Thematic session 1: Universal approaches to healthcare- Concept Paper

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1   Introduction

The VulnerABLE project is a two-year pilot initiative of the European Commission (DG SANTE), run by ICF, in partnership with EuroHealthNet, the UCL Institute of Health Equity, the European Public Health Alliance, Social Platform and GfK. The project aims to increase understanding of how best to improve the health of people living in vulnerable and isolated situations, identify and recommend evidence-based policy strategies, and raise awareness of the findings and support capacity-building within Member States.

The project involved a range of research activities, including a cross-national survey with 1,938 respondents belonging to potentially vulnerable groups[1] across 12 Member States; a literature, policy and data review of existing evidence on health needs and challenges of these groups; an inventory of good practices in addressing health challenges; expert focus groups and interviews with key stakeholders.

This paper has been prepared for the Dissemination Conference of the VulnerABLE project in November 2017. It brings together the key project findings on the topic of universal access to healthcare, as well as posing questions for the event.

2   Presentation of the theme

2.1   Defining a 'universal approach' and other key concepts

The 'social gradient in health' (Marmot, 2010, p.15) describes the situation whereby a lower social status is associated with poorer health, in terms of health status, barriers faced in accessing services, and the quality and responsiveness of healthcare received. The VulnerABLE project confirms that this challenge remains pertinent in the EU today. As shall be discussed, some argue that the most appropriate policy response to this issue lies in 'universalism' – or a variant of this.

The idea of universalism in policy originates from a concern for fairness in society; universalism in its general sense is about applying the same standards and entitlements to everyone (Thompson and Hoggett, 1996, p.33). In the context of welfare systems, this could mean, for example offering the same services or 'flat-rate' benefits to all people, regardless of their needs or situation (Carey and Crammond, 2017, p. 304). In the past, it was treated as an important way of fostering social unity and advancement (ibid, p. 303).

Specific universalism is a form of universalism that advocates establishing social rights to uphold the fairness and impartiality of decisions within a welfare state (Marshall, 1950, pp.46-56; Esping-Anderson, 1990, p.21). Some link this to the free and universal provision of public services (Carey et al, 2015, pp. 2-3)[2]. Historically, the notion of a universal welfare state (including the health system) represented a break from 'residualist approaches', under which government assistance was necessary only when other forms of support failed, such as family networks and the market.

A key concept to consider alongside universalism is 'selectivism', which refers to the targeting or customising of services and policies for particular groups (Carey et al, 2015, p.3). This form of targeting may occur based on means-testing ('negative selectivism'), although it may also be based on other factors, such as need ('positive selectivism') (Thompson and Hoggett, 1996, pp. 22-23). Another important idea is that of

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[1] The groups included in the project were: families who are in a vulnerable situation (e.g. lone parents with young children); having physical, mental of learning disabilities or poor mental health; the in-work poor; older people who are in a vulnerable situation; people with unstable housing situations (e.g. homelessness); prisoners (or ex-prisoners in vulnerable situation); persons living in rural/isolated areas in a vulnerable situation; long-term unemployed/inactive (not in education, training or employment); survivors of domestic violence.

[2] Note that citizenship is sometimes viewed as the prerequisite for the enjoyment of these rights (Marshall, 1950).

'particularism', under which the government should employ different standards in the treatment of individuals, depending on their circumstances and diverse needs, emphasising the choice and empowerment of service recipients (Carey et al, 2015, p. 3). To some extent, it is possible for selectivism to exist alongside universalism (Thompson and Hoggett, 1996, pp. 33-35).

As discussed in the next section, one of the greatest debates over the use of universalism is how it relates to 'targeting' (represented by selectivism) and how it responds to the diversity of needs in modern society (including the appropriateness of particularism in interventions).

2.2 Debates over universalism

The case for universalism:

The proponents of universalism in healthcare view it as critical for promoting equality. To some, universal approaches are simply more effective at reaching those in need than targeting (Mkandawire, 2005, pp. 9-12, 17). Evidence from the UK, for instance, suggests that targeting a region does not necessarily capture all those who need support and can benefit many who are not in need; indeed, in some cases targeting is accompanied by the 'creaming' effect, whereby services are accessed by the *least* marginalised of the marginalised communities (McLoone, 2001, n.d.).

