



Is It More Important to Address the Issue of Patient Mobility or to Guarantee Universal Health Coverage in Europe?

Comment on “Regional Incentives and Patient Cross-Border Mobility: Evidence From the Italian Experience”

Helena Legido-Quigley^{1,2*}

Abstract

This paper discusses whether European institutions should devote so much attention and funding to cross-border healthcare or they should instead prioritise guaranteeing universal health coverage (UHC), “addressing inequalities” and tackling the effects of austerity measures. The paper argues through providing the evidence in both areas of research, that the priority at European level from a public health and social justice perspective should be to guarantee UHC for all the population living in Europe and prioritise protective action for those who are most in need.

Keywords: Patient Mobility, Austerity, Financial Crisis, European Union

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*Correspondence to:

Helena Legido-Quigley

Email: ephhlq@nus.edu.sg

It is a paradox that when the European Parliament and the Council of the European Union, through its Directive 2011/24/EU on the application of patients’ rights in cross-border healthcare mobility,¹ have agreed on the rules for a patient in one country to receive care in another, some Member States have decided to exclude large proportions of their own population from their health systems.

These decisions have been justified on the grounds of the financial crisis which started in 2008 and have resulted in wide-ranging austerity measures and structural reforms across Europe. These economic and social policies are currently being questioned, both on economic grounds and because there is mounting evidence that European health status might be adversely affected.^{2–8}

The paper by Brena and Spandanora⁹ in this issue describes the regional incentives and patient cross-border mobility in Italy. It highlights how cross-border mobility is both relevant for equity reasons, due to the additional costs involved when a patient travels to another region, and for financial reasons owing to the difficulties in reallocating funding between regions. While these are valid concerns, and the authors raise important repercussions for other European countries, should European Institutions devote so much attention and resources to patient mobility, when there are far more pressing issues such as guaranteeing Universal Health Coverage (UHC) or understanding and tackling the effects of austerity measures in health and healthcare provision?

The research conducted on patient mobility across Europe concludes that the number of patients moving to other countries to receive healthcare are small and it only represents

an estimated 1% of the total health expenditure.¹⁰ Glinos, in an excellent opinion article,¹¹ already warned that too much attention was being paid to patient mobility in comparison to professional mobility. She described how patient mobility is narrow and self-limited, whereas professional mobility is expected to increase with the healthcare workforce shortages existent across the EU.

In addition, the available studies on patients’ experiences and preferences regarding cross-border healthcare suggest that most patients prefer to be treated near home, with family support, with a health system they can trust, with continuity of care, and with healthcare professionals that speak the same language.^{10,12,13} Therefore, while it is important to have the mechanisms in place to allow for patients to receive healthcare in another Member State, and for certain groups these are very useful (eg, patients living in border regions, tourists and retired migrants), the majority of patients still prefer to receive healthcare near their place of residence.

While a considerable amount of research has been conducted on cross-border healthcare mobility, little research has been undertaken on the health consequences of the financial crisis in Southern Europe.⁶ The valuable but limited available evidence suggests that suicides have gone up, with more detailed analysis showing this is the case in Greece,¹⁴ Italy¹⁵ and in some areas of Spain^{5,14} with increases being associated with rises in unemployment. In Greece, the prevalence of major depression has more than doubled and tuberculosis and HIV incidence has increased particularly among injecting drug users.^{16,17} In Spain, major depression related to unemployment has risen by nearly 20 percentage points¹⁴

¹Saw Swee Hock School of Public Health, National University of Singapore, Singapore, Singapore. ²Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine, London, UK.

and poverty has increased dramatically among children, with nearly 30% being at risk of poverty or social exclusion.^{18,19} The consumption of anti-depressants in Portugal has increased by 20% between 2007 and 2011.²⁰ However, these effects have been counterbalanced to some extent by decreases in road traffic and alcohol-related deaths.⁶

Even less research is available on the effects of austerity measures in comparison to that available and presented on the effects of the financial crisis. The main constraint that all researchers working in this field face is that there is a long delay in releasing health data. In addition, in most countries, data on those who are most vulnerable and who are experiencing the effects of austerity most severely are not available as they do not feature in national health surveys, which therefore are likely to underestimate the scale and magnitude of any problems. However, the available evidence suggests that the effects of financial crises can be ameliorated by social protection programmes. Iceland is provided as an example to support this argument since it has opted to reject austerity measures and as a result the effects of the financial crisis on health have so far not materialized.⁶

The main results of the research carried out on austerity measures, defined here as fiscal interventions taken by a government to reduce public expenditure, by cutting spending or increasing taxes, suggests that they may impact on health in three ways.⁶ Firstly, they can directly affect health status of individuals, particularly mental health, through experiencing unemployment or precariousness at work, loss or reductions in income (facing wage cuts, pay freezes), increases in personal and family debt, and in some cases house repossessions and homelessness. Secondly, cuts to government expenditure such as pensions, transfer of costs of healthcare and social and welfare provision to the individual, including the introduction of copayments for certain services, further impoverish individuals and households.²¹ Thirdly, cuts in the third sector, which in some welfare states play a key role in providing health and social services, especially when the state withdraws, affect those individuals that are in most need and are more vulnerable to economic crisis.

