Universal Health Coverage and the Pillar of Social Rights: Prioritising Inequality in EU Policy Frameworks

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Introduction

In the last two years, two important steps in the pursuit of a more social Europe have been taken. First, in September 2015, the UN adopted Agenda 2030 and its members committed to achieving 17 sustainable development goals (SDGs) to end poverty, protect the planet and ensure sustainability for the future[1]. Second, and finally published in April 2017, the European Commission adopted a European Pillar of Social Rights (EPSR), enshrining 20 principles to guide convergence towards better living and working conditions[2]. Both of these policy frameworks contain provisions on health, calling for greater access to and quality of care. At the centre of their objectives is the concept of universal healthcare coverage (UHC) – providing everyone with the health services that they need without causing financial hardship.

In addition to featuring, either directly or indirectly, as an objective of the SDGs, the EPSR, the Europe 2020 Strategy, the Charter of Fundamental Rights and a host of other EU policies and laws, UHC is a core marker of inequality in Europe. Affecting vulnerable and marginalised groups, as well as particular geographical regions, disproportionately, it reflects the broader health and socio-economic inequalities that exist between and within member states. This makes UHC both an important indicator of and a valuable lever to fight inequality and realise the objectives of both the EPSR and Agenda 2030.

This report makes the case for prioritising UHC within the emerging frameworks for implementing the EPSR and the SDGs. It first reviews the 'state of play' of these initiatives, identifying upcoming points of intervention. It then explores the relevance of UHC as an indicator and a policy lever for addressing the objectives of the EPSR and SDGs. Finally, it suggests a series of actions which might be taken over the next 12 months to ensure meaningful implementation of the EPSR and SDG #3 (concerning health). In four concrete recommendations, it asserts that the EU must: put UHC at the centre of the SDG Strategy in 2018; adopt consistent, coherent and relevant indicators; integrate monitoring into the European Semester and; mobilise EU funding frameworks for the pursuit of UHC.

[1] Transforming our world: The 2030 Agenda for Sustainable Development, United Nations, September 2015. Available here [accessed August 2017].
[2] Communication establishing a European Pillar of Social Rights COM (2017) 250 final, 26.4.17. Available here [accessed August 2017].

The European Pillar of Social Rights: latest developments

On 26 April 2017 the European Commission published its proposals for a European Pillar of Social Rights (EPSR). Aimed at earning Europe a 'social triple A', the final text of the EPSR follows a public consultation and contains 20 rights and principles, grouped into three chapters which cover access to the labour market, working conditions and social protection. The Pillar was published in two forms – one a recommendation and the other a proposal for an interinstitutional proclamation – and was accompanied by a communication, a staff working document, three supplementary initiatives and a reflection paper on the social dimension of Europe[3].

Domain 16 of the Pillar, which refers to healthcare, states that:

"Everyone has the right to timely access to affordable, preventative and curative health care of good quality."

The Social Pillar seeks to consolidate commitments which already exist within the EU *acquis*, rather than presenting new laws or initiatives (with the exception of those announced alongside the Pillar). It will thus remain formally non-binding, presenting a challenge in terms of implementation. In the absence of specific new legislation to enforce the rights that it contains, the Pillar relies upon commitments from national governments and monitoring via the EU's European Semester and open method of coordination (OMC) frameworks. The logistics of implementation have not yet been made clear – the EU will use a monitoring tool with a scoreboard of indicators, currently being developed, and legislation will be adopted 'where needed'. After a period of tough negotiations, with changes notably made to the preamble[4] of the declaration following the Council legal service opinion, an inter-institutional agreement could be reached leading to the proclamation of the Pillar.

The Sustainable Development Goals: latest developments

In September 2015 the UN and its member countries adopted the 2030 Agenda for Sustainable Development, comprised of 17 Sustainable Development Goals. The goals cover areas such as poverty, education, health and climate change, as well as peace, justice and access to strong governing institutions. The 17 SDGs are accompanied by 169 specific targets and, though still under construction, some 230 indicators. The goals are to be implemented via a 'global partnership' comprised of governments, the private sector, civil society, UN agencies, academia, the scientific

[3] These documents can all be found on the relevant Commission webpage, available here [accessed August 2017].
[4] The most pertinent change concerns paragraph 14 of the preamble which was reformulated to reflect more clearly that the rights/principles themselves are not legally enforceable until they are translated into dedicated action and/or separate legislation at the appropriate level.

community and other stakeholders. Applying to all members of the UN, the SDGs require a policy response from the 28 EU member states and the EU itself.

