Are EU mechanisms for collaboration good for equity of access?

A contribution to the debate on health services at the Open EU Health Forum

Brussels, 8 November 2005

Nicoline Tamsma,
National Institute for Public Health and the Environment
The Netherlands

1. Introduction

The organisers of this session have asked me to present some thorny issues involved in ensuring equal access to health services for all European citizens. They have also asked me to focus on the potential contribution of European cooperation through the 'open method of coordination' (or 'OMC 'in short). In doing so, I will draw on some of the work Philip Berman and I have done on the OMC on poverty and social inclusion.

2. What can we say about equity of access to services?

We do know inequity is a persistent feature across health systems in the EU. Services are not always equally available to people in equal need, nor can we say there is equity as regards service delivery or service utilisation.
We also know that service need as such is not equally distributed among our population. Lower socio-economic status is associated with more chronic conditions, more disability and more unhealthy life years. I would like to keep this population group in mind in my reflection on access to services.

Improving access is a broad challenge. Distance, delay, waiting and costs are all dimensions that affect access. Some *barriers* to access may be more relevant to disadvantaged groups than others. For example, car ownership and travel costs are factors that disproportionately affect people from lower socio-economic groups if people are to tackle a concrete access barrier such as geographical distance.
'Softer' factors such as health beliefs, and the ability to express one's needs and expectations should also be mentioned here, as should language barriers and cultural differences. At the same time, our modern health systems radiate towards the needs of assertive, well-informed, internet-literate health consumers. Thus, addressing these factors becomes more urgent than ever.

Health systems finance may cause *financial barriers* of different height and shape to people in different income situations. Health care may be funded from a variety of sources, such as taxation, social and private insurance, or out-of-pocket payments. We know that out-of-pocket payments are relatively unfair to people with less income.

Studies focusing on *service utilisation* show that richer, better educated people find their way to medical specialists and dentists more easily and more frequent compared to poorer, less educated people. On the other hand, people with less income tend to use more GP services and more emergency services. The latter is

especially worrying: late presentation of their health needs may have a negative impact on their prognosis.

3. So, how can EU mechanisms for collaboration help to improve access?

When looking at the 'open method of coordination' there are two of these processes that specifically address access to health services. I would like to look at both of them. But first I would like *to say something about the process itself*.

Subsidiarity is the starting point for every OMC. OMCs are designed to help member states tackle issues of common concern and learn from each other. This leads to sequential dialogues between member states and the Commission. Based on this dialogue, the Commission identifies joint objectives and indicators relevant to these objectives, facilitates cross-national learning, and measures progress. The member states keep a relatively strong focus on their domestic situation: on challenges at national level, on delivering joint objectives though their own national action plans (or 'NAPs'), and on what they want to learn from others.

The democratic element seems to be lacking in this process, but … member states are expected to involve stakeholder organizations in developing their NAPs. I would like to stress that national and European stakeholders wanting to influence the OMC need to do some careful planning so they can feed into the right bit of the process at the right time.

Whether or not an OMC will be good for health access depends on how well its key actors perform in this process.
The Commission part is basically played by DG Employment and Social Affairs, not by DG SANCO. They are operating under the banner of social protection and build on experience with similar processes on themes like employment, social security and pensions, and poverty and social exclusion. While that may not be a bad preparation for addressing equity of access to health services, health policy is a relatively new topic for them.
As for the member states, one may ask whether they will openly share their problems or showcase their policies; and how keen they are to learn from others. Whether the ministry in charge of health has some experience with OMCs already due to earlier involvement in EU collaboration on employment or social security. Or whether they intend to collaborate with stakeholders, and which ones they choose to invite to the table.

4. So, what lessons can we learn from the OMC on poverty and social exclusion?

Improving access to health and social services is a priority for tackling poverty and social exclusion across the EU. As such, it is part of the wider objective to improve access to public services.
Based on our review of 5 NAPs, my impression is that member states do not pick up this challenge in any elaborate way. Yes, citizens' legal entitlements to equal access to health care are commonly referred to. The same is true for waiting list issues. But the broad range of barriers I discussed earlier -including service costs!- were addressed insufficiently, or not at all.

There is, however, much scope for improvement. This OMC is meant to improve the living and working conditions of people in disadvantaged situations. That makes it a very appropriate instrument to improve equity of access. Member

states could be much more creative to address health access measures in their NAPs.

NAPs could, for instance, include specific information on equity of access. They could include an analysis of health needs of disadvantaged groups and concrete measures to meet these needs. And they could include measures that counteract negative consequences of health systems finance for people living in poverty or people who are disproportionately affected by ill health.

Allowing for a small range of specialist services for drug users or homeless people is not enough. Instead, efforts should include a wide range of activities that are also aimed at improving mainstream access and responsiveness. To achieve this, the health community may have to seek closer partnerships with social affairs ministries.

5. And what about the OMC on health and long-term care?

This process is progressing slowly, very carefully, but steadily. It is still a long was to NAPs, but broad objectives have been agreed. Together with experts form member states, the Commission is working on the identification of the most appropriate indicators. This element of the process is pivotal as the indicators selected are likely to influence or even steer future prioritisation.

The good news is that ensuring access is one of the three main objectives of the OMC, along with ensuring quality and financial sustainability. The Commission has stated that access can only be labelled as 'adequate' if ability to pay is no obstacle to receiving care. This is, of course, good news as well. What also makes me hopeful is the list of issues the Commission would like to see mapped within and across member states. That list includes unmet need, availability of services, population coverage, the burden of private spending, and waiting times per region.

In spite of this, I also have some *concerns*.
The first one has to do with *ensuring a good balance between the three main objectives*. Access should not become the new Cinderella of health policy, following after its sisters 'finance' and 'quality'. This challenge will be tough to meet as the EU has powerful competencies in the area of finance, and the origins of the whole process lie within pressures to contain public spending.

Secondly, *the focus is predominantly on acute health services and- to a lesser extent- on residential care*. Access to home care, to innovative forms of integrated services, to physical aids and to 'intelligent' devices (to name but a few) should be addressed more prominently, as should issues with respect to mental health.

Furthermore, we need to put more effort into developing the right *access indicators*, however difficult this may be. And we need member states to *gather data* on these indicators once they have been agreed.

Last but not least, health ministries and stakeholder organisations need to get to grips with this process that comes at them from a non-health angle, and anticipate how it may help to improve access at national level.

6. In conclusion, both OMC processes provide a great opportunity to safeguard the social values and common principles underpinning healthcare systems in Europe. Equity of access is central to those values.

The OMCs can also help member states to find a way out of the subsidiarity-dilemma that has been a feature in the EU health systems debate since Decker and Kohll. Both OMCs could generate good practices or even benchmarks that may feed into developments around health in the internal market.

The impact of the OMC on access at national level will be much up to the member states themselves. Each country does face specific challenges with respect to the common objectives. The OMC does enable countries to learn from each other and find solutions that match their national situation. To what extent they will indeed do so may depend on the efforts of their governments as well as their stakeholder organisations.