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PROVISIONAL VERSION

Ensuring access to healthcare for all children in Europe

Report[1]
Committee on Social Affairs, Health and Sustainable Development
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Summary

Even today, not all children in Europe enjoy equal access to healthcare services. Since the most recent economic crisis, access to healthcare has notably become more difficult for children and families living in precarious situations, for example due to unemployment, poverty or migration. Health systems across Europe are affected in different manners, but many of them need rebuilding or consolidation with a view to guaranteeing "the highest attainable standard of health" to all children, as provided by the UN Convention for the Rights of the Child (UNCRC).

The Parliamentary Assembly should express its concern about the persistent inequalities observed across Europe with regard to the availability and accessibility of health services for children and their subsequent health results. Next to adequate funding for public health systems and improved data collection in this field, member States should address the social determinants of health (including inequalities in education and income), develop health literacy programmes, provide special support to the most vulnerable groups of children and promote new approaches of child participation.

[1] Reference to committee: Doc. 13402, Reference No. 4027 of 07.03.14.

A. Draft Resolution[2]

1. European healthcare systems show significant gaps in the provision of healthcare to children, even though they remain amongst the most accessible globally. Under the impact of the most recent economic crisis and related austerity programmes, access to healthcare has notably become more difficult for children already living in precarious conditions or belonging to vulnerable groups, but all countries – poorer and richer ones alike – face their own specific challenges with regard to healthcare provided to children.

2. The Parliamentary Assembly is concerned about the inequalities across Europe and within European countries concerning the right of children to the "highest attainable standard of health", both in terms of availability and accessibility of healthcare services and health results. Quality healthcare services for children should not only be made available, but also be effectively accessible to all children in a country, whatever their socio-economic, ethnic or migrant background, geographical location, state of health or legal status in a given country.

3. The Assembly calls upon member States to comply with relevant international and European standards, including the United Nations Convention for the Rights of the Child (UNCRC), the European Social Charter (ETS no. 163) and the Convention on Human Rights and Biomedicine (ETS no. 164). Governments should promote child-friendly healthcare systems according to the relevant Council of Europe guidelines as a priority in public health policies. The importance of and way forward with regard to the health of children and adolescents is also outlined by the World Health Organization (WHO) in its new "European child and adolescent health strategy 2015-2020" - an essential reference in this field.

4. Whilst the most urgent task will be the one of rebuilding adequate services in countries where health systems have suffered from the economic crisis and austerity programmes, a further challenge consists in ensuring healthy living conditions and providing healthcare services to children and families living in precarious situations, due to unemployment, poverty, war or migration, for example. Child-friendly healthcare systems also require appropriate prevention programmes according to Assembly Recommendation 1959 (2011) on "Preventive healthcare policies in the Council of Europe member States".

5. Against this background, the Assembly calls upon member States of the Council of Europe to:

5.1. ensure adequate funding to develop healthcare systems of the highest standard possible to be provided to all children in an equitable manner across every country, which are comprehensive (thus including prevention, diagnosis, treatment, rehabilitation and palliative care), address health emergencies and chronic diseases in terms of physical and mental health, ensure the provision of medicines to all children, and put an emphasis on prevention from an early age, including ante-natal healthcare;

5.2. improve data collection in the health field with a view to measuring current gaps in children's access to healthcare and assessing the effectiveness of health policies, disaggregated by age group (smaller children and adolescents) and covering both physical and mental health issues;

5.3. address the fundamental social determinants of health, such as poverty, income inequalities and education levels, but also environmental determinants, with a view to improving health and access to healthcare services;

5.4. develop health literacy through specific programmes, dispensed via educational systems or targeted at specific categories of population, including disseminating basic knowledge of symptoms requiring medical attention and healthy ways of living, as well as information about the functioning of health systems;

[2] Draft resolution adopted unanimously by the committee on 11 October 2016.

5.5. promote a new approach for informing children about and consulting them on health decisions concerning them, and let children participate in the planning, design and delivery of healthcare where appropriate, thus implementing the highest standards of child participation;

5.6. provide special support to the most vulnerable groups of children, including by putting into place targeted programmes to respond to their specific needs, as well as by:

5.6.1. setting up regular screening programmes for all children via schools, including children living in poverty or in families with low levels of health literacy, in line with WHO standards in this field;

5.6.2. developing programmes to improve the presence of and access to health workers in remote rural areas through training, regulation and (where appropriate) financial incentives, as well as to support children and families in reaching the nearest healthcare centres;

5.6.3. improving access for children with disabilities to quality, affordable healthcare services by reviewing legislation and policies, increasing targeted budgets and improving service delivery;

5.6.4. in the light of the current refugee crisis, taking immediate action to guarantee access for children “on the move” (migrants and refugees) to quality healthcare independent of their legal status and without discrimination based on gender, age, religion, nationality or race;

5.6.5. in the same context, dedicating special attention and resources to children affected by armed conflicts, either by physical injuries requiring aftercare or by traumatising incidents having led to a significant increase in mental health problems amongst children;

5.6.6. taking action to guarantee access to quality healthcare for children of ethnic minorities, such as Roma and Traveller children, including through specific outreach programmes meant to overcome reluctances to turn to public health services;

5.6.7. providing specific training programmes for healthcare professionals to help them address culturally sensitive matters, such as sexual and reproductive health, and deal with traumatised children;

5.7. co-operate to provide support in delivering access to healthcare for all children to countries with the most need and the least resources;

6. Improved accessibility to healthcare systems should also include complaint mechanisms for patients encountering dysfunctions of the system and unequal treatment, inspection bodies in charge of supervising health facilities and quality management systems to improve services wherever needed.

