

Evaluating policies to improve access to healthcare: The system and the needs of patients' perspectives

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Structure

- What is “access“? Which components does it include?
- What does the EU have to do with it?
- What have EU Member States done to improve the various components of access?
- What still needs to be done?
 - the research agenda
 - the agenda for action



- The ability/ willingness to pay for care is a necessary (though not sufficient) condition.
- The financial basis to provide access will, for the vast majority mean being covered for health care, via insurance or via tax-funded state agencies.
 - Access is not only a matter of money, but money is the first hurdle.
 - First question:

Who is covered for health care?



- Being covered for “health care“ is one thing – but **which services/ benefits are actually included (or excluded) under this coverage?**

- *Examples: measles immunization, mammography screening, revascularization of cardiac vessels, liver transplantation*



- Being covered for services included under that coverage is good – but
do geographically accessible providers offer the services when they are needed/
appropriate?

- Accessibility will depend on the level and distribution of infrastructure, the topography of the country and transport; it will also have to be judged in relation to the service, e.g. a measles immunization should be available “around the corner“ while a 5-hour travel to a liver transplantation in a centre of excellence/reference might be acceptable.



Do geographically accessible providers offer the services when they are needed/ **appropriate?**

- The concept of “appropriateness” specifies general entitlements for the individual – in the simplest case, “mammography screening” to women of a certain age at certain intervals.



- Being covered for services which are included and are offered by accessible providers is good – but **do their capacities allow the actual delivery of these services**; or are they limited, as e.g. demonstrated by waiting lists?
- And finally: **Are covered accessible and available services acceptable?**

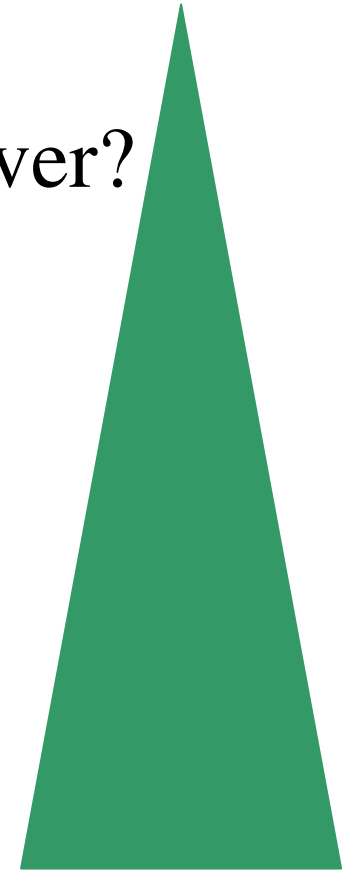
Reasons for non-acceptability include low quality or cultural reasons, e.g. offering reproductive services to women only by male physicians.



The 5 leading questions/ access hurdles

- Who is covered?
- What benefits are included under this cover?
- Do accessible providers offer services when they are needed/ appropriate?
- Do their capacities allow the actual delivery of the appropriate services?
- Are the available appropriate services acceptable?

CAVE:
Interference
of preferences!



Accessibility of health care

=A measure of the proportion of a population that reaches appropriate health services (WHO, 1998).

*WHO Regional Office for Europe (1998) Terminology –
A glossary of technical terms on the economics and
finance of health services; EUR/ICP/CARE0401/CN01*

CHARTER OF FUNDAMENTAL RIGHTS OF THE EUROPEAN UNION

(2000/C 364/01)



What does the EU have to do with it?

CHARTER OF FUNDAMENTAL RIGHTS OF THE EUROPEAN UNION

(2000/C 364/01)

Article 34

Social security and social assistance

1. The Union recognises and respects the entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, dependency or old age, and in the case of loss of employment, in accordance with the rules laid down by Community law and national laws and practices.
2. Everyone residing and moving legally within the European Union is entitled to social security benefits and social advantages in accordance with Community law and national laws and practices.

CHARTER OF FUNDAMENTAL RIGHTS OF THE EUROPEAN UNION

(2000/C 364/01)

Article 35

Health care

Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.



Access issues in the Peerbooms case

“In the Court’s view, the need to have resort to a system of prior authorisation, in the context of a system of agreements to provide health care, makes it possible to ensure that there is **sufficient and permanent access** to a **balanced range of high-quality hospital treatment** on the national territory, ...

Thus, the condition that the proposed hospital treatment in another Member State must be regarded as normal is acceptable only in so far as it refers to what is **sufficiently tried and tested by international medical science**.

... the necessity of the proposed treatment, ... must mean that authorisation can be refused only if the patient can receive the same or equally effective treatment **without undue delay** from an establishment with which his sickness insurance fund has contractual arrangements.”

Other access-improving measures by the EU

- E111, E106 etc. – ensuring that the coverage can travel (not the benefits, however!)
- The health insurance card from 2004 – same intention
- E112 – primarily a means of ensuring access to services in case of unaccessibility/ inexistence of appropriate providers or capacity limitations of accessible appropriate providers



What have Member States done to improve access?

- Extending coverage, e.g. introducing **universal coverage** in Belgium (1998) and France (2000)
- Making benefit catalogues more explicit and more rational (**Health Technology Assessment**)
- Improving access to accessible providers by allowing **free choice of provider** and **money-follows-patient** mechanisms (intra-country) AND **Euregio agreements** (trans-national)
- To tackle capacity problem: Introducing **waiting-time guarantees** and free choice of provider (intra-country) AND signing **contracts with providers in other countries** (trans-national)



What still needs to be done? The research agenda I

- To understand and compare the “**taxonomy**“ and **contents of benefit catalogues** – as well as the costs associated to individual services
(our 6th Framework proposal)
- To systematise – and then evaluate – **approaches for improving geographical access** to appropriate services, reaching from trans-border primary care in the neighbourhood to EU-wide “centers of excellence“ for rare conditions/ interventions
(our Public Health Programme bid)



What still needs to be done?

The research agenda II

- To analyse the impact – e.g. regarding equity – of **measures to tackle the capacity problem** (especially the trans-EU patient “shipping“)
- To understand citizens’/ patients’ **collective priorities** and underlying factors (as well as the relationship to individual preferences)



What still needs to be done?

The agenda for action

- Member States individually need to **cover those persons who are currently still not covered**.
- Member States and the EU should face the reality by thinking about an **EU minimum benefit catalogue** (as well as acceptable catchment areas for the services included).
- Member States should **make their national systems “borderless“** by extending the network of contracted providers.

