An examination of Roma health insurance status in Central and Eastern Europe

Charlotte Kühlbrandt, Katharine Footman, Bernd Rechel, Martin McKee

European Centre on Health of Societies in Transition, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, UK

Background: Roma in Central and Eastern Europe (CEE) face problems in accessing health care, and a lack of access to statutory health insurance schemes is a key factor. This study seeks to quantify differences in health insurance coverage between Roma and non-Roma and assess whether variations can be explained by socio-economic factors.

Methods: Secondary household survey data collected in 12 CEE countries in 2011 were analysed. A univariate analysis assessed the effect of Roma status on insurance coverage by country. Multivariate analyses were used to progressively adjust for socio-demographic factors, employment status and income. Country-specific literature was drawn on to examine the context of the findings. Results: Lack of insurance coverage for Roma populations varied considerably between countries, from 2.8% without insurance in Slovakia to 67.7% in Albania. Roma were significantly less likely to have health insurance than non-Roma in all countries except Slovakia and Serbia. The greatest differences in Roma and non-Roma insurance coverage were in Montenegro, Bosnia and Herzegovina, Croatia, Bulgaria and Romania. When adjusting for employment status and income, the gap between Roma and non-Roma remained significant in Montenegro, Croatia, Bosnia and Herzegovina, Bulgaria, Romania and Moldova. Conclusion: Roma are significantly less likely to have insurance coverage in most CEE countries, and this gap remains when adjusting for socio-economic differences between Roma and non-Roma in many countries. Much needs to be done to address the known barriers that Roma face in accessing insurance coverage, such as tackling problems related to documentation and the receipt of social benefits.

Introduction

The approximately 10–12 million Roma who live in Europe constitute its largest and most disadvantaged ethnic minority, accounting for up to 12% of the population in some countries. They face particular problems in accessing health care, and studies in countries such as Albania, Bosnia and Herzegovina and Montenegro have shown that Roma are less likely to seek care in case of illness. Barriers include co-payments, distance to health facilities, refusal or reluctance by health professionals to see them and a resulting fear and mistrust of health professionals. However, a key factor in many countries in Central and Eastern Europe (CEE) is a lack of access to statutory health insurance schemes.

Although the fact that Roma experience barriers in accessing health care has long been recognized, there are limited precise data on the scale of the problems they face, and the studies that do exist, typically within individual countries, are not easily comparable. An evaluation of one of the few programmes seeking to improve Roma access to care, the Health Mediator Programme, noted how progress was difficult to measure because routine data on utilization of services are not disaggregated. Moreover, a study that sought to measure how many Roma were enrolled in the statutory health insurance programme concluded that all estimates involved contested and sometimes controversial assumptions. Finally, if data were available, their interpretation would be uncertain, given the material disadvantage of many Roma; a study that compared health disparities between Roma and non-Roma in Hungary noted the challenge of separating ethnicity from socio-economic status. A secondary analysis of a 2004 United Nations Development Programme (UNDP) survey conducted in Bulgaria, Hungary and Romania found that socio-economic status explained a large part of the health disadvantage of Roma.

This study seeks to overcome some of the problems faced by earlier studies to identify and quantify disadvantages experienced by Roma in 12 countries in CEE. Specifically, this study seeks to (i) quantify differences in health insurance coverage between Roma and non-Roma populations in each country, (ii) assess how much of any disadvantage can be explained by socio-economic differences between the two groups and (iii) draw on country-specific literature to examine the context of the findings.

Methods

Regional Roma survey

We used data from household surveys conducted between May and June 2011 by the UNDP, the World Bank and the European Commission, in coordination with the European Union’s Agency for Fundamental Rights, and implemented by the Ipsos polling agency. Surveys were conducted in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Hungary, Macedonia, Montenegro, Moldova, Romania, Serbia and Slovakia. In each country, the survey included around 350 non-Roma and 750 Roma households living in proximity. The total number of households surveyed was 13,481 (9,207 Roma and 4,274 non-Roma).

