The Social Protection Committee

SPPM THEMATIC REVIEWS ON THE 2014 SOCIAL TRENDS TO WATCH

Towards better health through universal access to health care in the European Union

Contents

1. Executive Summary

Access to health care is a key element of social protection policies. In the context of increasing levels of unmet need for medical care since 2009, the SPC thematic review conducted jointly with the Working Party of Public health at Senior level (WPPHSL) on 18 November 2015 on the topic of access to health care provided an opportunity for Member States to exchange information on challenges, good practices and the lessons learnt from the implementation of health policies and reforms with relevance to access to health care. Member States reported on their country experiences, focusing on key dimensions of access, including allocation of resources to health care, coverage and affordability, and the availability of services. The meeting also highlighted the need for appropriate consideration of the competences of Member States as regards the definition of their national health policy and for the organisation and delivery of health services. The need for better data collection, indicator development and monitoring as key elements for understanding the barriers to access and for devising appropriate policy solutions has also been stressed. International organizations active in health policy, as well as several Commission Directorates-General, reported on their work with a particular focus on initiatives related to the evidence base on accessibility issues. The wide-ranging discussion produced a number of policy lessons relevant for further discussions on the challenges of securing appropriate and cost-effective access to health care and medical services.

2. Introduction and background

The joint thematic in-depth review on health policy reforms, which took place on 18 November 2015, was dedicated to the topic 'Towards better health through universal access to health care in the EU'. The EU's Charter of Fundamental Rights refers to the right to access preventive health care and the right to benefit from medical treatment[1].Moreover, the SPC considers access to health care to be a key element of the social protection policies that it is called upon to monitor pursuant to Art.160 of the TFEU. In the context of the social OMC objectives[2], Member States have committed to providing access for all to adequate health care, as well as to high-quality and sustainable health care. As defined in Article 168(7) of the Treaty[3], Member States are to take

[1] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2010:083:0389:0403:en:PDF

[2] The social OMC common objectives are annexed to the 2011 opinion of the Social Protection Committee on reinvigorating the social OMC in the context of the Europe 2020 Strategy http://register.consilium.europa.eu/doc/srv?l=EN&f=ST%2010405%202011%20INIT

[3] Art. 168(7) of the Treaty states that "Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them."

decisions on how to provide for reaching these objectives, being responsible for the definition of health policy, for the organisation and delivery of health services and medical care.

Accessibility to health care is multi-dimensional. In practice, it does not mean making all services available to everyone at all times but rather, striving to have health systems in place that deliver services that match the population's needs as closely as possible.[4] An underlying precondition for this objective is sufficient funding and investment, as inadequate public funding for the health system creates and exacerbates barriers to access. The other main dimensions that affect the timely and appropriate usage of health care include factors such as coverage and affordability: who is entitled to health care, what services are people entitled to (ie. what is included in the publicly funded benefits package) and how much of these services are covered or subject to co-payments? Services that are excluded from public provision must be paid for out-of-pocket by patients, either through direct private spending or through the purchasing of Voluntary Health Insurance, both of which can have adverse impacts on household spending. The availability of care, whether it be shaped by physical factors such as the geographical location of health care facilities or having adequate numbers of trained health professionals with the right skill mix to meet population needs, is crucial in ensuring access to required services, as is the availability of medicines and medical aids at reasonable prices. Long waiting times for particular services also constitute a significant barrier to timely access to care and are one of the major contributors to unmet need.

In recent years, the economic crisis has posed considerable challenges to maintaining access to health services and medical care. The 2014 SPPM results for the period 2008-2013 show that the unmet need for medical care increased in nine Member States, but decreased in only two Member States;.[5] In addition, a recent expert report on access to health services in the EU[6] cites EU-SILC survey data showing that in 2013, approximately 3.6% of the people living in the European Union experienced (self-reported) unmet need for health care, representing a reversal of the falling trend in previous years (from 5% in 2005 to 3% in 2009).

