Inequalities in healthcare access by type of visa in a context of restrictive health insurance policy: the case of Ukrainians in Czechia

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Abstract

Introduction: In Czechia, immigrants without permanent residence are not entitled to public health insurance and should purchase a commercial insurance.

Methods: Using data from a survey of Ukrainian immigrants and a country-wide Health Interview Survey for Czechs, we analyse inequalities in access to different healthcare services.

Results: Ukrainians with a permanent visa have lower access than Czechs to specialist and dental care. Ukrainians with a long-term visa have a lower access than Czechs to all types of care, and than compatriots with a permanent visa to primary care (adjusted Prevalence Ratio 0.45, 95%CI 0.34-0.61), hospitalization (0.29, 0.12-0.71) and emergency room (0.60, 0.37-1.00).

Conclusions: The exclusion of long-term immigrants from the public healthcare system should be revised on grounds of equity and public health protection.

Introduction

Since the collapse of the communist regime at the beginning of the 1990s, Czechia has rather successfully gone through a process of deep and intensive political and socioeconomic transition, and joined the European Union in 2004 (Večerník 2009). International migration was no exception to such development: circular long–term and permanent immigration in-flows to Czechia mostly motivated by economic reasons gradually became more and more important, and between 1993 and 2008 the number of foreigners staying officially in Czechia increased from 77,000 to 440,000, about 4 % of the population (Drbohlav et al. 2010). At the end of 2013, this figure was 441,500, of which 202,600 had a long-term visa and the rest a permanent residence permit (Czech News Agency 2014). The groups with most representation include economic migrants from the "East" such as Ukraine, Vietnam and Russia. Since this increase, research on integration issues has grown, including aspects related to immigrants´ health (Pikhart et al. 2010, Hmilicová and Dobiášová 2011).

The increased number of foreigners has compelled the adoption of appropriate legislation to address the provision of healthcare. Healthcare for Czech citizens, guaranteed by the Czech Constitution, is assured by a general health insurance paid by employees and employers, and covered by the State for citizens outside the labour market. Access to this public health insurance system is also provided to EU citizens and to third-country nationals with permanent residence and to long-term (more than 90 days) residents who are registered employees. For migrants with a long-term residence permit who are not employees (self-employed, children, parents and partners, students and others), this access is not granted. Some 100,000–120,000 persons (about one quarter of all foreigners), have been estimated to be in this situation (Hnilicová 2011). By law they are required to obtain a commercial health insurance as pre-condition to enter the country and hold it throughout their stay, however this is not claimable and insurance companies can even refuse high risk cases, e.g. seriously ill individuals (Vavrečková et al 2013). As recent settlers (or circulating transnational migrants), coming from more disadvantaged countries and without a stable employment, the majority tend to be in situations of financial vulnerability and unable to afford this kind of insurance, except perhaps by cutting other fundamental costs such as food, housing, heating or remittances. Lack of knowledge of the Czech health system can further affect their healthcare utilization.

There is a lack of objective data on the consequences of this situation on immigrants' access to healthcare in Czechia. A substantial body of scientific literature has documented differences between migrant groups and local populations in health care utilization in Europe (Norredam et al. 2010, Deville et al. 2011), due to socio-cultural, economic, administrative and legal barriers (Scheppers et al., 2006). The right to health implies equity in access to health care services for equal health needs. Health care services should be physically and financially accessible for all sectors of the population (UN-WHO, 2008). Most countries guarantee access to the public healthcare system for regular migrants (Laziosanità, 2011), however, legal barriers persist in some countries even for authorized immigrants, and Czechia appears as one of such cases. We hypothesize that this legal barrier results in a lower access to a wide range of healthcare services and professionals for long-term resident migrants as compared with the general Czech population, and also with permanent migrants from the same background. The present study aims to test this hypothesis through a survey of Ukrainians in Czechia and by comparing them with the Czech population in a national health interview survey.

Methods

A cross-sectional design is applied. Data for Czech nationals are extracted from the 2008 European Health Interview Survey (EHIS) carried out by the Institute of Health Information and Statistics of the Czech

Republic. From June to October 2008, 1,955 persons aged 15 and over were interviewed from a sample of 3,825 subjects (response rate 51%) originally selected from the Ministry of Interior information system of civil registration, through a two-stage stratified selection, with municipalities being the first stage and respondents the second stage. Data collection was conducted through personal interviews. In the present study we use data from Czech-born nationals aged 18 to 61 (same minimum-maximum as Ukrainians' survey) who completed the survey (n=1,258).

