Technische Universität Berlin

The EU and health policy – an introductory overview

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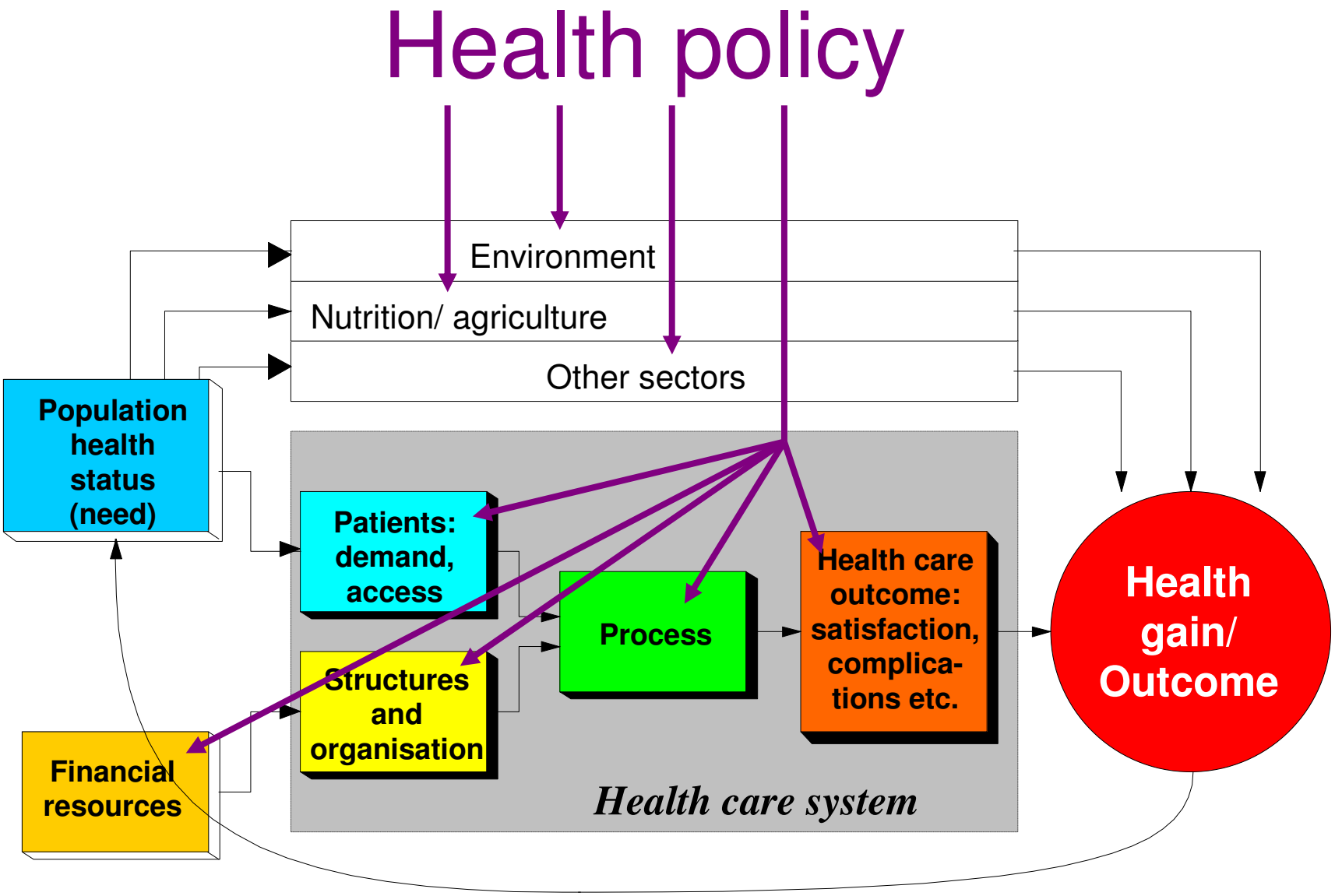
Health policy =
all measures to specifically
protect/ improve health of
population, i.e. prevention, cure
(“health care“) and rehabilitation