Departing from this context, the SPPM thematic review provided an opportunity for Member States to exchange information on challenges, good practices and the lessons learnt from the implementation (or planning) of reforms with reference to access to health care.

[4] Expert Panel on effective ways of investing in Health (EXPH), Summary of the Preliminary Report on Access to Health Services in the European Union, 25 September 2015. Available from: http://ec.europa.eu/health/expert_panel/opinions/docs/010_summary_access_healthcare_en.pdf

[5] Background note for the SPPM in-depth thematic review on health policy reforms.

[6] Expert Panel on effective ways of investing in Health (EXPH), Preliminary Report on Access to Health Services in the European Union, 25 September 2015. Available from: http://ec.europa.eu/health/expert_panel/opinions/docs/010_access_healthcare_en.pdf

3. Summary of meeting discussion

The meeting opened on a series of general interventions from various Member States stressing the need to take into account national competences in the area of health policy according to article 168 TFEU in the context of the discussions on access to health services. Some delegates questioned the ability of health indicators to represent an objective picture of the situation of health systems and services in the different Member States as well as their comparability. Several delegates highlighted that the result of the thematic review should remain separated from the European Semester and more specifically as regards the health-related country specific recommendations.

Three Member States (Cyrus, Estonia and Portugal) made presentations on their countries' health systems, commenting on health outcomes and highlighting health policies and reforms that have been designed specifically to tackle challenges in accessibility to health services or which have had a more indirect impact on ameliorating access to care. The presentations acted as a springboard for discussion and contributions by other Member States, which also reported on examples of such policies in their own countries. The sub-sections below aim to synthesise the main points that emerged during the presentations and discussion in relation to the main dimensions of accessibility.

Allocation – investing in the health system

Adequate health system funding is fundamental to securing required levels of quality services that meet population needs. As highlighted by the experiences of Greece and Portugal, this can be highly challenging in situations of economic crisis and severe budgetary constraints, putting extra strain on the health system just when more people are likely to use and depend upon publicly funded services due to growing pressures on household budgets.

Even without the fiscal context of having to reduce public deficits and to operate within smaller health budgets, health system funding also depends on a solid and sustainable financing base. Reporting on its implementation of a new universal health insurance system, Cyprus highlighted that while the system would be based mainly on payroll contributions by employees, the self-employed, other income earners and employers, the State would also contribute through tax transfers, thus ensuring a more diversified funding base. Estonia, whose health system is largely publicly financed through an earmarked tax on wages (the social tax) also echoed the desirability of diversification, in accordance with the conclusions of a joint national-WHO report in 2010. The report[7] found that in the face of changing demographic, labour market, technological and health

[7] Responding to the challenge of financial sustainability in Estonia's health system https://www.haigekassa.ee/uploads/userfiles/E93542.pdf
Responding to the challenge of financial sustainability in Estonia's health system: one year on https://www.haigekassa.ee/uploads/userfiles/WHO_analuus_ENG.pdf

utilization trends, meeting the challenges of future growth in health expenditure requires a broadening of the public revenue base for the health sector.

A further element highlighted by Croatia concerns the need to protect health care spending through tailored governance arrangements. Croatia's compulsory health insurance system is mainly financed by payroll contributions and from state budget transfers (c. 15%); however, until a recent reform in 2014, the state treasury collected, and allocated payments to providers (after negotiations between the ministries of Health and Finance) on behalf of the national health insurance fund. The 2014 reform separates the health insurance system from the treasury budget, thus granting the former more autonomy on spending.

Who and what is covered

While the issue of population coverage for health services affects different Member States to varying degrees – several examples in the discussion outlined strategies aimed at bridging coverage gaps to achieve the goal of universal coverage.