Some associate selectivism with additional social issues, particularly when based on means-testing. For instance, while targeting can be important and useful when it addresses multiple processes of exclusion, it can also pose risks, such as restrictive criteria for eligibility (leaving some people worse off if they end up outside the criteria) and the creation of future exclusion and stigma for the target groups (VulnerABLE interviews; Marmot, 2014). Indeed, in some cases, the procedures for accessing benefits/services can be complex or even invasive, dissuading applicants and contributing to low uptake (Gugushvili and Hirsch, 2014, p. 6). For example, if one compares the up-take rates of means-tested and universal benefits in the UK in 2009/2010, one can see that universal benefits have a greater level of uptake by those with the greatest need, in comparison to means-tested ones (ibid, p.55).

The internal diversity of target groups can also be ignored by selectivism (Marmot, 2010, p 90). Furthermore, policies that focus only on those in the lowest social position will not overcome inequalities affecting other groups experiencing deprivation (ibid, pp. 86, 90). Universal approaches can also help to avoid the development of a two-tier system in the standard of services available (Carey and Crammond, 2017, p. 305).

The challenges for universalism:

The detractors of universalism warn of its failure to respond adequately to the diversity of modern society, by advocating – for example – a 'one-size-all fits all' approach that does not meet different needs (Anttonen, 2012, pp. 1–15). For example, universal approaches after the Second World War were designed primarily by white men, and have been accused of failing to take into account the needs of women/ethnic minorities (Williams, 1992, p. 206). In particular, a uniform approach can be problematic against a backdrop of existing inequalities in society – for example, some would challenge a system if it were not to allocate greater *resources* to those whose need is obviously greater. It may be misguided to seek to tackle health inequalities specifically if efforts do not include a focus on the social structures that generate them in the first place (Birch, 2010, p. 884; see also Thematic Concept Paper 4 on the Social Determinants of Health).

The notion of universalism can itself be misleading. For example, purportedly universal healthcare systems in the UK and Nordic countries do not always guarantee equity of

access in practice (for example, see Calltorp and Larivaara, 2009, pp. 225-226). On a day-to-day basis, some believe it is not possible to pursue universalism due to constant decisions over service delivery (Carey and Crammond, 2017, p.304).

Working approach – 'proportionate universalism':

The VulnerABLE project has demonstrated that both universal and targeted approaches are necessary to tackle the issue of health inequalities. For the purposes of this paper, universalism and selectivism are not considered to be mutually exclusive, but rather to "sit on a scale of redistributive approaches that can […] counter, maintain or potentially increase social inequalities" (Carey and Crammond, 2017, p.307)[3].

Following on from the work from the Marmot Review and the UCL Institute of Health Equity, the project endorses the notion of 'proportionate universalism' as a way of reconciling key challenges in the application of these approaches. Under this view, health actions must be most intense for those experiencing the highest levels of disadvantage, but actions cannot only focus on those with greatest need, as this will not overcome the health gradient nor the wider issue (Marmot, 2010, p.16). Instead, "to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage*"* (Marmot, 2010, p.15)*.*

The universal aspect is important for sustainability and social support, as well as decreasing the risks of stigmatising and marginalisation (UCL Institute of Health Equity, 2014, p.154). However, the "investment and intensity of activity" should be proportionate to social need, to engage all the population in a way that fosters "a levelling-up of the social gradient" (ibid, p.154). Partly, this is because those in the highest social position are already in a stronger position to benefit from population-wide interventions, due to having greater resources available to them (Marmot, 2010, p. 86) – whether these resources be economic, social or environmental.

The guiding concept of proportionate universalism does not always resolve difficult questions when responding to the idea of vulnerability in health. For one thing, researchers interpret the concept differently, disputing whether it implies that those in the most vulnerable situation require greater levels of the same responses, or whether there should be a whole set of interventions and services in place to respond to varying needs (for example, see Carey et al, 2015, p.1; Birch, 2010, p.882). Furthermore, even if centrally-directed investments and actions for different individuals are 'proportionate' to social need, the reality for practitioners is that the design and delivery of healthcare services necessarily requires difficult choices over the scope and nature of programmes and interventions (Carey et al, 2015, p. 2). As a further problem, workshops for the VulnerABLE also reflected that current health and social care systems often fail to involve actively the people for whom the service is being provided, which can reinforce the experience of vulnerability.

Instead of serving as a panacea, the concept of 'proportionate universalism' offers important "principles for action" (Marmot, 2010, p.34), leaving discretion and flexibility open to Member State governments, regional authorities and local areas when it comes to the most appropriate forms of implementation. The VulnerABLE project has explored the ways in which universal approaches to healthcare can better serve the needs of

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[3] Due to space constraints, I do not devote much discussion to 'pre-distributive' approaches in this paper, although these can also be beneficial in tackling poverty and promoting health equity. These seek to change how the market allocates resources from the beginning e.g. through wage safeguards and inheritance taxes etc. (Carey and Crammond, 2017, p.306).

groups experiencing vulnerability, offering guidance on how to develop 'proportionate' responses in practice.