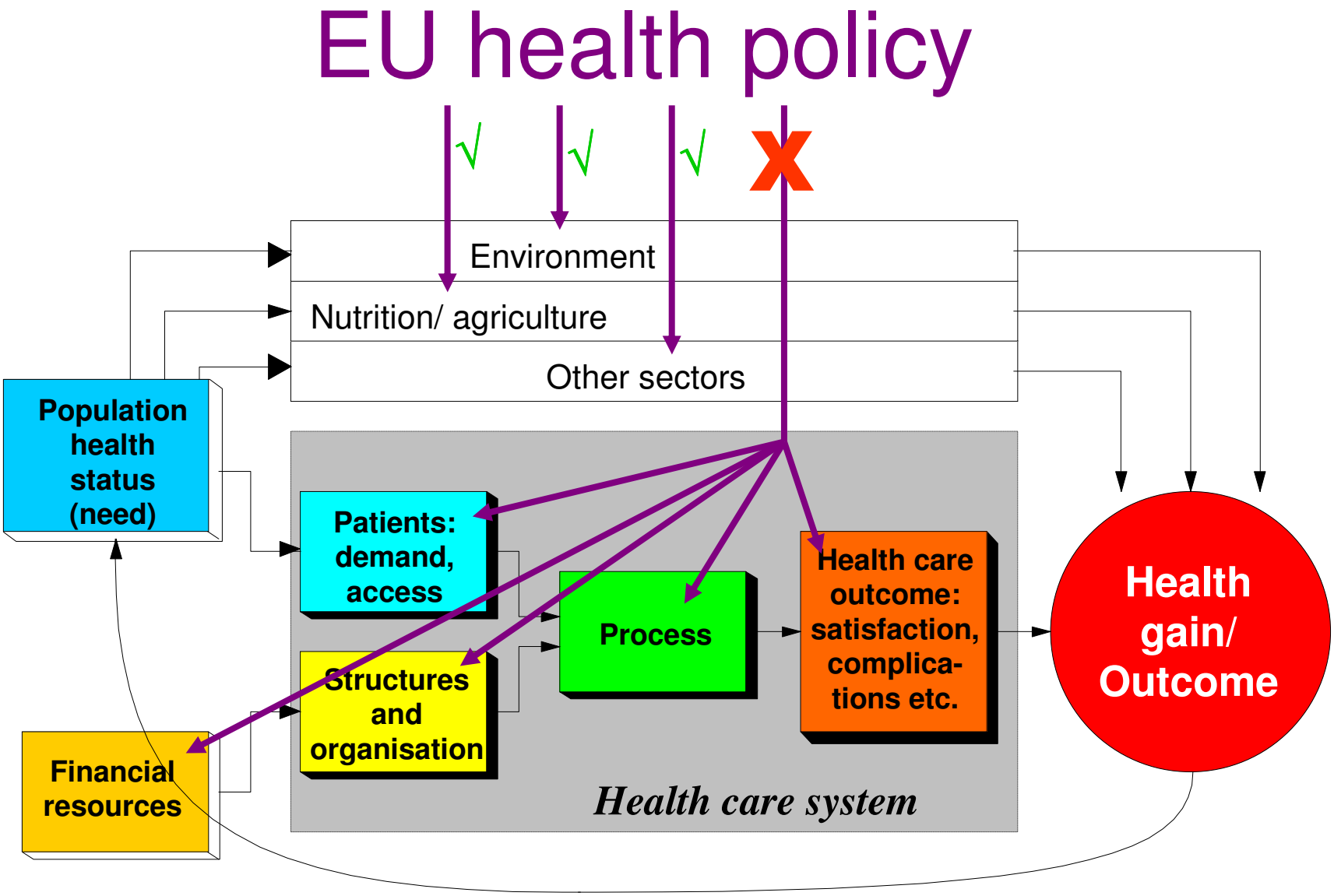

Health policy
Environment
Nutrition/ agriculture
Other sectors
Population health status (need)
Patients: demand, access
Structures and organisation
Process
Health care outcome: satisfaction, complica-tions etc.
Financial resources
Health care system
Health gain/ Outcome

Health (policy) in the EU Treaty

Article	Contents
3 par. 1 (p)	a contribution to the attainment of a high level of health protection
30	*restriction of free movement of goods in regard to health protection*
39 par. 3	*restriction of the free movement of workers in regard to public health*
46 par. 1	*restriction of right of establishment in regard to public health*
95 par. 3	attainment of a high level of health protection in regard to the approximation of laws
95 par. 6	*restriction of approximation of law in regard to public health*
95 par. 8	obligation to inform Commission in case of public health problems in field which has been a subject to prior harmonisation
137	health protection in the working environment
140	prevention of occupational accidents and diseases
152	**public health**
153	health protection as part of consumer protection
174 par. 1	health protection as part of environmental protection
186	*restriction of free movement of workers from associated overseas countries or territories in regard to health protection*

Article 152

- A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.
- Preventing human illness and diseases
  - fight against the major health scourges
  - promoting research into their causes, their transmission and their prevention
  - promoting research in health information and education
- "… excluding any harmonisation of the laws and regulations of the Member States. … Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care."