Ireland reported on a reform underway to extend the provision of GP services without fees to a greater proportion of the Irish population. It is implementing a staged rollout of free GP access beginning with children and older people over 70 years of age. Both of these groups are recognised as having particular needs with regard to primary care. GP services without fees were extended to all children under 6 years of age and those aged over 70 in July and August 2015) and it is envisaged that GP care without fees will be extended to all children aged 11 years and under in the latter part of 2016. Cyprus reported on reforms aimed at extending population coverage significantly, given the current situation where a large portion of the population does not have access to publicly funded services.. Currently, in Cyprus, a network of government-owned primary health care centres and hospitals covers approximately 80% of the population, with the rest of the population accessing health care through Voluntary Health Insurance or through private out-of-pocket spending at the point of service. The new health insurance system, covering all of the population, will be introduced in two phases, the first covering primary healthcare, medicines and laboratories, and the second acute and emergency care, with the whole system aiming to be in place by 2017.

Other countries reported strategies to extend coverage to sub-groups of the population that previously did not have access to publicly funded services: Estonia (certain categories of self-employed groups, such as artists), Sweden (undocumented immigrants), and Romania (developing common care services covering rural areas and vulnerable groups such as Roma, through a right to basic medical services). Moreover, Belgium is currently considering recommendations to improve the accessibility of health care for the most vulnerable groups (including e.g. prisoners and undocumented immigrants). In Greece, free-of-charge access has been extended to the uninsured and those who have lost their insurance due to unemployment during the crisis,

comprising of free hospital care and pharmaceuticals, provided the latter are supplied by hospitals or primary care givers.

In terms of benefits packages, Estonia highlighted that it will re-establish benefits for dental care for adults from 2017 (after it was de-listed in 2009 during the crisis) while Sweden reported on government proposals to introduce free health care for all those aged over 85, free mammography for women and free medications for children.

Italy is striving to update the list of services that must be equally provided across the country, the so-called "Essential Levels of Care" (*Livelli Essenziali di Assistenza – LEA*). The revision of essential levels shall particularly address health and social care, specifying different intensity levels according to the need of individuals and extending the full exemption for services aimed at selected rare and chronic conditions. New services shall be introduced through gains achieved in terms of control and reduction of inappropriate services (with a particular attention to image diagnostics). Health technology assessment needs to be recognized as a key activity run by central institutions in strict collaboration with Regions and local health authorities. The methodology for the constant evolution and update of the LEA shall also be formalized in a systematic manner, through a joint effort of the Ministry and associated national agencies. A specific organization will be created for the scope.

Affordability

The expert report on access to health services in the EU highlights that lack of affordability is the single most important factor behind self-reported unmet need in EU countries, with 2.4% of the EU population reporting experiencing unmet need due to cost in 2013.[8] Thus, a key policy objective is to safeguard the protection of vulnerable groups from financial hardship when using health services. Co-payments, in particular, can constitute significant barriers to accessing health care. Evidence shows that unless they are very selectively applied, user charges reduce the use of both low-value and high-value health services, and thus, can deter people from using appropriate and cost-effective care.[9]

In Greece, co-payments have been removed or exemptions widened. In particular, in April 2015, the €5 co-payment in all out-patient facilities was abolished in order to eliminate barriers to access. Similarly, Czech Republic reversed user charges introduced in 2008 as they did not have a significant impact on the over-use of care. Portugal reported on its modulated use of co-payments based on an extensive list of vulnerable or disadvantaged groups which are granted exemptions, including the unemployed and their families, children under 18 years of age, people

[8] Expert Panel on effective ways of investing in Health (EXPH), Preliminary Report on Access to Health Services in the European Union.
[9] K Swartz. Cost-sharing: Effects on spending and outcomes. Princeton: Robert Wood Johnson foundation, 2010.

with disabilities, pregnant women, patients with chronic diseases and refugees. As a result, in 2014, 5.4 million people – half the Portuguese population – was exempt from co-payments (the number of exempted citizens in 2011 was 4.3 million). In Spain co-payments exist only for prescriptions, not for hospital medicines or other services. Reforms have rationalised the level of co-payments for different groups to make the system fairer: retired people pay a 10% co-payment but with an annual ceiling of €40-70; higher income earners pay a 60% co-payment for medicines; and those on low incomes and the unemployed are exempt. The latest figures show that approximately 2.1 million people in Spain do not have to pay for prescribed medicines. Cyprus has taken note of financial protection measures in designing a co-payment structure for the new health insurance system: cost-sharing for certain services will aim to discourage overuse but there will be a ceiling for co-payments and free access for people with no income.