The methodology and sampling procedures have been described elsewhere. In summary, primary sampling units (30 households) were drawn at random from a list of settlements in which, according to census data, Roma represented >50% of the population. Households were randomly selected using the random walk method. The non-Roma populations were sampled from those living in close proximity (within 300 m) to the Roma settlements. Interviews were conducted by trained fieldworkers in the national language (and in Moldovan and Russian in Moldova). In each household, up to three household members were interviewed; the head of household was asked about the profile of each household
member and the household status, the primary carer of children was asked about early education and care of household members and one respondent (aged 16+) was then randomly selected (based on nearest birthday) from each household to be interviewed about their individual status and attitudes, including questions about health status and use of health care. Response rates varied from 56% in Moldova to 90% in Croatia and Macedonia for Roma respondents, and from 47% in Slovakia to 87% in Macedonia for non-Roma respondents; in most countries, the response rate among Roma respondents was slightly higher than that among non-Roma respondents.

To be included in the Roma sample, individuals were required implicitly to self-identify as Roma. Implicit identification was sought by asking respondents whether they were willing to be interviewed for a ‘survey among the Roma population’. Individuals who explicitly denied being Roma were not interviewed. The difficulties involved in the identification of Roma in surveys are well recognized, including degrees of assimilation and concerns over motives and consequences of surveys, but the approach chosen is considered best practice.  

**Secondary data analysis**

Potential differences in health insurance coverage between Roma and non-Roma respondents were examined using logistic regression. Insurance coverage was ascertained using the question ‘do you have any medical insurance either on your own name or through other members of your household?’ and those with insurance either in their own name or through other members of their household were grouped to provide a binary variable. A univariate analysis was first conducted to assess the effect of Roma or non-Roma status on insurance coverage in each country. Two multivariate analyses were then undertaken with progressive adjustment, first for socio-demographic differences (age, gender, and marital status) and second for the additional effects of employment status and monthly income, measured by asking respondents to estimate average monthly income over the past 6 months for the total household. Data were adjusted for the effect of the cluster sampling design.

**Results**

Lack of insurance coverage for Roma populations varied considerably between countries, from 2.8% without insurance in Slovakia to 67.7% in Albania (Table 1). The highest prevalence of non-insurance among Roma was in Albania (67.7%), Moldova (59.7%), Romania (49.3%) and Bulgaria (42.6%). In Albania and Moldova, however, the proportion of uninsured non-Roma was also much higher than in other countries (45.9 and 24.6%, respectively).

The univariate regression reveals significant variation in insurance coverage between Roma and non-Roma populations, with the exceptions of Slovakia and Serbia. In all other countries, Roma were significantly less likely to have health insurance, with the greatest differences in Montenegro (odds ratio [OR] 10.74; 95% confidence interval [CI] 3.91;29.54), Bosnia and Herzegovina (OR 8.67; 95% CI 4.52;16.62), Croatia (OR 7.97; 95% CI 4.00;15.85), Bulgaria (OR 6.75 95% CI 4.62;9.86) and Romania (OR 5.63; 95% CI 4.05;7.84).

This pattern remained after adjusting for gender, age and marital status in Model 1. However, further adjustment for employment status and income in Model 2 renders the gap insignificant (P ≤ 0.05) in Albania, the Czech Republic, Hungary and Macedonia. It remains significant in Montenegro (OR 7.72; 95% CI 1.31;43.57), Croatia (OR 4.48; 95% CI 1.38;14.59), Bosnia and Herzegovina (OR 3.75; 95% CI 1.20;9.37), Bulgaria (OR 3.51; 95% CI 1.50;8.23), Romania (OR 2.39; 95% CI 1.41;4.03) and Moldova (OR 2.18; 95% CI 1.28;3.70).

**Discussion**

Roma populations in many CEE countries have low levels of health insurance coverage, with a high proportion uninsured in Albania, Moldova, Romania and Bulgaria. In all but 2 of the 12 countries studied, Roma are less likely to be insured than non-Roma living in close proximity. The differences persist in many of the countries even after adjusting for income and employment status. As well as constituting a substantial health risk to those without health insurance, this situation is likely to strain health systems. Those Roma who are excluded from health insurance coverage often rely on (nominally free) emergency services, the beneficence of individual health professionals and advice from pharmacies. Where care-seeking is delayed till emergency services can be used, conditions are likely to be more serious when eventually treated, and more costly to the health system. Furthermore, due to widespread discrimination and the request for informal payments, there have been many instances when Roma have been refused emergency care.