EU health policy
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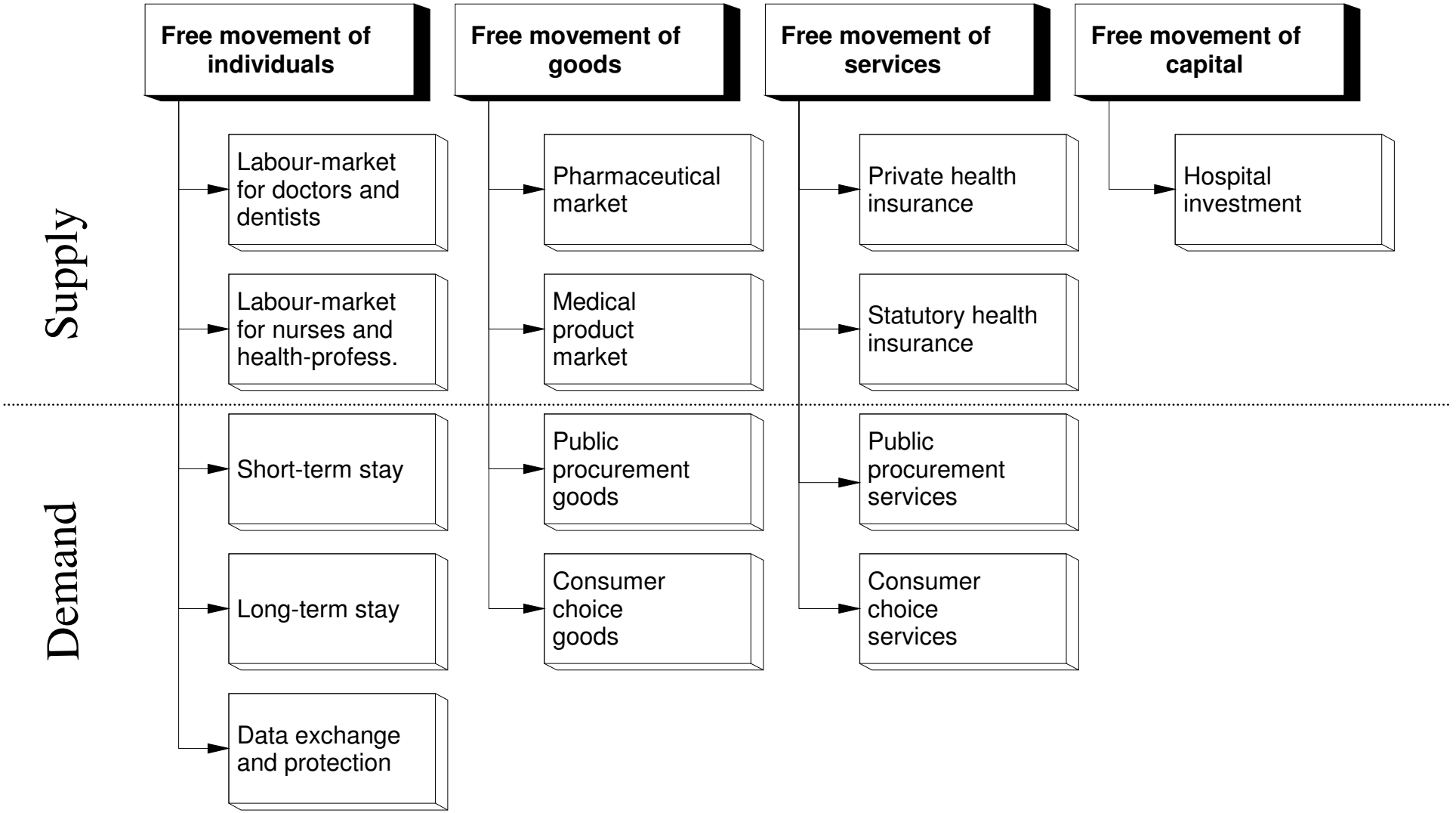
In addition:

- Article 152(5) only relates to Public Health measures
- Other EU policies do interfere with health systems, i.e. do not fully respect the responsibilities of the Member States:
  - occupational law (working times in hospitals!)
  - competition law (reference price setting)
  - Single European Market (internal market) – *especially as interpreted by the European Court of Justice*