Other examples of strategies to limit the amounts paid as out-of-pocket payments came from Estonia. Over the period 2012-2014 reforms focused on pharmaceuticals, which constitute the largest share of out-of-pocket payments made by households. Implementation of the policy to prescribe by active ingredient has been successful – 86% of prescriptions issued by doctors in 2014 were based on active ingredient, resulting in more patients filling prescriptions with cheaper medicines and paying lower co-payments. Furthermore, since 2012 public campaigns to promote the use of generic pharmaceuticals ("Choose the cheapest medicine"), have reinforced the slow decrease in the average cost of prescriptions that has been occurring since 2009 (data from 2014) and has stabilised co-payment expenses by patients.

Availability of services

Geographic barriers to accessing health care have given rise to several policy initiatives. Estonia, France, Lithuania and Portugal mentioned policies offering greater employment or training incentives for doctors to practice in rural and remote areas. Health resource planning instruments can also help to tackle this challenge: Lithuania mentioned that it had set up a specialist training planning committee to tackle the problem of uneven distribution of doctors while Cyprus believes that the restructuring of its primary care system will provide better health care access to more regional (rural) areas. Greater use of tele-medicine and IT resources were also cited as tools for overcoming locational difficulties in accessing health care: Portugal has replaced some face-to-face medical consultations with non-face-to-face ones, through the reinforcement of IT resources, the introduction of electronic renewal of prescriptions and telemedicine while France has set aside €80 million for new technologies in remote areas.

Both Portugal and Estonia reported on the availability of trained health professionals, namely doctors. In Portugal, there was a 9% increase in the number of doctors in the National Health System, rising from 23,334 in 2011 to 25,443 in 2015, accompanied by an increase in the number

of doctors completing their GP speciality training (from 195 in 2011 to 357 in 2015, an 83% increase). Meanwhile, Estonia has tackled the 'brain drain' problem in the health sector through salary agreements between the social partners aimed at competitive wages, gradual increases in resources dedicated to training of health professionals and state-financed courses for health professionals intending to return to the health system after working in other sectors.

Timely access

Long waiting times are a significant barrier to accessibility of health services. Estonia reported on some initiatives designed to improve timely access to care, including the gradual increase in the number of e-consultations and e-visits which will save time for doctors and patients. There should also be a central e-registration system for all public hospitals in place by 2017. Other plans include recruiting more family care nurses for GP teams in order to boost appointment times: currently in primary care 87% of patients are able to see a GP within four to five working days while 28% get a same-day appointment.

Denmark and Sweden related their experiences with maximum waiting time guarantees. In Denmark, there is right to prompt diagnosis within 30 days, and clinical guidelines to ensure consistency across the country. There is a two-month limit on waiting times for public hospitals and patients can then choose to be treated in a private hospital if this time limit is exceeded. When it comes to serious illness, the time limit is one month. In addition, 50 guidelines for uniform treatment are under preparation. Furthermore, the government is planning to propose a bill granting a right to treatment within 30 days. Meanwhile, Sweden has undertaken a number of reforms to address waiting times with mixed results. An access guarantee was introduced some years ago in conjunction with financial incentives. This led to shorter waiting times but also unintended consequences, since time limits do not take account of patient severity or 'need'. The lesson learned is that access guarantees do not resolve the structural causes of long waiting times.