B. Explanatory memorandum by Ms Kyriakides, rapporteur

1. Introduction

1. Children have manifold needs to be fulfilled so that they can experience a safe and happy childhood and become adults capable of living autonomous and happy lives. From birth onwards, they all need food, shelter, safety and protection. Next to basic physical care, they also require affection, emotional security, stimulation, guidance and control, responsibility and increasing independence, in line with their respective age.[3] According to the United Nations Convention on the Rights of the Child (UNCRC), children must be guaranteed the full set of human rights. In the spirit of the indivisibility of fundamental rights, these also include social rights such as the right to the highest attainable standard of health, social security, adequate standards of living, education, as well as rest and leisure.[4]

2. Despite widespread awareness of children's needs of protection and care, many children in Europe still do not see their basic needs met - for various reasons. The financial and economic crisis has hit numerous countries, and austerity measures have exacerbated inequalities, caused by socio-economic developments, demographic trends and increased migration flows. In this context, many families, even in Europe, have difficulties in obtaining a regular and adequate income, in providing full parental protection and care for their children or in accessing various public services.

3. Amongst the essential needs of children that remain unsatisfied in the current socio-economic context is the effective and full access to healthcare services. Cuts applied to public budgets under austerity programmes regularly ignore the specific needs of children and the short- and long-term consequences that limited support to them may cause for their personal well-being, development and equal opportunities, as well as, in the long-term, for society on the whole. The present report wishes to explore some of the main challenges with regard to the full provision of healthcare services to children and point to the areas where action is needed most urgently.

4. Specific questions with regard to children are: In which ways are they hindered or discriminated against in their access to healthcare? Which are the main categories of children in need of special support in accessing healthcare services? Such questions have, amongst others, been explored via a fact-finding visit to Greece in October 2014, an exchange of views with international experts at the Committee meeting held in Chișinău (Republic of Moldova) in May 2015, and addressed by a dedicated written contribution from the organisation Médecins du Monde (MdM). I would have liked to spend more time on examining the situation prevailing in different countries, given that all countries of Europe are facing the challenge in one way or the other, but such comprehensive research would clearly have exceeded the scope of this report.

2. Standards of healthcare: which measures to apply in evaluating children's healthcare?

5. Identifying gaps in legislative and political action involves the confrontation of real-life situations with European standards. The Council of Europe itself, although unfortunately having ended its specific intergovernmental activities in the health field a few years ago, has developed a number of instruments in this area. The Parliamentary Assembly continues to monitor developments in the public health sector through our Committee, and has pointed to a number of issues in the past years.

[3] National Society for the Prevention of Cruelty to Children (NSPCC): A child's needs and rights, NSPCC factsheet, September 2012, http://www.nspcc.org.uk.

[4] United Nations Convention on the Rights of the Child, full text in English: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx.

2.1. International standards in the health field

6. Children's right to the "highest attainable standard of health" is first guaranteed by Article 24 of the UNCRC, whilst, at Council of Europe level, the "right to protection of health" more generally is also enshrined in the European Social Charter (ETS no. 163) and the "Oviedo Convention" (Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine; ETS no. 164) requiring from member States to ensure "equitable access to healthcare of appropriate quality" within their jurisdictions.

7. In 2011, the Committee of Ministers of the Council of Europe also adopted a more specific, but non-binding, standard on child-friendly healthcare: the "Guidelines on child-friendly healthcare". These guidelines call for healthcare services to take into account children's rights, needs, characteristics, assets, evolving capacities and own opinions.[5] At EU level, Article 35 of the Charter of Fundamental Rights states that "everyone has the right to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices".

8. As parliamentarians, it is our responsibility to contribute to the effective implementation of these standards. The Parliamentary Assembly for its part has already pointed to the lack of comprehensive health prevention policies in many countries through its work leading up to Recommendation 1959 (2011) on "Preventive healthcare policies in the Council of Europe member states", in which it called upon governments to "support a good start in life for families and young children by strengthening preventive healthcare before pregnancy and for mothers and babies in pre- and post-natal, paediatric and school clinics, and through improvements in the educational levels of parents and children". Effective health policies should always contain a strong component of early prevention given that many health problems occurring in adult life may be prevented through appropriate screening or treatment in childhood.