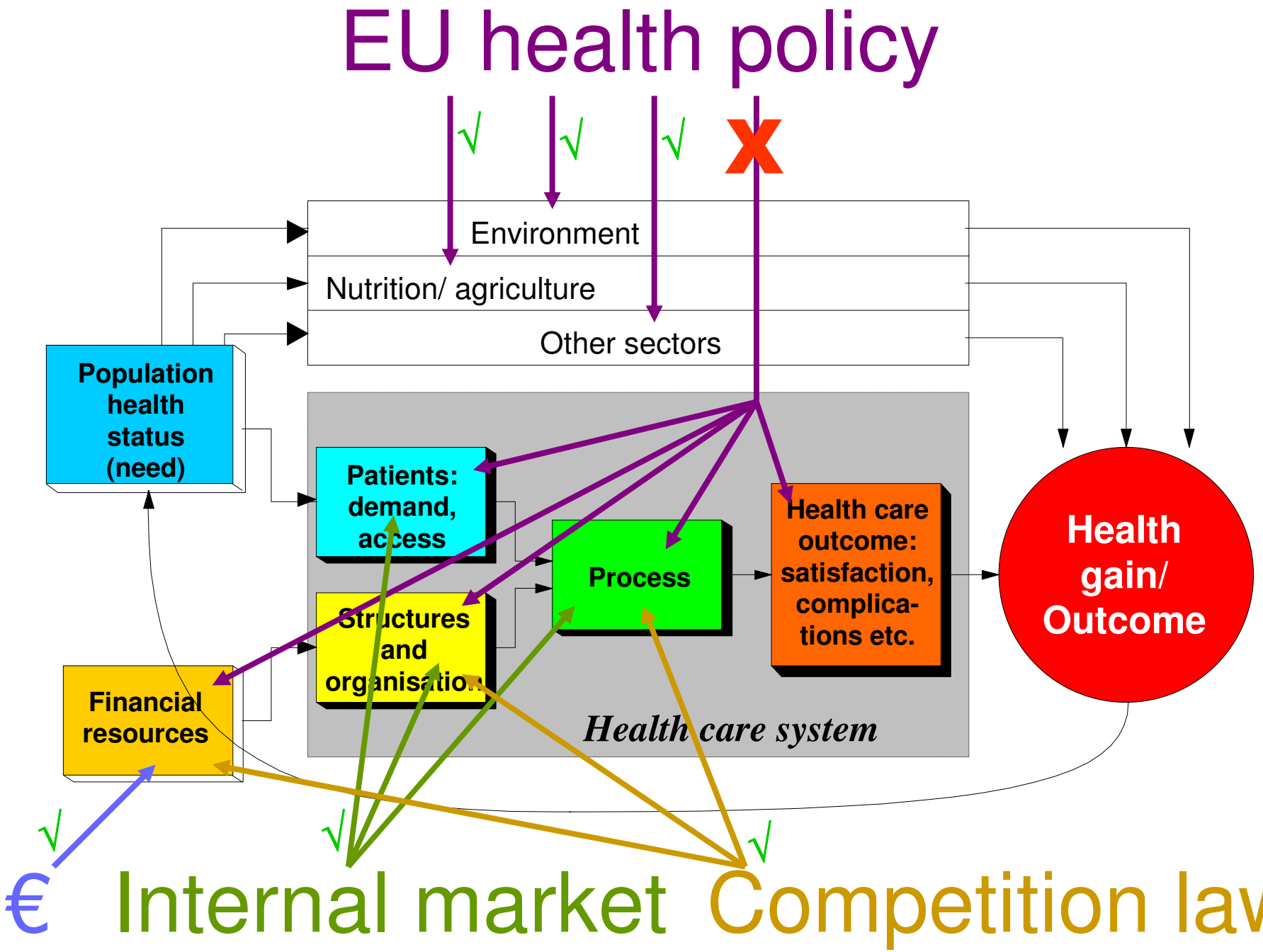
The four freedoms of the internal market and sub-categories relevant to health care



- Regulation 1408/71: free movement of persons (esp. workers)

ECJ rulings:

- 1998 Kohll & Decker: free movement of goods and services also applies in health care (only in ambulatory sector?, only in cost-reimbursement systems?)
- 2001 Peerbooms & Smits-Geraets:
  exclusion of benefits need to be evidence-based
  (in the medium run = EU benefits catalogue?!);
  pre-authorisation may not be refused in cases of unduly waiting times or capacity shortages
- 2003 Müller-Fauré & Van Riet: general entitlement for reimbursement of ambulatory services;
  for hospital services, this may be limited, but the criteria must be clearly defined (*but:* what is ambulatory? what services must be planned?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Internal market
Competition law

http://www.tu-berlin.de/fak8/ifg/mig/files/2002/publications/EU&HealthServices/EU&HealthServices.htm

"At European level, health services have to adapt to market rules, while at national level, health services are seen as part of a social model.

To overcome this situation and to ensure the social status of health services, we need – possibly paradoxically – to develop a European health policy."

If we accept that conclusion, the question is:

Should European health policy be based mainly on the “regular” instruments (regulations, directives etc.) or on the “open method of coordination” (OMC)?

What is the OMC?

- Member States define – supported by the Commission – objectives and appropriate indicators for evaluation
- How to reach objectives is entirely up to Member States
- Member States have to regurarly provide data on progress; the worse should learn from the better („best practice“); non-achievement of objectives needs to be justified

How could the open method of coordination be applied to health care?

Objectives in Commission report 12/01:

- General access to health care
- High quality of health services
- Financial sustainability of health care

But: which indicators, how to quantify these objectives?