3   Key findings from the project

3.1   The model of healthcare systems across EU Member States

Many have sought to classify the healthcare systems of different EU Member States – and welfare state regimes more generally – according to certain models (for example, see Esping-Anderson, 1990, pp.26-29; Bambra et al, 2010, pp.400-402). The purpose of these models is to encapsulate the various ways in which Member States provide welfare and healthcare services.

Typically, these models differentiate between the form of access to healthcare services, as well as the funding model. In 'Bismarckian' systems (for example, Germany, Austria, the Netherlands), access to support is based on social insurance, often administrated through an employer (Ferrera, 1996, p.19; VulnerABLE project interviews). To some, 'Bismarckian' systems reflect specific universalism, as they offer universal coverage depending on someone's occupational situation (Carey et al, 2015, p. 3). In Southern Member States (such as Italy, Greece, Portugal and Spain), the systems of income maintenance and social protection are often seen as more fragmented, due to greater emphasis placed on family support networks (Ferrera, 1996, pp.19-21; VulnerABLE project interviews)[4].

The Member States most commonly associated with universalism in healthcare are the UK and the Nordic countries (VulnerABLE project interviews; Magnussen et al, 2009, p.4; Carey and Crammond, 2017, pp. 303-304). The 'Nordic model' of healthcare centres on universalism, high social transfers and interventionism, striving for equality of the highest standards (Lundberg et al, 2008, p.191). Within Anglo-Saxon or Beveridgean systems (such as in the UK), access to healthcare is free and universal at the point of access, funded through general taxation (VulnerABLE project interviews; Magnussen et al, 2009, p.9); however, access to other forms of social transfer may be modest and means-tested (Bambra et al, 2010, p.402).

Such models can be helpful in conceiving the broad characteristics of Member State healthcare systems, but it is worth bearing in mind their shortcomings. For example, while healthcare systems in Finland, Denmark, Norway, Sweden and Iceland are broadly based upon the principles of universalism and equity (the 'Nordic model'), they differ in key ways – for example, their funding models, the use of financial incentives for providers, the extent to which responsibility for key healthcare services is decentralised (Magnussen et al, 2009, pp.10-14). Furthermore, the systems in these Member States are not static, but rather subject to change over time[5]. The classic Beveridge/Bismarck distinction is over whether health systems are funded by tax or social insurance, but in reality both systems can involve funding from public or private funds (Magnussen et al, 2009, p.9). Similarly, whilst the wider welfare state is typically considered more fragmented in southern Europe, the organisation of healthcare systems in these countries reflects a more "universalistic approach" (Ferrera, 1996, pp.22-24).

The most developed welfare states all combine universal, means-tested and other targeted programmes to cater to their citizens' particular needs; it is the balance of these approaches that differs significantly (Gugushvili and Hirsch, 2014, p. 5). The

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[4] According to workshop participants, some existing systems have been compromised further over the last eight years due to austerity measures.

[5] For example, growing emphasis since the early 1990s on 'new public management' and patient choice (Magnussen et al, 2009, pp.4-5).

precise system under which healthcare and support are delivered impacts upon the best model for addressing the needs of vulnerable and isolated groups, reinforcing the need to adapt any 'good practices' to the local context (VulnerABLE project interviews).

3.2 Conceiving 'proportionality' in universalism

The VulnerABLE project has explored how universal approaches can be proportionate in scale and intensity to the needs of those in vulnerable situations. This section draws out key lessons for this balancing act, using examples from the project. Some examples are drawn directly from the VulnerABLE case study inventory, available online[6].

Universal approaches in healthcare can still leave behind people in vulnerable situations behind, unless further outreach work is taken

The project confirmed a key finding in the literature: namely, that universal approaches do not automatically guarantee access to individuals in vulnerable situations, as reflected in the difficulties in accessing healthcare faced by all the groups examined. For example, parents experience physical and practical barriers in accessing healthcare services (Katz, La Placa and Hunter, 2007). In addition to caring responsibilities, reduced mobility, age, geographic remoteness, unemployment, low income, an unstable housing situation and being deprived of liberty can all pose obstacles to accessing services.

Specialised outreach services can be an important way of overcoming barriers to accessing services, especially for those in unstable stable situations (rough sleepers). For example, in London (the UK), the National Health Service operates a 'Find and Treat' Unit, which travels across the London boroughs and screens homeless people for Tuberculosis (TB)[7]. The programme currently screens 10,000 high risk individuals for TB per year using a mobile digital x-ray unit. This works within every London borough and travels to support Public Health England (PHE) with national outbreaks using a van with diagnostic and information technologies and includes a private consultation / examination area with disabled access. The practice was evaluated in 2011 by the Health Protection Agency on behalf of the Department of Health and found to be cost-effective in fighting TB among hard to reach groups[8].