9. Guidance for improving health services for children and adolescents may also be found in the new "European child and adolescent health strategy 2015-2020" of the World Health Organization (WHO) aimed at "[enabling] children to realize their full potential for health, development and well-being" and "reduce their burden of avoidable disease and mortality". Amongst health priorities under this current programme, WHO quotes the remaining challenges linked to preventable death and infectious disease, early childhood and adolescent development, reducing exposure to violence, promoting health ways of living through nutrition and abstention from tobacco and alcohol consumption, tackling mental health problems and protecting children and adolescents from environmental risks. More specific recommendations are made by WHO in its 2014 "European framework for quality standards in school health services and competences for school health professionals".[6]

2.2. Access to healthcare – defining the concept

10. The Sustainable Development Goals (SDG) adopted by the United Nations in 2015 intend to achieve "universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all" under Goal 3 ("Ensure healthy lives and promote well-being for all at all ages"). To achieve universal health coverage, health policies and health systems should be based on the

[5] Guidelines on child-friendly healthcare, adopted by the Committee of Ministers on 21 September 2011: http://www.coe.int/t/dg3/children/keyLegalTexts/PREMS124412_GBR_2029_GuidelinesHealthCare_BAT_A4_WEB.pdf.

[6] The two WHO documents are accessible via the following links:
http://www.euro.who.int/__data/assets/pdf_file/0010/253729/64wd12e_InvestCAHstrategy_140440.pdf?ua=1;
http://www.euro.who.int/__data/assets/pdf_file/0003/246981/European-framework-for-quality-standards-in-school-health-services-and-competences-for-school-health-professionals.pdf?ua=1.

principles of (i) availability; (ii) accessibility; (iii) acceptability; (iv) contact; and (v) effective coverage.[7]

11. The World Health Organization (WHO) defines accessibility as "a measure of the proportion of the population that reaches appropriate health services", understanding availability as including physical access, travel facilities and affordability (user fees, health expenditures and transport).[8] Universal health coverage means achieving good health services *de facto*, so coverage and access are complementary ideas.[9] Even if services exist and people have access to them, they might not always use them; access also involves the opportunity or ability to receive health services and, as such, can be measured by utilisation rates. Another accessibility measure is the outcome of services in terms of health results. Measuring equity of access to health services is a core component of performance assessments for health systems.[10]

12. A major issue about access to healthcare services lies in the situation of vulnerable groups, such as persons with disabilities or migrants, who may meet financial, organisational, social or cultural barriers in accessing healthcare services.[11] National health policies should therefore also include measures aimed at lifting such barriers. Continuity of access is crucial and must be based on need rather than ability and/or willingness to pay.

2.3. Child participation in healthcare provision - luxury concept or state of mind?

13. Next to accessibility questions, "child-friendliness" in public service provision has received increasing attention over the past decade. The concept includes the participation of children in all decisions concerning them, inspired by article 12 of the UNCRC stating that "a child who is capable of forming her or his own views [should have] the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child".[12]

14. The above-mentioned Council of Europe guidelines on child-friendly healthcare also contain a chapter on child participation, specifying for the health field that: a child should give his or her free consent, or if not yet able to do so, see his or her opinion taken into account in proportion to his or her age and degree of maturity; all children should be given appropriate information before medical interventions; children should be given the opportunity to take part in social decision-making processes, including the assessment, planning and improvement of healthcare services.

15. Although, in different contexts, child participation may be based on very sophisticated (and sometimes costly) procedures of consultation or collaboration, it is first based on a new state of mind. It includes recognition of the fact that every child is a bearer of the full set of human rights. So even in countries where public authorities do not have the funding to develop specific child-participation mechanisms, their participation in decisions concerning them should be allowed and promoted. The area of healthcare where children's health, identity and well-being is concerned, is crucial in this respect.

3. The issue at stake - children's access to child-friendly healthcare services

16. To fully grasp the issue at stake, it is important to look into general determinants of the access to healthcare in Europe, but also into challenges specific to children and the most vulnerable groups amongst them. An important distinction to be made in practice is the one between children and

[7] Tanahashi: Health service coverage and its evaluation, WHO Bulletin 56, 1978.
[8] Barriers and facilitating factors in access to health services in Greece. World Health Organization 2015.
[9] Universal health coverage and universal access, Bulletin of the World Health Organization, 2013.
[10] Allin, Hernández- Quevedo & Masseria, 2009; Hernández-Quevedo & Papanicolas, 2013; OECD, 2004a.
[11] Guilford et al.: What does 'access to health care' mean? (Abstract), Journal of Health Services Research and Policy 2002; http://www.ncbi.nlm.nih.gov/pubmed/12171751.
[12] See also UN Committee on the Rights of the Child (2009), General Comment No. 12 on the right of the child to be heard.

adolescents. Whilst both are defined as children (in the sense of minors under 18), according to the UNCRC definition, smaller children and adolescents are not concerned by the same health issues but have special needs according to their age group and specific risks linked to it.

3.1. General determinants of health and access to healthcare for children in Europe

17. Access to healthcare services means that people have the power to demand appropriate health resources in order to protect or improve their health. Whilst some may have unhindered access to health services, others may encounter obstacles in gaining access. Amongst the legal, financial, cultural or geographical barriers for certain groups are:

- a lack of insurance coverage (especially affecting migrants, ethnic minorities, the long-term unemployed or the homeless);
- the inability of affording the direct costs of care (e.g. for low-income groups);
- a lack of mobility (e.g. for disabled persons);
- a lack of language competence (for migrants and ethnic minorities);
- a lack of access to information (for the poorly educated, migrants or ethnic minorities);
- time constraints (e.g. for single mothers);
- specific financial barriers for low-income groups and patients with chronic diseases;
- health literacy and health beliefs (including certain traditions and cultural practices) of specific social groups, also hindering access to facilities and information on sexual and reproductive health;
- uneven geographical coverage and lack of healthcare services and workers in remote rural areas.