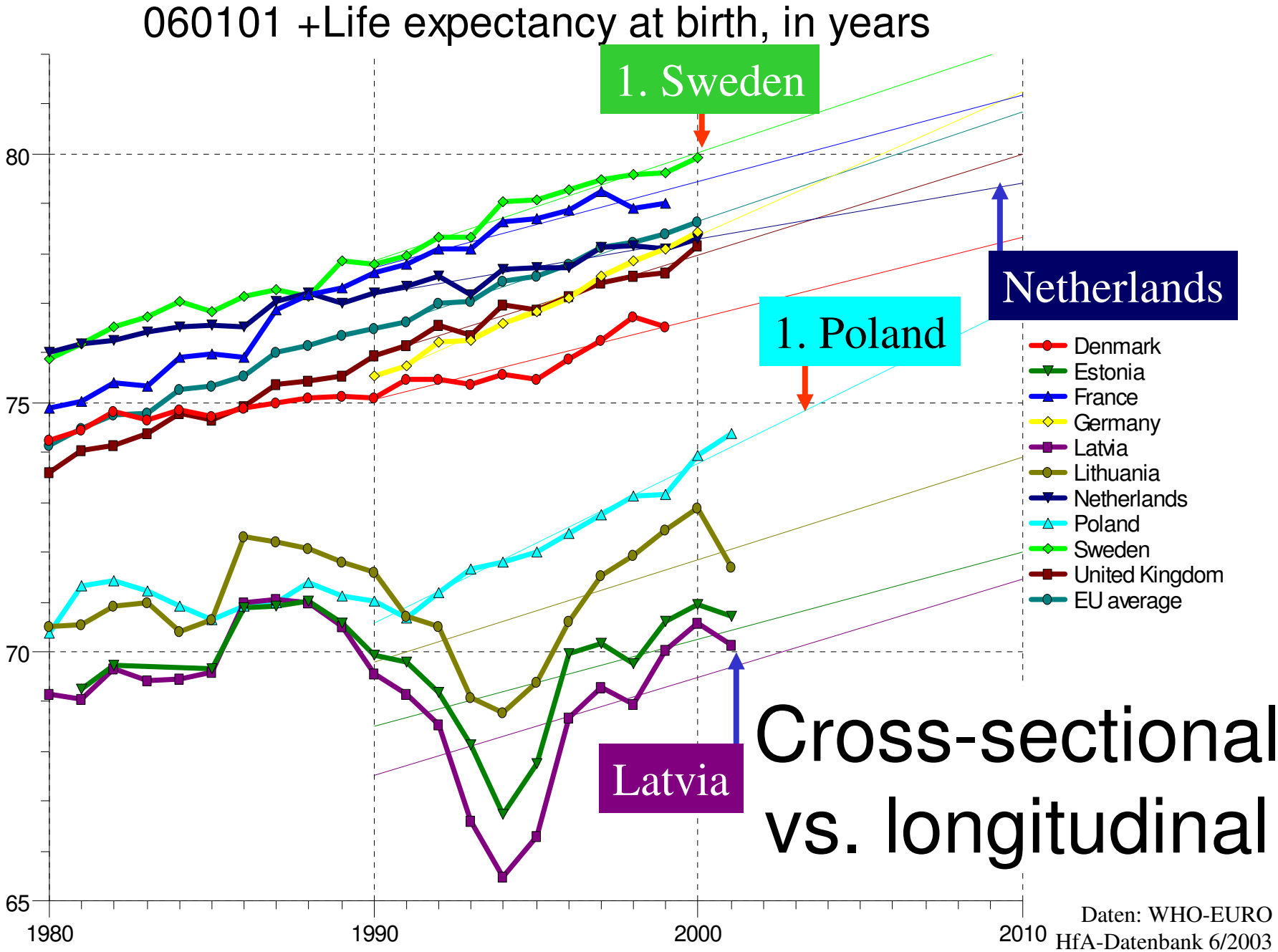
Which objectives are really relevant?