Although we have suggested the way in which austerity measures may adversely affect health, nevertheless they have been introduced extensively across Southern Europe, particularly in Greece, Portugal and Spain. In Greece, one of the directives of the so-called Troika (The European Central Bank, the European Commission and the International Monetary Fund) was that the public expenditure on health should be capped at 6% of gross domestic product (GDP),²² which led to reductions in hospital budgets,²² cuts in salaries,²³ and reduction in staff.²³ In addition, cancer screening programmes,²⁴ mental health services, prevention and treatment programmes for illicit drug use, and municipal public health services experienced further cuts.²² Further copayments were introduced for medicines, user fees increased for outpatients visits, and new fees were introduced for prescriptions. It is estimated that up to 2.5 million people have been left without health insurance.²⁵

In Portugal, as part of the €78 billion bailout package agreed with the Troika, the Government had to reduce healthcare expenditure. Portugal's health expenditure per capita was €1888 in 2011, scoring below the Organisation for Economic

Co-operation and Development (OECD) countries average of €2395. Health expenditure per capita in Portugal fell 2% between 2009 and 2011.²⁰ The new austerity measures included phasing out tax relief for private insurance; reducing state subsidies to the public sector; reduction in prices paid for drugs; lower wages for health workers; and cuts in expenditure on prevention and public health. In addition, existing user charges were increased.²⁶

In Spain, the budget allocation for health and social services was reduced by 13.65% in 2012 and 16.2% in 2013, with some regions imposing additional budget cuts. Furthermore, the funds made available through the Dependency Law (2006) for elderly and disabled people in need of social services have been reduced by 1.592 million euros (£1326 million), leaving many vulnerable people and their families without the needed support.²⁷ The biggest reform introduced by the current Government is the Royal Decree-Law 16/2012²⁸ which came into force in September 2012 and ended with the principles that have been the flagship of the Spanish health system for the last three decades, which is universal coverage and free services at the point of delivery. At its stands; the Royal Decree-law 16/2012, has de facto excluded 873 000 non-residents from receiving preventive and primary care services (with exceptions for pregnant mothers and children).¹⁹ Furthermore, copayments for drugs have been extended. Pensioners now have to pay for the cost of their medicines. Those with higher incomes will pay 10% of the cost of their medicines, with the rest having to pay €8, €18, or €60 monthly payments depending on their pension income.²⁹

While new research is slowly becoming available in Southern Europe, and acknowledging that we have only been able to provide a broad summary of the literature here, European non-for profit organizations have already been drawing on their experiences, suggesting that the impact of austerity measures has been more devastating than the few available statistics suggest. They describe immigrants who are pregnant being denied treatment and their children being denied vaccination; patients improperly billed for emergency care; and patients being refused healthcare when they are eligible. There have also been reports of increases in copayments particularly affecting individuals and families without income, individuals and families with low incomes and people living in rural areas.³⁰ Our own research conducted in Spain suggests that patients are putting their lives at risk, while acknowledging that feeding their families takes priority in these circumstances. The following quote from our research conducted in the Autonomous Community of Valencia highlights patients' daily struggle, with this quote being one of the many examples reported. In this case, the healthcare professional suggested that increased copayments lead to the death of a patient: "He was a cardiac transplant patient, he stopped taking his medication and died. [...] He stopped taking it because he did not have enough money (I20)."³¹ There are public health implications of these measures for the entire population. Austerity measures are a setback for prevention, monitoring and control of both communicable and non-communicable diseases. Lack of supervision for patients with contagious diseases and lack of vaccination and prevention programmes are areas of great concern. Furthermore, as we have illustrated earlier, increased

copayments for medications or for attending services affect those who are most vulnerable and result in patients not complying with medication regimen or delaying treatment. Therefore, is it more important to address the issue of patient mobility in Europe or to guarantee UHC? Only when measures to assure UHC and to tackle the impacts of austerity measures are introduced, we can then assure that patients who travel to another Member State will receive healthcare of good quality and equitable. Thus, the priority at European level from a public health and social justice perspective should be to guarantee UHC for all the population living in Europe and prioritise protective action for those who are most in need. But, how can we transform these values into practice and policy? The proposed solution is twofold. First, countries should adopt measures to provide access and free services to those who are most vulnerable and who have been, recently in many countries, excluded from the health system. Spain is an example of where change is possible. Not without their difficulties and political pressure from Central government, some of its Autonomous Communities (eg, Valencia, Mallorca) have decided to reintroduce free healthcare for undocumented migrants bypassing regulations at National level.

Secondly, at European level there is a need to discuss what is the role of the EU in the context of the new global Sustainable Development Goals as agreed by the Heads of State and Government and High Representatives at a meeting in the United Nations headquarters.³² The key goal proposed to improve health and wellbeing is to guarantee UHC in all countries, as well as assuring financial risk protection. In the context of the current migration drama that Europe is experiencing, the EU needs to step up in its role to find solutions for the most vulnerable and to become a real agent of social justice. A step in the right direction would be to start really advocating for UHC within the European territory and making sure that access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines are available for all.³²

Ethical issues

Not applicable.

Competing interests

Author declares that she has no competing interests.

Authors' contributions

HLQ is the single author of the manuscript.

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