SDG #3 commits states to 'Ensure healthy lives and promote well-being for all, at all ages'. Moreover, the Agenda 2030 report states that:

"To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind."

In November 2016 the Commission published a document outlining the 'key actions' that are already in place and which contribute to Agenda 2030[5]. In relation to SDG #3, for example, these included EU initiatives on HIV/AIDS, cross border health threats, AMR, and the range of projects funded under the Health Programme. In June 2017, reflecting broader dissatisfaction with the absence of concrete actions in the Commission's plan, the Council of the EU adopted conclusions which understand the SDGs and Agenda 2030 to be 'an opportunity and positive prospect for the European Union'[6]. As such, it calls on the Commission to produce by mid-2018 'an implementation strategy outlining timelines, objectives and concrete measures', as well as a gap analysis of how existing policies will contribute to achievement of the goals.

Universal Health Coverage: a marker for inequality

Universal health coverage (UHC) is at the core of both the EPSR and the SDGs. It is also a feature of European health and social systems which has come under great strain in the aftermath of the economic crisis. In 2015 the International Labour Organisation found that 10 EU member states had announced fiscal consolidation policies with the potential to impact upon universal coverage[7], whilst the European Health Report concluded that 'moving towards universal health coverage still requires considerable action' as a result of falling public expenditure and increasing out-of-pocket payments[8]. Moreover, the OECD's Health at a Glance Report[9], published in November 2016 as part of the 'State of Health in the EU' cycle, found that:

'Most European countries have achieved universal (or near-universal) coverage of health care costs for a core set of services, which usually include consultations with doctors, tests and examinations and hospital care…Four European countries, however, have at least 10% of their population that is not covered for health care costs (Cyprus, Greece, Romania and Bulgaria).'

[5] Communication on next steps for a sustainable European future COM(2016) 739 final, 22.11.16. Available here [accessed August 2017].
[6] Council (2017) Conclusions on a European response to the 2030 Agenda, 20.6.17. Available here [accessed August 2017].
[7] International Labour Organisation (2015) 'World Social Protection Report 2014-15', available here [accessed August 2017].
[8] The European Health Report 2015, World Health Organization. Available here [accessed August 2017].
[9] OECD (2016) Health at a glance: Europe 2016, available here [accessed August 2017].

The European Health Report attributes much of the recent stalling, or even reversal, of progress on UHC in Europe to fiscal consolidation measures taken in the aftermath of the crisis. This should not mask the reality, however, that UHC was not uniformly present across the member states prior to 2008. In several countries, mostly in Eastern Europe, between 4% and 19% of the population were reporting unmet medical need, either because of cost, waiting times or distance to travel. Though UHC is written into the constitutions of many of these countries, lack of resources has often hindered progress towards this goal[10]. More broadly, a survey of 29 European countries (prior to the onset of the economic recession) found that 'despite most European countries having mandates for universal health coverage, individuals who are low income, in poor health, lack citizenship in the country where they reside, 20–30 years old, unemployed and/or female have systematically greater odds of feeling unable to access care'[11].

Two groups which face particularly high barriers to accessing healthcare area the Roma community and those with mental health problems. In 2016 the Fundamental Rights Agency found that only 74% of the Roma population are covered by national basic health insurance schemes and that up to 29% are limited in their activity by a long-term health complaint[12]. Other research has found that Roma communities are two to three times more likely to have reported an unmet medical need in the last 12 months, compared to non-Roma populations in the same geographical area[13]. When addressing these barriers, the experience of the Roma community reveals the importance not only of cost, distance and waiting times for care, but also of promoting trust in the health system and ensuring the cultural acceptability of care, as key factors of UHC[14].

Mental health care is another area where access to care is far less than universal. Data on need for and uptake of mental health services across Europe is far from comprehensive but research suggests that there is a high level of unmet need for care and a significant treatment gap (measured as the percentage of those suffering with a specific condition who are not receiving treatment for it) – for major depression, for instance, this ranges from 36% to 79% between member states[15]. The proliferation of mental health problems since the economic crisis has been well documented[16] and the mental health case illustrates the importance of taking both supply side – availability of appropriate treatment – and demand side – recognition of the need for treatment and willingness to undertake it – barriers to access into account when promoting UHC.