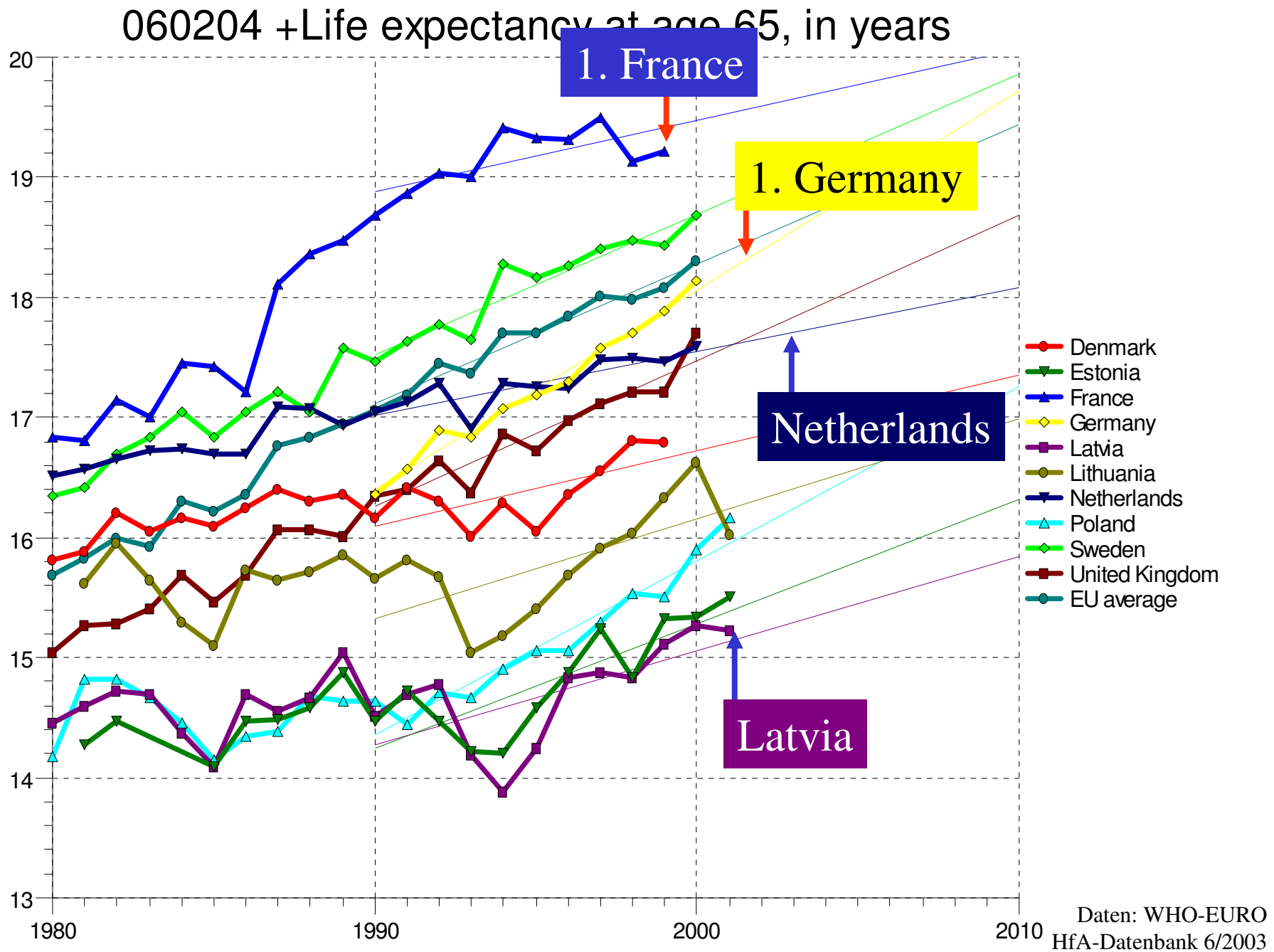
- to achieve a high population health status for the entire population (healthy life expectancy),
- to design health systems and make them function according to justified population health needs and expectations,
- to ensure access to needs-based and effective health technologies,
- assuring a fair *and* sustainable financing of health care.

What needs to be considered methodologically?

- Indicators need to be 1. based on data which – in all Member States – are collected *objectively*, are available in *good quality* and *timely*, and 2. *valid*.
- Data must *transnationally comparable*, which is not always the case (e.g. health expenditure as % of GDP).
- *Context* is relevant for interpretation, e.g.:
  Did expenditure only drop because certain services have been removed from the benefit catalogue?
- Emphasis on *health care outcomes* not inputs!
- *Indices* should *not* be used.

- to achieve a high population health status for the entire population (healthy life expectancy)


060101 +Life expectancy at birth, in years
1. Sweden
Netherlands
1. Poland
Latvia
Cross-sectional
vs. longitudinal
80
75
70
65
1980
1990
2000
2010
Denmark
Estonia
France
Germany
Latvia
Lithuania
Netherlands
Poland
Sweden
United Kingdom
EU average
Daten: WHO-EURO
HfA-Datenbank 6/2003