As part of new measures, Ireland has introduced a waiting list initiative to reduce maximum permissible waiting times for outpatient appointments and inpatient-day case treatments in the acute sector, and a range of additional services to support the earlier discharge of patients who no longer require medical attention in hospital. Ireland referred to the establishment of Hospital Groups, as part of overall acute services reform, to facilitate a more coordinated approach to the planning and delivery of services within and across hospitals, with an increased focus on small hospitals managing routine urgent or planned care locally and more complex care managed in the larger hospitals. It reported that it was through these groups that the issue of timely access and long waiting times was being addressed as part of the regular performance and accountability process with waiting list initiative funding provided to both maximise capacity across public and voluntary hospitals and to finance outsourced hospital care.

Finally, several different examples were mentioned of policies designed to expand the volume of services, which has a positive impact on access. Portugal cited its 24-hour telephone service in the National Health Service (*Saúde 24*) that increases accessibility to health services (circa. 2000 telephone contacts per day) and rationalizes the use of resources, through screening of calls, counselling or referral of patients for the most appropriate services to meet their needs. In addition, between 2011 and 2015, 143 family health care units were created, along with 129 units for community care; there was also an 8% increase in the number of home care teams. Lithuania reported on the prioritised payments for outpatient services, day care and short-term care which are designed to strengthen the shift from hospital to outpatient services, and consequently the number of patients treated. In order to strengthen primary care in Austria, from 2015 multi-profession group practices are being piloted, with a target of reaching a 1% coverage level in each federal state by the end of 2016. This will aid patients to access multiple required services.

The importance of good data and monitoring

A number of discussion points focused on the importance of good data and monitoring to safeguard access and to understand existing barriers within country-specific contexts. At an international level, the process of expanding and collecting appropriate and comparable indicators to measure dimensions of access (to augment existing indicators such as unmet need) is at an early stage. In this regard, the JAF Health Care System Access Indicators are a promising start for building a solid evidence base.

At the individual Member State level, some countries provided illustrations of existing monitoring activities. In France, equal access to healthcare is supervised by parliament. Since 2005, the monitoring framework has listed main objectives, and assessed results and actions. The framework sets out indicators, together with a detailed methodology, to show how healthcare is dispensed in different areas, what is paid for by families, and who cannot access healthcare because of lack of funds. Belgium's HSPA report, defined nine indicators to evaluate accessibility to healthcare. Access is evaluated along three dimensions: financial access, health workforce and waiting time. Financial access is described along three dimensions: the population coverage, service coverage and the portion of healthcare costs covered through health insurance. Italy has operated a national evaluation system since 2006 to monitor the provision of guaranteed health services listed in the national benefits package by the country's 21 regional governments (which are responsible for regional health care systems). Ongoing development of the evaluation system includes plans to update classification systems and evaluation methodologies.

5. International cooperation – a co-ordinated approach

In addition to the European Commission services involved in data collection and analysis of health related evidence, a new element in the in-depth review was the involvement of international organizations which presented their work on health policy and access to health care.

WHO Europe's work on strengthening health systems through a people-centred approach takes its vision from the European health policy framework Health 2020 and builds on the principles of the Tallinn Charter. Recent examples of cross-country work related to access to health services in Europe include: analysis of the impact of the economic crisis on health systems and health and an overview of markets for voluntary health insurance (both with the European Observatory); a report on access to new medicines; and work with the OECD to facilitate dialogue between health and finance ministries on the financial sustainability of health systems. Work with member states involves providing in-depth, contextualised policy analysis at country level. Recent engagements in country-level analysis of access and other health system performance issues has taken place in Croatia, Cyprus, Estonia, Greece, Hungary, Ireland, Latvia, Portugal and Slovenia and in non-EU countries such as Albania, Armenia, Belarus, Georgia, Kyrgyzstan, Republic of Moldova, Turkey and Ukraine. Financial protection against high health care costs – a major dimension of health system performance – is closely linked to health care accessibility and affordability. WHO Europe is carrying out a regional study to assess how well health systems across Europe protect people from experiencing financial hardship when using health services. It will be measuring the extent to which out-of-pocket payments for health care push people into poverty or represent a catastrophic financial burden on households in 30 countries, including around 15 EU member states. Country-specific reports will be available in 2016 and 2017, with a regional performance assessment following in 2018.