18. Amongst the categories of the population regularly seen as disadvantaged in the health field in Europe are the Roma and Traveller population, people with physical disabilities or mental disorders, people suffering from chronic diseases, the unemployed, people with poor living or working conditions, migrants and refugees, the elderly and women.[13] Children, who are generally dependant on their parents (or other adults) support in accessing healthcare services, meet specific obstacles. These can be linked to their families' socio-economic situation, educational level or level of "health literacy", including a basic understanding of the human body, of the symptoms and causes of diseases and of the national health system's functioning.[14]

19. In this respect, we also need to distinguish between access to health and healthcare services. The living conditions encountered by many children may already represent serious health risks as such, for example due to bad housing conditions, undernourishment, unhealthy life-styles or domestic violence. Access to healthcare services then becomes another issue in which children regularly encounter the same difficulties as adults.

3.2. Children and health – topical challenges as observed across Europe

20. A paper specially prepared by the International NGO Médecins du Monde (MdM) in 2015 for the purpose of the present report, provides the following observations:[15]

- Socio-economic barriers in accessing healthcare are similar in different European countries. They often involve loopholes in legal provisions, financial hardship and difficult living

[13] Dorota Sienkiewicz, European Public Health Alliance: Access to Health Services in Europe, European Social Watch Report; http://www.socialwatch.eu/wcm/access_to_health_services.html.

[14] The US Office of Disease Prevention and Health Promotion (ODPHP) defines health literacy as follows: "Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions", see fact-sheet downloaded on 22 June 2016, via: http://health.gov/communication/literacy/quickguide/factsbasic.htm.

[15] I would like to thank the highly specialised staff of Médecins du Monde (MdM), an INGO operating in 16 Council of Europe member States, to have provided most useful observations for this report: Communication of Médecins du Monde – Doctors of the World International Network to the Council of Europe PACE Committee on Social Affairs, Health and Sustainable Development, April 2015 (available upon request from the Secretariat).

conditions, administrative barriers, a lack of understanding about healthcare systems and language barriers;
- Such barriers exist from an early age of children (2013: close to 70% of pregnant women without access to ante-natal care before coming to an MdM health centre; nearly 50% of minors lacked essential vaccines (such as mumps, measles and rubella, pertussis or tetanus)), in some cases, birth certificates had been refused to children whose mothers were unable to pay for services;
- Access to healthcare for children is determined by their parents' ability to access health services;
- Children (and their fundamental rights) have been the first victims of the economic crisis and subsequent austerity measures (including through increasing xenophobia);
- Particular vulnerability is observed amongst undocumented and unaccompanied minor migrants, children of seriously ill migrants and Roma and Traveller children.

21. Some of the specific problems of migrants as identified by MdM notably concern children: overcrowded accommodation and living conditions affecting child development, poorly equipped housing (water, heating, sanitation), unhealthy surroundings, residential instability causing stress, and stress and fears linked to the families' unstable situation, as well as xenophobia, racism and discrimination. MdM as an organisation becomes part of the solution offered to children given that they regularly provide emergency healthcare to those most in need, including migrant and refugee children.

22. In their 2012 reply to the Office of the High Commissioner for Human Rights (OHCHR), the Office of the Children's Commissioner for England identified the following main challenges in terms of children and healthcare, which can also be considered as typical to a certain extent:[16,17]
- The impact of poverty on children's and young people's health (e.g. specific pathologies linked to poor nutrition and lack of physical exercise);
- Lack of direct involvement of children in planning, design and delivery of health and social care;
- Unmet health needs of young people within the youth justice setting and care system (increased mental health problems amongst children in institutional care);
- The effects of parental alcohol misuse on the lives of children and young people;
- Health needs of unaccompanied and separated children (increased prevalence of post-traumatic stress disorders (PTSD));
- Health needs and data sharing related to child sexual exploitation (more data needed for effectively fighting abuse and health consequences).

23. Reports on current determinants of children's access to healthcare were received from various international experts[18] who conveyed the following key messages to our Committee:
- Child protection mechanisms still need to be improved significantly in Eastern European countries, where access to health services remains a long-term challenge, and includes the

[16] Office of the Children's Commissioner / Championing Children and Young People in England: Response to the Office of the High Commissioner for Human Rights (OHCHR), Study on Children's Right to Health, London, October 2012: http://www.childrenscommissioner.gov.uk/sites/default/files/publications/Right_to_health.pdf.

[17] In 2014, the Children's Commissioner also drew attention to the fact that the government's draft child poverty strategy for 2014 to 2017 needed to be strengthened, in particular where fiscal decisions and economic policy undermined childcare policy. The office was joined by other experts warning that child health in the United Kingdom was at risk in the economic crisis. Sources: (1) Office of the Children's Commissioner for England: Response to the government's child poverty strategy 2014-2017, published on 23 May 2014, London, http://www.childrenscommissioner.gov.uk; (2) Wolfe, Ingrid: Child health at risk in the economic crisis: what can we do? published on 12 November 2012, www.opendemocracy.net.