[10] Waters et al. (2008) 'Health insurance coverage in Central and Eastern Europe: Trends and challenges' Health Affairs Volume 27(2). Available here [accessed August 2017].
[11] Cylus and Papanicolas (2015) 'An analysis of perceived access to health care in Europe: How universal is universal coverage?' Health Policy Volume 119(9). Available here [accessed August 2017].
[12] Fundamental Rights Agency (2016) Second European Union Minorities and Discrimination Survey: Roma. Available here [accessed August 2017].
[13] Arora et al. (2016) 'An examination of unmet health needs as perceived by Roma in Central and Eastern Europe' European Journal of Public Health Volume 26(5), available here [accessed August 2017].
[14] Hanssens et al. (2016) 'Accessible health care for Roma: a gypsy's tale a qualitative in-depth study of access to health care for Roma in Ghent' International Journal for Equity in Health Volume 15(38), available here [accessed August 2017].
[15] Alonso et al. (2007) 'Population level of unmet need for mental healthcare in Europe' British Journal of Psychiatry, available here [accessed August 2017]; Barbato et al. (2014) 'Access to mental health care in Europe', available here [accessed August 2017].
[16] Gili et al. (2013) 'The mental health risks of economic crisis in Spain: evidence from primary care centres, 2006 and 2010' European Journal of Public Health Volume 23(1), available here [accessed August 2017].

UHC must therefore be understood as a marker for broader inequality. Disproportionately affecting the poor, the young, the unemployed, women, those without citizenship and those in Eastern European member states, weaknesses in UHC embody and determine many of the inequalities that the EU's regional, cohesion, gender, labour and social policies were designed to address. As such, it should be prioritised as a key indicator and central objective of a 'more social' Europe and a social 'Triple A'. The next section of the report explores practical ways in which this can be achieved.

Implementing the EPSR and SDG #3: recommendations for action

This section of the report makes five concrete recommendations for action to prioritise UHC and facilitate meaningful implementation of both the EPSR and

Universal health coverage is a goal that has been embedded in the European Pillar of Social Rights and is another key objective of the Sustainable Development Goals'

(2016 Health at a Glance Report)

UHC is not a 'silver bullet' for reducing health inequalities, and should not be understood as such[17]. However, it does hold the potential to remove some of the most common barriers to accessing care, and to lay a foundation for tackling more complex inequalities within the health system[18]. By putting it at the centre of implementing structures for the EPSR and the SDGs, the EU can support the reduction of health and broader inequalities both within and between member states. The following five recommendations offer ways in which meaningful progress might be made in the next 12 months, presenting an agenda for concrete and immediate action. EPHA and its members remain committed to assisting the Commission and member states in implementing the EPSR, meeting the SDG targets and reducing health inequalities.

1.Put UHC at the centre of the SDG Strategy

In June 2017 the Council of the EU called upon the European Commission to publish a strategy for action to implement the SDGs by mid-2018. This is a valuable opportunity to recognise and integrate the importance of UHC as a lever for achieving the targets of SDG #3. The Commission's gap analysis, which will accompany the Strategy, should contain a dedicated section on target 3.8, which calls explicitly for the achievement of UHC, 'including financial risk protection, access to quality essential health-care services and

[17] See, for instance, Asaria et al. (2016) 'How a universal health system reduces inequalities: Lessons from England' Journal of Epidemiology and Community Health. Available here [accessed August 2017].
[18] Hone et al. (2017) 'Association between expansion of primary healthcare and racial inequalities in mortality amenable to primary care in Brazil: A national longitudinal analysis' PLOS Medicine, available here [accessed August 2017].

access to safe, effective, quality and affordable essential medicines and vaccines for all'. This will highlight the inconsistencies and oversights in current EU policy frameworks which hamper achievement of UHC and exacerbate inequalities in access to care, and thus present an agenda for further action. The Strategy itself should note the relevance of UHC for existing EU policy objectives, as well as the findings of the gap report, and identify UHC as a central lever for achievement of the SDGs.