OECD looks at cross-country data and cooperates with international partners and individual countries. More specifically, it promotes: good ways to monitor access to care; looking beyond inequalities not only in access but also in outcomes; assessment of limitations in policies. The OECD presentation highlighted that while most EU countries have near-universal coverage, the fact that people still do not always access healthcare they need makes it necessary to *reassess* services, waiting lists, quality, etc. With regard to inequality of outcomes, looking at the social determinants of health, and working with other policy areas to reduce health inequalities are key. Unemployment and working conditions also play a big role: for example, long working hours increase the risk of stroke and heart attack.

European Observatory on Health Systems and Policies carries out analysis of best practice, working side by side with other partners, with a view to adding value through policy interventions. It carries out: i) health system profiles; health system and policy monitoring, systematically updated online; ii) cross-country analysis and case studies, for example on the impact of the crisis. It works with 600 experts across the region; and iii) knowledge-brokering: working with Member States to present data, running closed-door sessions with specific countries. The Observatory works with other organizations by testing the usefulness of indicators, including 1. What do you want to measure? 2. What indicators will measure the phenomenon? 3. What data are available and of what quality? 4. How should data be interpreted? 5. Will they lead to policy interventions? As Member States tend to go straight from indicators to policy solutions, which may not always be the right ones, the Observatory focuses on interpretation.

A variety of European Commission units also reported on their mandates and work in the area of health policy:

DG SANTE – has a mandate from the Council (since mid-2014) to identify tools and methodologies for Health System Performance Assessment (HSPA), with a view to strengthen the effectiveness of health systems. It is assessing both the effectiveness of health systems and ways to increase accessibility, aiming for socio-economic convergence. It is assisted in its HSPA work by an expert group and among other things, produces methodologies that can be helpful to Member States. DG SANTE also carries out fact-finding missions to prepare input for the European Semester, leading to 13 recommendations for the 2015 cycle in the area of health.

DG ECFIN has worked with Member States on, for example, age-related expenditure including health. It feeds into the report on public finance sustainability and contributes to the Semester process. The DG tries to identify areas for reform, putting forward Country Specific Recommendations (CSR) related to fiscal sustainability for some countries. It works closely with DG Santé and DG EMPL, and assesses the typology of health system reforms.

DG EMPL supports the Social Protection Committee (SPC) and the Indicators Sub-Group (ISG) in their work under the Open Method of Co-ordination (OMC) on health. This long-standing cooperation covers the development of indicators and the Joint Assessment Framework (JAF). The DG is involved in the European Semester and economic governance, and works closely with DG Santé and ECFIN on employment guidelines. Guideline 8 calls on Member States to improve the quality, sustainability and accessibility of healthcare. Given the importance of access, DG EMPL gives financial support from structural and investment funds also in the area of health, and particularly through the European Social Fund (ESF).

DG CONNECT highlighted the digital single market, which offers job creation and economic opportunities. Health systems are a core topic through: i) Projects (Horizon 2020) addressing health through access, quality, sustainability and efficiency. The 'breaking silos' approach means that findings are not just directed to the academic community; ii) European innovation partnership on active and healthy ageing: the third conference of the partners took place in December 2014; and iii) the silver economy and silver economy solutions regarding ageing and long-term care.

In the absence of a representative from DG RTD, the meeting heard that the DG's objective is to help create reliable, resilient and sustainable healthcare systems, through a series of framework programmes. The current one is Horizon 2020. The previous FP7 programme funded more than 100 research projects in health.