Until the early 1990s, health care in CEE was mainly funded from general government revenue and entitlement was based on citizenship, although in practice this was usually implied from residence. After the collapse of communist regimes, many countries abandoned the previous systems, which were viewed as monolithic, unresponsive and incompatible with the adoption of market mechanisms. In their place they created (or re-established) statutory health insurance schemes, funded by contributions from employers and employees, and entitling those insured, and their dependents, to certain services. Alternative arrangements usually exist for those unable to pay contributions or those without formal employment, but depend on individuals being eligible for social benefits. It is not possible, from the data used in this study, to ascertain why Roma may be disproportionately affected by barriers to obtaining insurance in some countries, but we draw on country-specific literature to shed light on the factors that may be at work.

**Documents and identification**

Some Roma, such as those living in the Czech Republic and certain former Yugoslav republics, including Croatia, Slovenia and Macedonia, found that they were denied citizenship when those countries became independent. Laws often defined citizenship on the basis of the majority ethnic group, excluding many Roma. Later, the war in Kosovo led to the displacement of many Roma living there, who then lacked Serbian identification documents. Others, despite being citizens, lack the documents to prove it, or lack birth certificates and other forms of personal identification required to register with a health insurance scheme. This has been reported in Moldova, Bulgaria, Romania, the former Serbia and Montenegro and Macedonia. Non-registration of traditional Roma marriages may also exclude spouses from coverage in some countries, while in the Czech Republic, some Roma are disadvantaged by the need to demonstrate permanent residence or unemployment status. In Macedonia, many Roma are categorized as ‘habitual residents’, a status that acknowledges long-term residency, but provides neither official residency nor citizenship, both necessary requirements for coverage.

**Proof of unemployment and entitlements to social support**

Most governments pay insurance contributions for certain groups, such as pensioners and those who are unemployed or receive social benefits. In theory, Roma without jobs should therefore be eligible for coverage. In practice, this is not always the case. In some countries, Roma face difficulties in receiving social benefits, which then impacts their health insurance status. A 2006 report noted, ‘where Roma are not among those receiving social benefits – sometimes as a result of arbitrary and racially discriminatory
action of authorities – they are not entitled to state-provided medical insurance for the socially vulnerable groups either’. Their exclusion may be a consequence of having worked in the informal economy, as is the case with more than two-thirds of adult Roma in Bulgaria, rendering them ‘administratively invisible’. Even where unemployed Roma are entitled to have their contributions paid, in some countries, this does not happen because the responsible local authorities lack funds.

### High contribution premiums and low incentives for joining

For Roma who are engaged in the formal economy, some may find contributions unaffordable; in Bosnia and Herzegovina, employees pay 12.5% of their base salary, in Macedonia 7.8% and in Montenegro 8.5%. Affordability has been cited as a particular problem in Moldova, alongside the absence of appropriate identification and a lack of awareness of the need for insurance coverage. Yet, even in countries where premiums are low, Roma may have few incentives to join the social health insurance scheme. The benefit package in Albania is limited and many Albanians, Roma and non-Roma, do not register, while doctors do not differentiate insured and uninsured patients. This may explain why insurance coverage in Albania is low for both groups, with the Roma disadvantage disappearing after adjustment for employment status and income.

### Recent introduction of social health insurance and fragmented systems

In some countries, the creation of a social health insurance scheme is relatively recent. Moldova introduced compulsory health insurance only in 2004. A UNDP survey in 2007 estimated that only 23% of Roma in Moldova had registered. Our study shows a somewhat higher figure (45%), consistent with a general improvement in uptake: in 2007, coverage of non-Roma was reported to be 59%, rising to 75.4% in 2011. Even though a social health insurance system was introduced in Bosnia and Herzegovina in the early 1990s, the system is highly fragmented, lacking coordination and transparency. However, even some countries with well-established schemes, such as Bulgaria, can have low population coverage.

### Discriminatory behaviour towards Roma

Systematic discrimination against Roma is well documented, both within and outside of health care settings. Roma across Europe...
often face abuse from health workers and are refused medical benefits or treatment.17 Although available data do not allow to judge whether there are differences across the 12 countries in terms of the levels of discrimination encountered by Roma, differences in health insurance coverage (after adjusting for socio-economic factors) could at least be partly due to different levels of discrimination.