[18] I would also like to thank the experts having contributed to the hearing organised by the Committee at its meeting in Chisinau (Republic of Moldova) on 19 May 2015: Mr Vadim Pistrinciuc, Vice-President of the Parliamentary Committee for social protection, health and family, Republic of Moldova; Mr Iñaki Gonzalez, Advisor to the Ombudsman of Andalusia, Spain; Ms Charikleia Tziouvara, Paediatrician, Doctors of the World (Médecins du Monde (MdM), Greece.

need to address specific issues like child or maternal mortality, or access to care in rural areas;

- Action is also needed in Western Europe: data from Spain, for example, shows that access to healthcare is an issue for the 26.3% of the population living under the poverty line and the 34.9% of the population at risk of poverty or social exclusion. Health results are worse amongst children living in vulnerable families. Growing poverty had also contributed to an increase in domestic violence. The middle class was increasingly affected by the crisis, sometimes leading to the loss of homes;
- According to MdM data, 62.9% of the people seen by the organisation in Europe had no healthcare coverage, the main barrier being restrictive legislation excluding certain groups. The fear of being expelled would prevent many migrants from attending health services, notably in countries where professionals were obliged to report undocumented migrants;
- MdM subsequently called on all European countries to: (1) disconnect migration and health policies; (2) improve vaccination across Europe; (3) ensure solidarity, equality and equity in public health systems for everyone living in Europe; (4) ensure access to vaccination and paediatric care for all children (including prenatal care).

24. For this report, special attention was paid to the situation in Greece where I had the opportunity of undertaking a fact-finding visit in October 2014 at a time when the country particularly suffered from the effects of austerity programmes and budgetary cuts in the health system.[19] During my visit to Athens, I learned that accessibility for children to healthcare was limited in particular in rural and insular areas due to the lack of paediatricians and financial difficulties, whilst all children had access to vaccination and received support for accessing other health services if needed (e.g. unaccompanied children). Already according to earlier reports, austerity measures imposed on Greece in 2010, including cuts to health services, have affected people through increased rates of child poverty and malnutrition, HIV infections, suicides (and attempts), and stillbirths. Other dramatic effects are yet expected in cancer screening and management.[20]

25. In 2012, the UN stated that "the right to health and access to health services [was] not respected for all children in Greece". Reduced access to prenatal health services for women had led to an increase in neonatal and post-neonatal deaths.[21] In 2013, UNICEF drew attention to the number of children whose parents had lost their social insurance coverage.[22] This was confirmed by the WHO report on "Barriers and Facilitating Factors in Access to Health Services in Greece", noting that the economic crisis had resulted in more than 2.5 million people losing their social insurance rights.[23]

26. MdM, currently running 16 programmes for different target groups in Greece, noted that, amongst other social problems (e.g. more than 40% of children living in poverty, rising intolerance and xenophobia), a topical challenge was the 30% of the population without health coverage. Amongst migrants, only formal asylum seekers, undocumented migrants under 14 years of age and women giving birth, were provided with public health services (except for pre-natal care), and significant problems existed in cases of chronic or serious illness. The country did not have sufficient means to respond to the needs of all people arriving in Greece, many of whom had suffered from torture or undertaken life-threatening boat trips.[24]

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[19] I would like to thank the Greek delegation for their warm welcome in Athens on this occasion, and professional support in organising interviews with main stakeholders.

[20] The Lancet: The Greek health crisis, Vol. 386, 11 July 2015, www.thelancet.com; for The Lancet's Health in Europe Series, see: http://www.thelancet.com/series/health-in-europe.

[21] Kentikelenis; Karanikolos; Reeves; McKee; Stuckler: Greece's health crisis: from austerity to denialism, Health Policy, The Lancet Vol. 383, 22 February 2014, www.thelancet.com.

[22] "Unicef: One child in three in Greece is at risk of poverty or social exclusion", Enet, 3 April 2014, http://www.enetenglish.gr.

[23] WHO/Regional Office for Europe: Barriers and Facilitating Factors in Access to Health Services in Greece, Geneva 2015.

[24] As explained by Ms Charikleia Tziouvara, Paediatrician, Doctors of the World (Médecins du Monde (MdM), Greece, at the above mentioned hearing held in Chișinău (Republic of Moldova) on 19 May 2015; see footnote 7.

27. Whilst Greece was hit by the crisis in a severe manner and has been in the first line of countries receiving migrants and refugees in the past years, problems may also be observed in wealthier countries, such as Switzerland. Over the past decade, the Swiss health sector has suffered from an insufficient number of paediatricians and seen an increasing centralisation of paediatric care. Consequently, the UN Committee for the Rights of the Child recommended to the Swiss government to take action ensuring a high level of paediatric care. However, it has to be noted that efforts have been made to increase equality in the health sector. Most recently, insurance premiums for children for low and middle income families have seen a reduction of at least 50%.[25]

28. With regard to child and adolescent health generally, special attention also needs to be paid to mental health issues. Relevant measures should both be part of preventive health strategies (for mental problems that may be treated before reaching adult age), others will accompany persons concerned all their lives. According to WHO, 10-20% of children and adolescents experience mental disorders worldwide, and half of all mental illnesses begin by the age of 14 (and three quarters by the mid-20s).[26] If untreated, certain neuropsychiatric conditions may lead to disabilities and influence children's development, their educational attainments and potential to live fulfilling lives. Addressing children's and adolescent mental health problems is a complex matter and requires specific strategies following differentiated approaches. Such strategies must tackle depression, eating disorders and other, sometimes hereditary, mental health problems, but also relate to substance abuse or the psychological effects of violence experienced or witnessed by children.[27]