For Ukrainians, we use a survey carried out in the city of Prague and in the Central Bohemia region between May and October 2012. Only citizens of Ukraine, who had been in Czechia at the moment of the survey for more than 6 months (visits to Ukraine shorter than one month were tolerated) and who, at the same time, remitted money (as this was the primary focus of the survey) qualified to take part. Snowball sampling was applied by approaching the Ukrainian community, starting from firms, church, schools, ethnic associations, relevant intergovernmental and non-governmental organizations and the researchers' own contacts. Only one member per family could be interviewed. Data was collected through personal interviews. When filling in the questionnaire the respondents could use Czech, Russian or Ukrainian version. Both respondents and the mediators who found them were rewarded. A total of 321 subjects were successfully contacted. We exclude eight subjects with missing data on sex and we analyse data from the remaining 313 respondents.

The main independent variable is the combination of nationality and type of visa, comparing Czechs born in Czechia (EHIS), Ukrainians with permanent residence permit and Ukrainians with long-term residence permit. Dependent variables include questions on healthcare access fully comparable from both surveys: in the last twelve months, any hospitalization; visit to a general practitioner (GP); visit to a specialist; visit to a dentist; in the last two days, having taken any prescribed drug. Visits to emergency room were also analysed within the Ukrainians' survey. As adjustment variables, following the conceptual framework proposed by Andersen (2008), we used sex, age, educational level, marital status, employment status indicating predisposing factors and self-rated health status as a proxy measure of need for healthcare.

We performed a descriptive analysis of all variables in the three groups (Czechs, Ukrainians - permanent and long-term visa holders). Then, for each dependent variable, we fitted two types of robust Poisson regression: one with Czechs as reference, and the other excluding Czechs, with permanent resident Ukrainians as reference. All regressions were adjusted by sex, plus other variables that were significantly associated with the healthcare use variable in a bivariate model. Stata 11 was used to run all analysis.

Results

Descriptive statistics are shown in Table 1. Long-term visa holders are predominantly men (69.6%) and slightly younger than the other two groups. Migrants, and especially permanent visa holders among them, are more likely to hold a university degree, to be in paid work, to be married and to report a fair health status. Permanent visa holders are similar to Czechs in the likelihood of having visited a GP, more likely to be hospitalized, less likely to have visited a dentist or another specialist, and less likely to have taken a prescribed medication. Long-term visa holders are less likely than either of the other two groups to have accessed any type of healthcare.

Results from multivariate models are shown in Table 2. Controlling for all adjustment variables, permanent immigrants were significantly less likely than Czechs to visit a specialist (PR 0.38, 95%CI 0.26-0.55), dentist (PR 0.69, 95%CI 0.57-0.83) or take prescribed drugs (PR 0.63, 95%CI 0.44-0.89), but not to have been hospitalised or to have visited a GP. Immigrants with a long-term visa have a much lower access to all types of care than Czechs, and a significantly lower access than compatriots with a permanent visa to GPs (PR 0.45, 95%CI 0.34-0.61), hospitalization (PR 0.29, 95%CI 0.12-0.71) and emergency care (0.60, 0.37-1.00).

Discussion

This study has shown that the access by Ukrainian immigrants with a long-term visa to most types of healthcare, including primary care, is substantially lower, not only than native Czechs, but also fellow nationals with a permanent residence permit. This happens in a context where these immigrants, unless they hold a paid job, are excluded from entitlement to public healthcare insurance, and despite the fact that they are expected (legally obliged) to purchase commercial health insurance. On the other hand, even permanently settled immigrants, despite their legal access in equal conditions, still have a lower utilisation of specialized care and prescribed drugs than native Czechs.

Lack of differences in hospitalisations and GP visits between natives and permanently settled immigrants coincides with findings from most studies in European countries with universal public healthcare coverage, where, if any, a higher use of GP by migrants has been reported (Cooper et al. 1998, Stronks et al. 2001, Saxena et al. 2002, Regidor et al. 2009, Uiters et al. 2009, Norredam et al. 2010). Immigrants' lower use of specialist services has also been reported by some (Stronks et al. 2001) but not all studies in the Netherlands (Norredam et al. 2010), and has been a constant finding in Spain (Regidor et al. 2009) where, as in Czechia, immigration has been a more recent phenomenon and newly arrived migrants may have more difficulties sorting out organisational barriers to access this level of care.

In contrast, long-term visa holders report substantially lower rates of access to health services than those of both Czechs and compatriots with a permanent visa. Considering that 85% of them were in paid work, and employees should be granted access to the public insurance system according to the existing legislation (Hnilicová et al. 2011), a new survey has been carried out also collecting information on health insurance, in order to assess its contribution directly and rule out other potential explanations such as lack of knowledge or distrust in the system. The dual system for migrants, with access to the public system restricted to the most established categories, and a compulsory commercial health insurance as alternative for the rest, has been considered discriminatory (Vavrečková et al 2013) and may undermine migrants' present and future health, through the inability to alleviate acute illnesses and delays in diagnosis and treatment leading to diseases worsening or becoming chronic, not to mention the feelings of exclusion and discrimination. Of course one can expect even lower access for the not negligible numbers of undocumented migrants existing in the country (Medová and Drbohlav 2013).