Mobile health services have also been used to support those living in remote areas. For instance, in Finland, the South Karelia Social and Health Care District (Eksote) ran the 'Mallu bus', designed to be an easy-to-use medical service for people in rural areas, offering health monitoring services, pharmacy tasks and minor operations. These services were delivered through an integrated mobile facility, a converted mobile caravan[9]. An evaluation of the service at the end of its pilot stage showed that it offered cost-efficient and easy-to-access healthcare for areas in which residents are unable to access a dedicated healthcare centre[10]. Other specialised services focus on those who lack entitlement to the public health system. For instance, Open.med Munich offers medical treatment to people without medical insurance, with the aim of improving the

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[6]https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_casestudyinventory_en.pdf

[7] https://www.uclh.nhs.uk/ourservices/servicea-z/htd/pages/mxu.aspx

[8] Full evaluation not published – for this case study, details of the evaluation have been taken from NHS London, 2011, Model of Care, *TB services in London.* For full information, see the VulnerABLE case study inventory:
https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_casestudyinventory_en.pdf

[9] https://enrd.ec.europa.eu/sites/enrd/files/fi-mallu-does-the-rounds-gp_web.pdf

[10] Full details of evaluation results and sources available in VulnerABLE case study inventory:
https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_casestudyinventory_en.pdf

health of all those in Germany, including those without legal residence status. Similarly, Age Platform Europe identified a range of group-specific initiatives that can benefit the health of older people, for example programmes of disease prevention.

VulnerABLE research participants highlighted that while specialised outreach services can be beneficial, the long-term goal should be to integrate those that they serve into wider public health system (without compromising the notion of person-centred care – see below). For example, key ways to reduce inequities in urban and rural health outcomes would be to integrate rural health more effectively into the curricula of medical students, as well as investing in the recruitment and retention of healthcare professionals (VulnerABLE focus group).

Likewise, focus group participants agreed that, in relation to rough sleepers, mobile hospitals and health services are useful to make detections, but after that, there is a need to work to put people into the existing social network and healthcare system. It was recommended not to advocate for a parallel healthcare system, but to promote measures aiming to make the mainstream healthcare system better able to respond to individuals' needs and issues.

Separatist approaches can result in two-tier systems if they are not part of the public health agenda

People in prison were one of the key target groups of the VulnerABLE project. The findings in relation to this group demonstrated the particular risk of delivering healthcare services that are separate from the public health agenda. In part, the degree of separation relates to Member State differences in departmental responsibility for prison healthcare. In Europe, it is relatively rare for prison health to come under the responsibility of the Ministry of Health, affecting the degree to which it is seen as a public health concern (expert interviews).

The research highlighted that the separation of prison healthcare from the wider public health agenda can be highly detrimental to the quality of care that people in prison receive. When prison health is not under the remit of the Ministry of Health, this can result in a 'two-tier' system when it comes to the quality of care delivered in prisons versus the quality of care delivered to the public (as confirmed in interviews and the focus group conducted for the VulnerABLE project). Project interviews also suggest that not having prison health under the remit of the Minister of Health can result in additional cost/insurance issues when trying to deliver specialized treatments.

Focus group participants pointed out that, as the health needs of the population are higher than average (given that health issues are overrepresented amongst those who enter prison), the resource needs of prison healthcare systems are also much higher, in terms of physical resources, human resources and time required with each patient. One participant urged a focus on *"equivalence of outcomes, not equivalence of inputs"* when resourcing prison health systems.

Some benefits associated with moving prison health into the public health agenda include: better training of prison healthcare staff; more consistent health guidelines on the same diseases; better monitoring of prison health indicators; and greater availability of specialised treatments in prisons, such as transplants and dialysis. However, participants in interviews and focus groups have emphasised the political difficulties of making such a change, and warned that it can create additional funding pressures if not managed properly.

Capacity-building amongst healthcare professionals and shared clinical standards are vital for making services more responsive to the needs of individuals in vulnerable situations

Even when those in vulnerable situations can access healthcare services, this does not mean that these are responsive to their needs. The research highlighted the critical need for capacity-building amongst health professionals to sensitise them to the issues facing different groups. This can also be important so that clinicians do not treat all members of a single group as 'vulnerable', but instead take a more sensitive approach when assessing their needs.