29. Coming back to more general observations valid for many countries, an integral part of prevention strategies, including in terms of mental health, should be efforts to avoid "unhealthy" life situations for children, including for those living in large child-care institutions. A recent study lead amongst Romanian children (aged 12) showed that early institutional care may have detrimental effects and lead to physical and mental development setbacks which would then require significant medical interventions at a later stage in their lives. The study further revealed that an optimal solution for children without parental care would be stable long-term foster care placements.[28] As said previously, unhealthy life situations may also find their origin in other social determinants, such as poor living conditions caused by unemployment, absence or sickness of one or both parents. Finally, we must not forget about the increasingly frequent environmental causes, such as living nearby nuclear power stations, waste incineration plants or other polluting infrastructure facilities, or limited access to safe drinking water or good sanitary facilities.[29]

30. Finally, an aspect not to be neglected is the one of children's access to medicines.[30] For many years, the European Union (EU) has tried to promote the development of child-specific medicines by the pharmaceutical industry.[31] However, testing medicines on children is not always easy (e.g. due to the lack of parental consent) or cost-effective, and the market share of child medicines is estimated at only 3% of the "adult" market, which does not justify major investment for pharmaceutical companies.[32]

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[25] UN Committee on the Rights of the Child: Concluding observations on the combined second to fourth periodic reports of Switzerland, Geneva 26 February 2015.

[26] For further information, see the dedicated webpage by WHO: http://www.who.int/mental_health/maternal-child/child_adolescent/en/.

[27] WHO: Investing in children: the European child and adolescent health strategy 2015–2020, adopted at the 64th session of the WHO Regional Committee for Europe, Copenhagen 15-18 September 2014, http://www.euro.who.int/__data/assets/pdf_file/0010/253729/64wd12e_InvestCAHstrategy_140440.pdf?ua=1.

[28] The Lancet (editorial): Ending institutionalisation of children, Volume 386, No. 9991, 25 July 2015, reviewing: Humphreys, Kathryn (and others): Effects of institutional rearing and foster care on psychopathology at age 12 years in Romania: follow-up of an open, randomised controlled trial, www.thelancet.com.

[29] WHO: Investing in children, see footnote 25.

[30] Finney, Elisabeth: Children's medicines: a situational analysis, November 2011, published in the framework of the WHO programme "Make medicines child size", http://www.who.int/childmedicines/progress/CM_analysis.pdf?ua=1.

[31] See: Regulation (EC) No 1901/2006 of the European Parliament and of the Council of 12 December 2006 on medicinal products for paediatric use:
http://ec.europa.eu/health/files/eudralex/vol-1/reg_2006_1901/reg_2006_1901_en.pdf.

[32] Kurth, Nicola: *Vergessene Patienten – Warum es so wenige Medikamente für Kinder gibt* (Forgotten patients –

3.3. Vulnerable Categories of Children

Poor children

31. Evidence gathered by European experts shows that in particular children coming from disadvantaged social backgrounds suffer from inequalities in accessing healthcare. There is certainly room for improvement in terms of accessibility and responsiveness to the needs of poorer children: in some countries, children are covered by insurance only if their parents are, hence if their carers cannot afford insurance, children are not insured.[33] The economic crisis and austerity measures targeting social programmes such as healthcare and welfare support have affected poor and disadvantaged children to a greater extent, undermining their right to the highest standards of health.[34]

32. In some countries, problems are found to be cutting across different categories of children. For the Republic of Moldova, for example, WHO findings suggest that both poor people and people in rural areas belong to the most excluded, preferring to avoid contact with health services until it becomes impossible to delay.[35] Amongst the most marginalised groups in the country also is the Roma and Traveller population, with a significant share of children having no health insurance.[36]

33. The Republic of Moldova, one of Europe's poorest countries, is just one example where we can see how inequalities in the health sector were exacerbated and health services deteriorated following the financial crisis, whilst this certainly occurred in a similar manner in various other countries. Moldova's current share of health expenditure (5.3% of GDP in 2014) is actually smaller than in other countries of the region, whereas the share of private health expenditure (5.0% in 2014) is relatively high.[37] As a result, the poorest are facing excessive health costs, and, due to a lack of consistent planning, family medicine is marked by significant deficits, particularly in rural areas.[38] Income disparities significantly affect children's health: stunting (malnutrition leading to growth failure) strikes nearly four times more children from poor families.[39] High levels of substance abuse and alcohol consumption among adolescents and low knowledge on HIV/AIDs prevention put young people at risk.[40]

Children in remote rural areas

34. Significant discrepancies also exist between the rural and urban populations in terms of access to high quality essential services such as health services. Evidence indicates disparities in the presence and number of qualified healthcare personnel, proximity to large hospitals, effectiveness of emergency care services, quality of the infrastructure and demands on health workers. Other inequalities include access to specialised services, health promotion and prevention activities, as well as financial barriers.[41] The latest "Health at a Glance: Europe 2014" report by the

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why there are so few medicines for children), Der Spiegel online, 09.07.2015.