Limitations of this study can be linked to sampling method, sample size and survey questions. The sample of immigrants is limited to one country of origin, Ukraine. Nevertheless, this allows for a relative homogeneity in terms of culture and familiarity with healthcare systems, and Ukrainians are the largest group of migrants in Czechia (Drbohlav et al. 2010). Snowball sampling may be questioned as a method for obtaining a representative sample but is considered a standard for research on hard-to-reach populations (Atkinson and Flint 2001). Moreover, it has been shown that nationwide health surveys may also have substantial limitations regarding representativeness of immigrant populations (González-Rábago et al. 2014), and a wide variety of recruitment sources were used. Around 60% of Ukrainians live in Prague or the Central Bohemia region where the survey was conducted (Czech News Agency 2014). The selection criteria of persons having sent a remittance to their home country may have excluded the most economically vulnerable migrants, probably even less likely to be able to afford their own health insurance and access healthcare. The relatively small sample size hinders further comparisons as for instance stratification of analysis by sex.

These findings urgently require the attention of healthcare policymakers both in Czechia and elsewhere. Excluding groups of migrants from the public system and relying on commercial insurance can result in

inadequate access to healthcare. The persistence of inequalities in access to specialized care for migrants admitted to the public system also deserves further attention.

In conclusion, striking inequalities in healthcare access emerge in a context characterised by the exclusion of some categories of long-term immigrants from the public healthcare systems. While future studies should assess the specific contribution of health insurance, health authorities should urgently revise this policy on grounds of equity and public health protection.

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Table 1. Descriptive statistics by nationality and type of visa (percentages). Czech (2008) and Ukrainians (2012) residents in the Czech Republic.

		Czechs (N=1,258)	Permanent stay Ukrainians (N=86)	Long-term visa Ukrainians (N=227)
Age	*Mean*	38.6	38.3	37.4
Sex	Men	50.0	52.3	69.6
	Women	50.0	47.7	30.4
Education	Basic	9.8	1.2	4.1
	High technical	36.1	17.2	35.9
	High general	39.6	32.2	29.1
	University	14.5	49.4	30.9
Marital status	Married	53.5	66.7	61.5
	Single	33.1	18.4	17.2
	Other	13.4	14.9	21.3
Employment	Paid work	73.4	89.4	84.7
	Unemployed	4.0	2.3	10.8
	Other	22.6	8.3	4.5
Health status	Very good	31.5	12.9	14.7
	Good	43.1	54.1	56.7
	Fair	19.5	31.8	25.9
	Poor	5.9	1.2	2.7
Hospitalisations	% 1 or more	8.6	14.0	4.4
Visits to emergency room	% 1 or more	n/a	25.3	13.6
Visits to general practitioner	% 1 or more	67.6	64.0	25.0
Visits to dentist	% 1 or more	73.6	54.6	38.7
Visits to specialist	% 1 or more	55.0	25.6	16.9
Prescribed drugs	% any	44.9	30.9	17.3

Table 2. Prevalence ratios (95% CI) of healthcare access (any visit in last 12 months) by type of visa. Czech (2008) and Ukrainians (2012) residents in the Czech Republic. Model 1: reference Czech-born. Model 2: reference permanent visa holders.

		Model 1	Model 2
Hospitalisations	Czech-born	1	---
	Permanent stay	1.80 (0.97-3.34)	1
	Long-term visa	0.51 (0.26-1.02)	0.29 (0.12-0.71)
Visits to emergency room	Czech-born	n/a	---
	Permanent stay	n/a	1
	Long-term visa	n/a	0.60 (0.37-1.00)
Visits to general practitioner	Czech-born	1	---
	Permanent stay	0.92 (0.78-1.10)	1
	Long-term visa	0.36 (0.29-0.46)	0.45 (0.34-0.61)
Visits to dentist	Czech-born	1	---
	Permanent stay	0.69 (0.57-0.83)	1
	Long-term visa	0.53 (0.44-0.63)	0.84 (0.64-1.09)
Visits to specialist	Czech-born	1	---
	Permanent stay	0.38 (0.26-0.55)	1
	Long-term visa	0.31 (0.23-0.42)	0.83 (0.50-1.39)
Prescribed drugs	Czech-born	1	---
	Permanent stay	0.63 (0.44-0.89)	1
	Long-term visa	0.42 (0.30-0.58)	0.63 (0.38-1.04)

Poisson regression adjusted by sex, age, education level, employment status, marital status and self-rated health.