As an example, literature on the specific policy responses to address the health needs of people with disabilities largely focuses on improving the provision of health care services through training to increase the knowledge and skills (as well as change attitudes) of healthcare professionals in treating this vulnerable group (for example, see Devine and Taggart, 2008; Hardy et al., 2011). For instance, a Chronic Heart Disease (CHD) education resource was piloted among a residential community support organisation working with adults with complex learning disabilities. The training was organised in response to the fact that CHD is more common among those with complex learning disabilities. As a result of the training, staff showed an increase in knowledge in CHD topics, which could lead to increased understanding of cardiac health by those who are in regular contact with this group and thereby improve health outcomes (Holly and Sharp, 2014, pp. 110-116).

The use of specialised clinical standards can also better support the particular needs of different groups in universal systems. For example, health-care providers must offer appropriate clinical interventions to support survivors of domestic and intimate partner violence, including post-rape care (such as, pregnancy/STI prevention, access to abortion, long-term mental health services) (García-Moreno et al., 2014, pp. 1568, 1572-1573). Both the World Health Organisation (WHO) and the UK National Institute for Care Excellence (NICE) have published detailed guidelines and quality standards for delivering care to those who have experienced these forms of violence (WHO, 2013; NICE, 2016).

The notion of 'person-centred care' was mentioned in relation to older people (VulnerABLE focus group). A specific example of person-centred care is to have specialised nurses or practitioners with time to consider the specific issues faced by the person they are providing care to, and get specialised services on board. In Germany, these are organised by insurance companies, while in other countries it can be in the hands of charities or other not-for-profit organisations.

Empowering target groups to act as the co-producers of their care and treatment they receive can be highly beneficial in helping to meet their needs and can be more line with principles of good governance

One of the most consistent project findings across different groups was the need to empower service users themselves to become co-producers of their care and treatment; this is associated with greater effectiveness in meeting their needs. For example, in Ireland, the Community-based Health and First Aid in Action (CBHFA) aims to raise prison inmates' awareness about community health, personal hygiene, first aid and well-being. The Education and Training Boards Ireland (ETBI) delivers training sessions to volunteer inmates, who are then supported by Irish Prison Service nurses and healthcare professionals to undertake peer-to-peer awareness raising and implement the component projects of the programme. The programme has been associated with a range of positive evaluation results and has now been extended to all of Ireland's prisons[11].

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[11] Full details of evaluation results and sources available in VulnerABLE case study inventory: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_casestudyinventory_en.pdf

In general, the VulnerABLE project highlighted the importance of other mechanisms to consult and engage those targeted by different services in their design and delivery. This represents some engagement with the notion of particularism, in that it recognises that the assessment of 'need' relates closely to political perspective, and that offering more choice and empowerment to those using services is fundamental to meeting their needs.

3.3   Recommendations

Adopt the principle of proportionate universalism when approaching the issue of health inequalities. This means that "actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage" (Marmot, 2010, p.15).

Recognise that the most significant barriers to healthcare access continue to be socio-economic, but that vulnerability in health is complex, resulting from multiple processes of social exclusion.

Consider specialised outreach services for those who face additional barriers in accessing healthcare, with a long-term view to moving these individuals into the mainstream health system (whilst maintaining the notion of person-centred care).

Avoid the development of two-tier health systems, whereby targeted services are of a lower quality than those offered to the general public.

Undertake capacity-building amongst healthcare professionals and propagate specialised clinical standards to make services more responsive to the needs of individuals in vulnerable situations.

Empower target groups to act as the co-producers of their care and treatment they receive, particularly through peer-to-peer models of healthcare design/delivery.

4   Thematic session overview

Universal health coverage: How can universal access to healthcare be guaranteed for everyone irrespective of their age, gender, socio-economic and health status?

- Setting the scene: main themes and project results – **David Pattison, Lead Trainer- vulnerABLE Project team**

- Presentation of two good practices:

- *Family Centres in Sweden*- **National Institute of Public Health, Vibeke Bing,**

- *'Open.med Munich'*- **Lucy Jones, Head of the Domestic programs of Medecins du Monde UK**

- Comments from **Daniel Lopez-Acuna, Expert Group on Social Determinants and Health Inequalities**

- Q&A session

5   Questions for the conference

- How can healthcare systems guarantee universal access in practice?

- What mechanisms can make healthcare systems more responsive to the diverse needs of those in vulnerable situations?

- How can universal systems empower individual service users to be co-producers of the care and treatment they receive?

How can Member States ensure that a cross-cabinet approach to improving universal access to health, social, educational and anti-poverty policies and services for all citizens, but especially for the most vulnerable?

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