**Government’s failure to acknowledge inequalities**

Of the 12 countries studied, all (except Moldova) are participants in the Decade of Roma Inclusion, a partnership of governments, international agencies and the Roma civil society. They pledged to improve the socio-economic status and inclusion of Roma living within the boundaries of their state. For the moment, however, it is apparent that at least with respect to insurance coverage, there is still some way to go. It is striking that despite this commitment, those countries with the least equal health insurance status (Montenegro and Croatia) fail to acknowledge that there is a problem. A year after the survey data were collected by UNDP, revealing that Roma were almost eight times less likely to report having health insurance than their non-Roma neighbours, the 2012 progress report on the Decade of Roma Inclusion by the Montenegrin government claimed that Roma ‘(with the status of internally displaced or refugee persons or persons seeking asylum or special protection) enjoy services same as other beneficiaries of health care [sic]’.27 Roma who are not Montenegrin nationals are reported to ‘enjoy [the same] right to health care as regular insured citizens, both in terms of scope and content of health services’. The progress report by the Croatian government on the Decade of Roma Inclusion similarly makes no mention of lacking health insurance coverage, instead focusing attention on Roma health almost exclusively on the prevention of infectious diseases.28 In contrast, the report by the government of Bosnia and Herzegovina acknowledged that there were >5000 Roma without health insurance in 2010, and also noted that there was an action plan to improve coverage.29

**Policies aiming to improve health insurance coverage for Roma**

In Croatia, failure to acknowledge inadequate health insurance coverage of Roma is all the more surprising, as even before the implementation of the Decade of Roma Inclusion, Croatia introduced a National Programme for Roma (2003), engaging members of the Roma population in the design of the programme. It included several targets for Roma health, including the monitoring of utilization and access to health care.29 The evidence reported in this paper indicates that it has failed to close the insurance coverage gap between Roma and non-Roma, although progress from an even lower baseline is possible. In Serbia, however, where Roma (along with other minorities) are exempt from social health insurance payments, we found no difference between Roma and non-Roma health insurance coverage. On the other hand, even in Serbia, exempting Roma from health insurance payments has not protected them from high out-of-pocket health expenditure.31

For several years, the Roma Health Mediator Programme, operating in Bulgaria, Macedonia, Romania, Serbia and Slovakia, has worked to increase Roma participation in the social health insurance system by assisting Roma in obtaining relevant documents and identification, among other activities.3 The programme has achieved some important successes, providing >9000 Serbian Roma with health insurance cards and helping >2000 Bulgarian Roma to obtain health insurance between 2008 and 2010.4 In Bulgaria and Slovakia, the ministries of health or state municipalities now directly employ Roma health mediators, which means that they are at least officially endorsed by state institutions. Yet, given the large population of Roma in the 12 countries studied, this programme can, on its own, only make small inroads, and a large scale-up across CEE would be necessary to improve the health insurance status of Roma. In some countries, the opposite trend has been observed: as a result of recent decentralization in Romania, municipalities can now decide whether to hire mediators previously contracted by the central government. Consequently, the number of Roma health mediators has shrunk considerably.

**Limitations**

Our study has several limitations. First, data are based on self-reported insurance status and therefore cannot be compared directly with other data.20 However, perceived health insurance status is likely to be a major determinant of whether people obtain timely care. Second, insurance status compares Roma and their close non-Roma neighbours, many of whom are likely to be relatively
disadvantaged themselves. If the study had compared Roma experiences with those of a representative sample of the whole population, unadjusted disparities may have been larger, although in Moldova, where we do have comparable data, the difference in lack of coverage between non-Roma in this survey and the general population in another survey is small (24% vs. 22%). Third, interpretation of the observed differences is limited by the sparse literature on the barriers faced by Roma in many countries. Even where there is literature on specific problems faced by Roma, it has often arisen from small-scale local studies and may not be generalizable to the whole country. Moreover, Roma may face barriers that have not yet been described in the published literature. For these reasons, it is not possible to say with confidence why the gap in some countries is narrower than in others. Nevertheless, quantifying the scale of the possible to say with confidence why the gap in some countries is narrower than in others. Nevertheless, quantifying the scale of the

