they have been ignored and/or mistreated by medical personnel.

6. Conclusions

46. To guarantee the fundamental right to health, the Assembly should recommend that everyone living in Europe should be able to enjoy equal access to health care regardless of their financial situation, their residency status or their place of residence. The Council of Europe member States should therefore take all necessary measures to reduce and eliminate inequalities in access to care. To identify inequalities in health and access to health care and the factors leading to them, States should gather reliable data on the health status and use of health services by people living in their territory.

47. With regard to the factors associated with the health system, States should reduce user charges, with particular attention to the most disadvantaged social categories, and ensure access to health-care facilities and competent health professionals throughout their territory. They should also strengthen free linguistic assistance in health-care facilities at all stages of service provision (consultation, provision of medical information, etc.). This includes translation and mediation services for people who do not speak or understand the language, sign language and other forms of support for persons suffering from sensory or intellectual impairments.

48. States should also ensure the availability of information on the health system, including vaccination and screening programmes, especially for disadvantaged groups, and provide health education programmes.

49. States should also tackle the socio-economic factors influencing health, such as access to employment and housing. This is especially important in the current context of economic crisis in Europe, which should on no account be used as an excuse giving governments a free hand to take retrograde measures disregarding the fundamental right to health, to the detriment, in particular, of vulnerable groups, who, moreover, are often hardest hit by economic crises. The crisis should be viewed as an opportunity to rethink health systems and increase their efficiency.

50. Lastly, health and humanitarian considerations should take precedence over all other considerations. The Council of Europe member States should therefore dissociate their security and immigration policies from their health policies.