Recommendation: Put UHC at the centre of the SDG Strategy, building on relevant findings from the gap analysis and recognising its role in achievement of the SDGs.

2.Adopt consistent, coherent and relevant indicators

A core element of implementing the EPSR and achieving the targets of the SDGs is the establishment of indicators that can be used for monitoring. The documentation of the EPSR stated that it would be supported by a scoreboard of indicators linked to its 20 principles. In addition to the detailed targets contained in the SDGs, the Council has called upon the Commission to compile a further set of indicators to measure progress towards them in the member states. Such instruments are vital to ensuring meaningful implementation and progress towards the goals of the EPSR and the SDGs, but they must be developed in an efficient manner. While the Social Protection Committee's Sub-Group (SPC-ISG) may expand on its indicators work to monitor the European Pillar of Social Rights, the currently existing health indicators need to be critically evaluated. The commonly used indicator on self-reported unmet need for medical care derived from EU statistics on income and living conditions (EU-SILC) has methodological limitations to track progress in UHC across member states. While useful in terms of locating problems regarding access to healthcare on a country specific level, health coverage and out-of-pocket payments are better suited for monitoring UHC while allowing for better data comparability. These indicators are used by the OECD and should be adopted across EU policy frameworks including monitoring of the SDGs.

Recommendation: Adopt consistent, coherent and relevant indicators by engaging with stakeholders already involved in health data collection when designing new scoreboards and monitoring instruments.

3. Integrate monitoring into the European Semester

The primary weakness of both the EPSR and the SDGs is the absence of a clear implementation and enforcement mechanism. The Pillar 'applies' only to euro area member states and, even for these countries, has no legal force, making its implementation dependent upon political will. The SDGs are technically binding for all countries, but no plan for reaching the targets or measuring national progress has yet been published. Recognising the potential limitations here, the Council has called for the Commission to conduct implementation of the SDGs, wherever relevant, within the context of the European Semester[19]. Similarly, the implementation of the EPSR and

[19] Council (2017) Conclusions on a European response to the 2030 Agenda, 20.6.17. Available here [accessed August 2017].

its social scoreboard is to feed into the Semester process[20]. As well as facilitating the monitoring and guiding of implementation, embedding these objectives within the Semester contributes to rebalancing the process in favour of social goals. The Semester sustained considerable criticism in its early cycles for its narrow focus upon the fiscal dimension of health; whilst considerable improvements have been made, explicit inclusion of objectives relating to UHC, inequalities and quality of care would represent a genuine 'socialisation' of the Semester process.

Recommendation: Integrate monitoring into the European Semester, making use of indicators and recommendations on UHC, access, quality and inequalities.

4.Mobilise EU funding frameworks for the pursuit of UHC

A recent Commission report noted both the range of health-related initiatives that have been funded by the European Structural Investment Funds (ESIF) and the significant scope for further investment in the future[21]. Similarly, there is potential for the European Fund for Strategic Investments (EFSI) to be used for the strengthening of health systems and infrastructure, though limited guidance is available to this end[22]. Aware of the importance of mobilising funding frameworks in support of key priorities, the Council recently called on the Commission to assess how the programmes and instruments of the next multi-annual financial framework (MFF) can be utilised in support of realising the SDGs. It is vital that the pursuit of the SDG objectives and the realisation of the EPSR principles, not least of all via the expansion of UHC, is supported by funding sources at the EU level. This means creating priority headlines under the ESIF and MFF, producing guidance on the use of the EFSI and building flexibility into the conditions of the macroeconomic governance framework.

Recommendation: Mobilise EU funding frameworks for the pursuit of UHC, by creating headlines, guidance tools and flexibility to facilitate their use.

[20] More details on the website of the EPSR social scoreboard, available here [accessed August 2017].
[21] See ESIF for Health Project, website available here [accessed August 2017].
[22] EPHA (2017) The future of EU investments for health. Available here [accessed August 2017].

About EPHA

EPHA is a change agent – Europe's leading NGO advocating for better health. We are a dynamic member-led organisation, made up of public health NGOs, patient groups, health professionals, and disease groups working together to improve health and strengthen the voice of public health in Europe. EPHA is a member of, among others, the Social Platform, the Health and Environment Alliance (HEAL), the EU Civil Society Contact Group and the Better Regulation Watchdog.
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