060204 +Life expectancy at age 65, in years
1. France
1. Germany
Netherlands
Latvia
20
19
18
17
16
15
14
13
1980
1990
2000
2010
Denmark
Estonia
France
Germany
Latvia
Lithuania
Netherlands
Poland
Sweden
United Kingdom
EU average
Daten: WHO-EURO
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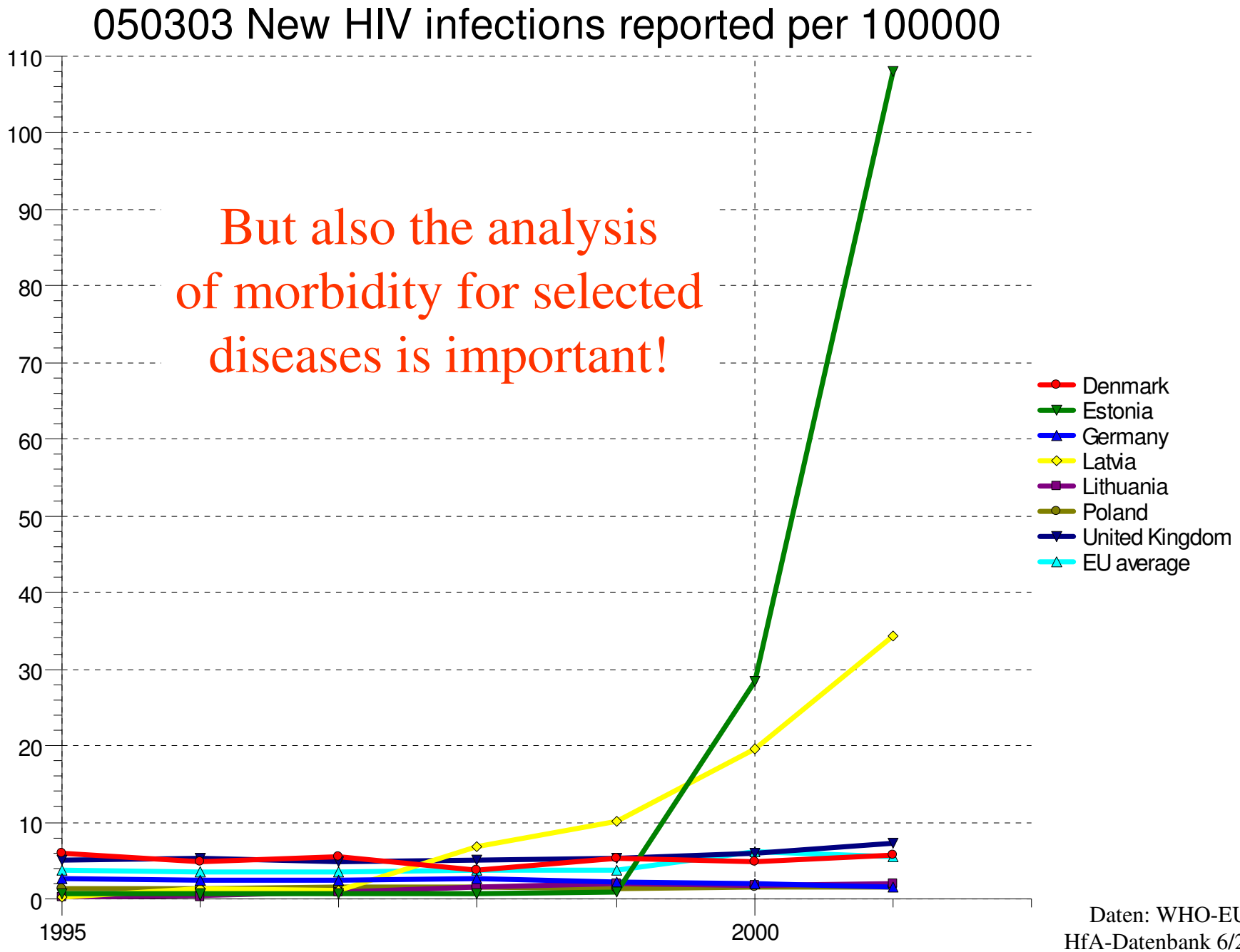
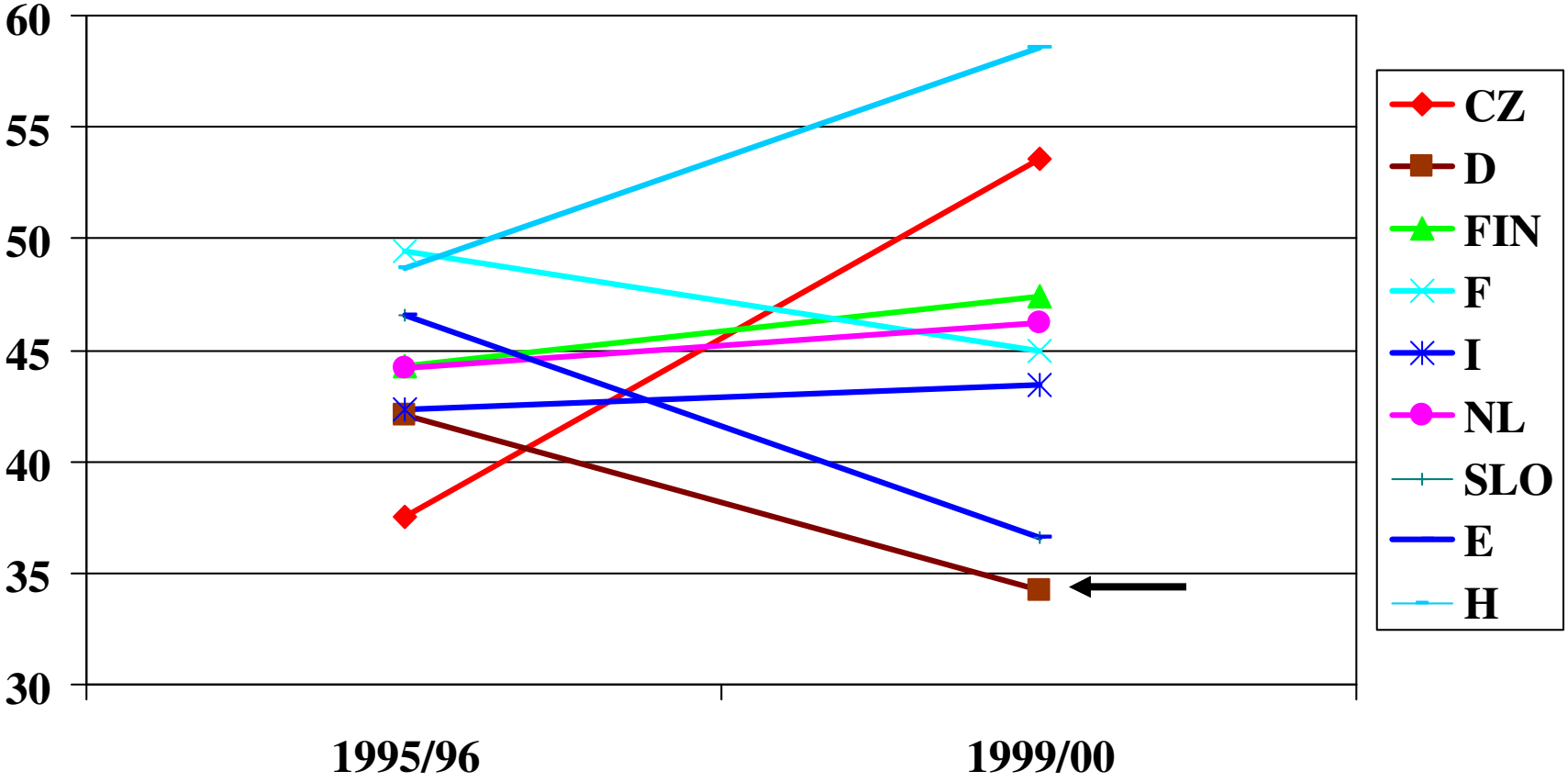