[33] European Commission Network of Independent Experts on Social Inclusion: Investing in children: Breaking the cycle of disadvantage - A study of national policies, Synthesis Report, Assessment of what member States would need to do to implement the European Commission Recommendation, Hugh Frazer and Eric Malier, April 2014.

[34] Hooson: Europe's poorest children are suffering most from austerity measures, say researchers, Swansea University Media Centre, 10 December 2015, http://www.swansea.ac.uk/media-centre/latest-research/europespoorestchildrenaresufferingmostfromausteritymeasuressayresearchers.php.

[35] WHO Regional Office for Europe: Barriers and facilitating factors in access to health services in the Republic of Moldova, Republic of Moldova Health Policy Paper Series No. 9, 2012, Copenhagen.

[36] Cace, Cantarji, Sali, Alla: Roma in the Republic of Moldova, UNDP Moldova, 2007, Chisinau, http://www.undp.md/publications/roma%20_report/Roma%20in%20the%20Republic%20of%20Moldova.pdf.

[37] World DataBank: World Development Indicators, Health expenditure private (% of GDP) for Moldova, http://databank.worldbank.org/data/reports.aspx?source=2&country=MDA&series=&period=.

[38] Turcanu, Domente, Buga Richardson: Republic of Moldova: health system review, European Observatory on Health Systems and Policies, Health System in Transition Vol. 14 No. 7, 2012.

[39] UNICEF: Annual Report 2014: Moldova, Geneva 2014.

[40] UNICEF: Republic of Moldova Multiple Indicator Cluster Survey, 2012, http://mics.unicef.org/surveys.

[41] WHO Regional Office for Europe: Rural poverty and health systems in the WHO European Region, 2010, http://www.euro.who.int/__data/assets/pdf_file/0019/130726/e94659.pdf.

OECD confirms that in all member countries, the density of doctors is much greater in urban regions.[42]

35. In this context, the United Kingdom, for example, has introduced a promising policy practice to ensure better access to health services in remote areas: "rural proofing – policy maker's checklist"[43] to ensure that the needs of rural populations are taken into account during the development and implementation of policies and programmes. In 2013, the Department for Environment, Food And Rural Affairs (DEFRA) published National Proofing Guidelines which provide support and advice to government officials.[44] However, the scope of this report did not allow to explore the implementation of these policies and their actual impact in more detail.

Children with disabilities

36. Another vulnerable category are children with special needs due to physical or mental disabilities. According to the World Health Organization (WHO), people with disabilities report seeking more healthcare and having greater unmet needs. Health prevention activities seldom target people with disabilities.[45] For children and adolescents with disabilities even easily curable illnesses like fever or diarrhoea can become life-threatening if left untreated; some children may not survive childhood because of a lack of primary healthcare facilities; rehabilitation services are often concentrated in urban areas and expensive, thus are non-accessible for many; children with disabilities will often have to be left in institutions by their parents while receiving care – with profound psychological consequences.[46]

37. Countries should develop specific programmes guaranteeing better service access and inclusion for children with disabilities and find solutions to reduce "out-of-pocket" expenditure for families. Children should be empowered through information and peer support, whilst professionals should receive specific training and tools, including to overcome communication difficulties encountered by some children.

Children "on the move"

38. Because of their exposure to migratory stress, children "on the move" (including migrants and refugees) are particularly vulnerable, not least because their health can quickly deteriorate when they do not have access to adequate care.[47] As reported by MdM, the two main barriers encountered are administrative problems (lack of legal access to healthcare) and a lack of understanding or knowledge of rights. Additional elements that may discourage children from seeking healthcare include language barriers or fear of being arrested.[48]

39. Grave concerns are also being raised over the impact of living conditions in refugee camps on children's health, whilst healthcare services in camps are very limited.[49] Healthcare services for migrants and refugees must be adapted so as to avoid increasing anxiety in both individuals and the wider community, including through training of healthcare professionals to address culturally sensitive issues and to overcome communication difficulties. States must be made aware that it is

[42] OECD: Health at a Glance: Europe 2014, Paris 2014.
[43] WHO Regional Office for Europe: Rural poverty and health systems in the WHO European Region, 2010, http://www.euro.who.int/_data/assets/pdf_file/0019/130726/e94659.pdf.
[44] Gov.UK: Planning and development – guidance: Rural proofing guidance, https://www.gov.uk/guidance/rural-proofing-guidance, accessed 6 June 2016.
[45] See WHO fact-sheet No. 352 on "Disability and Health": http://www.who.int/mediacentre/factsheets/fs352/en/.
[46] UNICEF Innocenti Research Centre: Digest No. 13: Promoting the Rights of Children with Disabilities", Florence 2007, http://www.un.org/esa/socdev/unyin/documents/children_disability_rights.pdf.
[47] WHO Regional Office for Europe: Migration and health: key issues, http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues#292937, accessed 28 June 2016.
[48] Chauvin, Simmonot, Vanbiervliet: Access to healthcare in Europe in times of crisis and rising xenophobia, Doctors of the World, April 2013.
[49] Isakjee, Dhesi, Davies: An Environmental Health Assessment of the New Migrant Camp in Calais, University of Birmingham, September 2015, https://www.doctorsoftheworld.org.uk/files/Calais_Health_Report.pdf.

not only in the interest of the individual to receive healthcare and be rightfully cured, but also in their own interest to deliver it, for example to avoid the spreading of infectious diseases.