Conclusions

It is important to bear in mind that health insurance coverage is a necessary but not a sufficient factor in ensuring that Roma can access timely and high-quality health care. However, there is much that could be done to address the known barriers that Roma face in achieving coverage, such as tackling problems related to documentation or the receipt of social benefits. Clearly, Roma in many countries remain at a major disadvantage. The stark inequalities in insurance coverage are only a small part of the plight faced by Roma, but they are symptomatic of their exclusion from the systems that societies use to protect their members from social and economic hardship.

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Conflicts of interest: None declared.

Key points

- Numerous barriers prevent Roma in Europe from accessing health care, but there are limited precise data on the scale of the problems faced.
- Although the situation varies considerably between countries, Roma are significantly less likely to have health insurance than non-Roma in most of CEE, even after adjusting for variations in socio-economic and demographic factors.
- Much needs to be done to address the known barriers that Roma face in accessing insurance coverage, such as measures to tackle problems related to documentation and the receipt of social benefits.

References


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The right of access to health care for undocumented migrants: a revision of comparative analysis in the European context

Amets Suess1,2, Isabel Ruiz Pérez1,2, Ainhoa Ruiz Azarola1, Joan Carles March Cerdà1,2

1 Andalusian School of Public Health, 18011 Granada, Spain
2 Centre for Biomedical Network Research - Epidemiology and Public Health (CIBERESP), Spain

Correspondence: Amets Suess, Andalusian School of Public Health, Cuesta del Observatorio, 4, E-18011 Granada, Spain, Tel: 0034 958 027 400, e-mail: amets.suess.easp@juntadeandalucia.es

Background: The recent introduction of adjustment measures in the Spanish context by means of the Royal Decree-law 16/2012 (RDL 16/2012), which limits access to health care for undocumented migrants, raises the question about the state of the matter in different European Union member states. Methods: Narrative review of comparative studies published between 2009 and 2012 that analyzes the right to health care for undocumented migrants in the European context. Results: The review shows a high degree of variability regarding health care entitlements of undocumented migrants in different European countries, a frequent legal restriction of access to health care, as well as barriers in the effective access to health care. The studies coincide in recommending access at all health care levels, regardless of the administrative status of the person seeking treatment. The analysis of the impact of the current economic crisis on access and quality of the health care directed to undocumented migrants, as well as the knowledge of the migrants’ perspective are identified as future research areas. Conclusions: Compared with other European countries, the introduction of the measures established in the RDL 16/2012 modifies the place of the Spanish Public Health Care System from being situated in the group of countries that permit undocumented migrants access to all health care levels, towards the category of highest restriction.

Introduction

In the context of the current economic crisis, various austerity measures have been introduced in the Spanish health care, education and labour sector. In relation to health care policies, the Royal Decree-law 16/2012 (RDL 16/2012) acquires a prominent role. The document comprehends measures related to the regulation of access to health care, prescription drug co-payment, the services portfolio of the Spanish Public Health Care System, as well as the classification of health care professions.

While previous laws establish the access to health care of registered foreigners on equal terms as people with Spanish nationality (table 1), the RDL 16/2012 introduces an access regulation according to the condition of ‘insured’ and ‘beneficiary’. The access to health care of undocumented migrants is limited to emergency services and to the process of pregnancy, natal and post-natal care. Only in the case of migrants aged <18 years, the principle of equal terms in the access to health care is maintained. After the limitation of access to health care established in the RDL 16/2012 entered into force, differentiated application levels can be observed in the Spanish autonomous communities.

The changes introduced in the Spanish context raise the question about the regulations in force in other European countries, as well as the impact of the economic crisis on the health care entitlement of this population group.

In 2009, the International Organization for Migration (IOM)1 edited a revision of 21 comparative studies published between 1986 and 2008 regarding migrants’ health, health care entitlements, barriers in the effective access to health care and perceived quality of health care in the European context.

In the recent bibliography2–11 multiple studies and reflections regarding the interrelation between economic crisis, health care cuts and health can be observed. At the same time as highlighting the multidimensional and non-linear character of the relationship