050303 New HIV infections reported per 100000
110
100
90
80
70
60
50
40
30
20
10
0
1995
2000
But also the analysis of morbidity for selected diseases is important!
Denmark
Estonia
Germany
Latvia
Lithuania
Poland
United Kingdom
EU average
Daten: WHO-EURO
HfA-Datenbank 6/2003

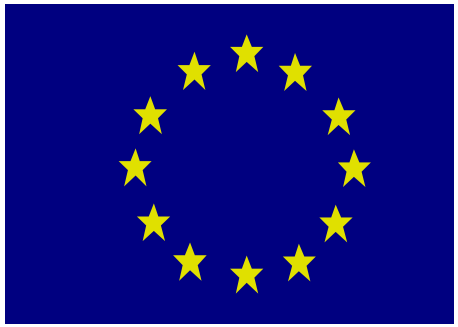
- to ensure access to needs-based and effective health technologies

Sufficient blood pressure control 6 months after a CHD hospitalisation



Daten: EUROASPIRE „Clinical reality of coronary prevention guidelines“, Lancet 2001; 357: 998

How could the application of such objectives/ indicators influence European health systems? (1)



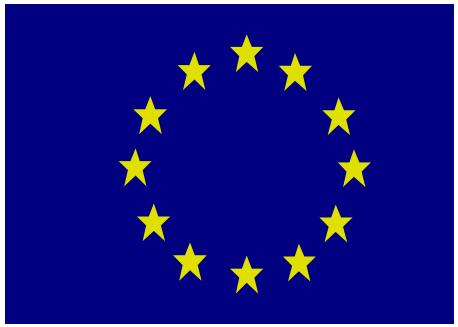
Initially probably not directly, but

- *Comparability* of services, their access and quality *will increase*,

and thereby contribute to the *Europeanisation of health care systems*, already on the way through

- mobility of short- and long-term tourists,
- cross-border contracts/ Euregios,
- ECJ rulings on Kohll/ Decker, Peerbooms etc.,
- the coming EU-health insurance card.

How could the application of such objectives/ indicators influence European health systems? (2)



This will in the medium-term probably lead to

- a European *benefit catalogue* (but not equal prices),
- Europe-wide rules/ standards for *accreditation* and *quality assurance*,
- Europe-wide diagnosis/ treatment *guidelines*.

This could make *Europe more concrete for its citizens* and help to *remove the conflict between markets and the social model.*