40. Good practice is known from the United Kingdom where, in the framework of its National Health Service (NHS), asylum seekers, refugees and trafficking survivors are amongst the groups that are exempt from all charges relating to healthcare. The NHS is meant to ensure free access to primary care, walk-in centres, accidents and emergencies as well as diagnosis and treatment of infectious diseases. Any urgent or immediately required treatment, including ante-natal care, must be delivered; however it may be charged additionally afterwards.

41. Despite the easing of access for asylum seekers, refugees and trafficking survivors, migrants are a particularly vulnerable category of the population in the UK in terms of access to health services. More specifically, the government has been more indisposed towards irregular immigrants with regards to healthcare access, as proven for instance by the introduction of the Migrant and Visitor NHS Cost Recovery Programme, which led to hospitals routinely asking about someone's immigration status before they access healthcare. MdM labelled children of undocumented migrants as one of the most vulnerable groups in the UK, with 50% of the children attending the organisation's family clinic having had no access to healthcare, including essential vaccinations.[50]

Children from ethnic minorities

42. Children from ethnic and linguistic minorities, in addition to being victims of structural discrimination, are often raised in poor socio-economic conditions, hence undermining their access to adequate health services. Roma and Traveller children are amongst the most vulnerable group identified. Evictions and deportations result in the discontinuation of care, poor compliance with medication and ineffective monitoring and follow-up. Other barriers that Roma and Traveller populations face, but which are also observed among other minority groups, include language difficulties, lacking health literacy, discrimination, lack of insurance as well as physical barriers such as mobility and distance.[51] Finally, data available on minority communities, and more particularly children, is fragmented, therefore hindering the development of effective social inclusion policies.[52]

Ante-natal healthcare

43. As already underlined by the Assembly in Resolution 1959 (2011) on "Preventive healthcare policies in the Council of Europe member states", ante-natal healthcare is a pre-condition for children's health. Although European countries aim at universal health coverage, inequalities in access to maternal healthcare persist. Challenges include gaps in statutory coverage, specific eligibility criteria or limited scope of benefit. For instance, social and maternity protection often requires formal employment, full-time contracts or permanent residency. Hence, women employed part-time or facing difficulties accessing the labour market do not always qualify for protection. This means that the most vulnerable groups are often excluded from social health insurance, hence being at higher risk of out-of-pocket expenditure.[53]

[50] Doctors of the World UK: Access to Healthcare for people facing multiple vulnerabilities in the UK, London, August 2015, https://mdmeuroblog.files.wordpress.com/2016/02/leaflet_access-to-healthcare_mdmuk_bd_pages.pdf.
[51] European Commission: Roma Health Report: Health status of the Roma population, Data Collection in the Member States of the European Union, Executive Summary, August 2014, http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_es_en.pdf.
[52] UNICEF: Focus on children from ethnic and linguistic minorities in Central and Eastern Europe and Central Asia, 2016, http://www.unicef.org/ceecis/2016_Children_from_minorities.pdf.
[53] International Labour Office (ILO)/Social Security Department: Social Security Policy Briefings, Paper 8 - Social Security for All, Addressing inequities in access to health care for vulnerable groups in countries of Europe and Central Asia, Xenia Scheil-Adlung and Catharina Kuhl, Global Campaign on Social Security and Coverage for All, Geneva 2011:
http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---soc_sec/documents/publication/wcms_secsoc_25201.pdf.

4. Conclusions and recommendations: action required urgently and in the long-term

44. After having looked at topical challenges, European standards and expert recommendations, I wish to point to a number of legislative, political and administrative measures which would be needed to improve access to healthcare services for all children both to address the most urgent problems and to induce structural changes in a sustainable manner, with a view to forwarding them to governments of Council of Europe member States in the form of an Assembly Resolution.

45. Whilst Europe, in comparison with other regions of the world, certainly has more or less solid healthcare systems in which much attention is paid to children's specific needs, there are still significant gaps in certain areas and inequalities both across and within European countries. For the sake of our children, we should do our utmost to fill these gaps because their well-being now and in the future are of the greatest importance for our societies on the whole. Healthcare services for children should therefore not only be made available, but also accessible to all children in a country, whatever their socio-economic, ethnic or migrant background, geographical location, state of health or legal status in a given country. Services for children should also be based on the highest standards of "child-friendliness" and involve information, consultation and participation of children to the greatest extent possible.

46. The most urgent situations to be tackled are probably the ones in countries where welfare and public health systems have suffered from the economic crisis and related austerity programmes and need rebuilding. A big challenge is also represented by the significant migration and refugee flows, in the context of which public authorities are not only asked to provide healthy living conditions for children and families, but also to ensure both basic and specific healthcare services to them. In the long-term, investing into child-accessible and child-friendly healthcare systems needs to focus on prevention programmes not only involving families directly, but also through child care and educational institutions.

47. Against this background, member States of the Council of Europe should be invited to apply the measures presented in the preliminary draft resolution.