Eurofound works to improve living and working conditions in Europe. It studies access to social protection in times of crisis: three recent reports have focused on social benefits, children's services and access to healthcare, the latter taking a multi-dimensional approach. It also publishes the *European Quality of Life* survey. In 2016, Eurofound will introduce a larger module on access to and quality of healthcare, and will survey citizens' experiences of GP treatment, hospital services and emergency healthcare. A full pilot in all 28 Member States will start in Spring 2016, with the final survey being carried out in Autumn 2016.

Eurostat highlighted that good data are vital for comparison and policy-making. Eurostat focuses on improving the timeliness and comparability of data and identifying what information policy-makers need, which in turn feeds into EU initiatives. It is working on:

- Future of health statistics collected from survey data embedded in a framework regulation, for 2020. Important health variables should be included in a three-year module of the Survey on Income and Living Conditions and the Global Activity Limitation indicator (GALI) to be included in the Labour Force Survey every two years. This will allow for health indicators broken down by socio-economic status.

- Progressive development of a regulation for healthcare with more harmonised indicators and definitions in order to increase comparability among Member States.

- With OECD and WHO, a new data collection on health workforce mobility – to better understand the movements of doctors and nurses.

- More timely mortality data and expenditure data aligned to the 2011 SHA methodology (from 2016 onwards)

In addition, Eurostat is working on methodological improvements on long-term care and out-of-pocket expenditure, with more developments in 2017.

6. Policy conclusions

The wide-ranging exchange between Member States and examples of country experiences produced useful insights and lessons. In terms of health outcomes, such as life expectancy, it is clear that some countries are doing better than others – and in some countries these outcomes can be related to health care and access to health services. Indeed, it would be useful to know more about all of the relevant factors in countries with high life expectancy rates. Moreover, countries that are successfully offering better health care are not necessarily the richest ones; these cases offer examples that we can learn from.

The context of the economic crisis and its impact on health systems should remain central to policy discussions on access to care. In this regard, preventive activities and services is a sound investment because poor health contributes to unsustainable economies. The sustainability of health systems is also a key consideration but should not be used to create a false dichotomy between sustainability and the goal of achieving equality (of access, of meeting health needs, or health status). In addition to these general conclusions, an over-riding finding from the Review is that when it comes to access to health care, Member States have been addressing the same challenges but in their own, country-specific way. Keeping in mind the importance of national context and of national competences in the field of health, some policy conclusions aimed more specifically at promoting accessibility of health services, include:

Allocation

- Population need is the best basis for determining public funding for health care and for allocation decisions. Health care allocation decisions should also be informed by scientific evidence of the effectiveness of the interventions.

- Health is a matter of national competence. It should remain a priority area even in times of severe fiscal pressure. In this regard, access to health care is a political choice. In times of economic crisis, Member States have found good and innovative solutions to provide adequate access to health care.

- Health care resources should be employed as efficiently as possible to ensure value for money.

Universal coverage

- Universal access does not mean providing everything for everybody all the time. All countries have covered low quality and ineffective treatments. Therefore, more clinical and economic assessment is necessary.

- Gaps in the public coverage of population groups affect Member States to different degrees but the over-riding commitment to achieving universal access is at the core of European values and represents a global aspiration.

- However, acknowledging achievements in promoting universal coverage should not overlook the fact that vulnerable groups in particular have suffered in terms of unmet need for health services during the economic crisis and should continue to be a particular focus.

- Relatedly, exclusions from coverage of some population groups may end up being inefficient for the health system in the longer term as those groups will likely end up using more expensive emergency services.

- Another significant challenge in the move towards universal coverage is the current refugee crisis in Europe and meeting the health needs of this group; we can learn from the different ways that Member States are providing care.

Financial protection

- User charges have increased in many countries. Co-payments need to be nuanced instruments, which do not discourage usage of necessary or appropriate care and which offer sufficient financial protection through ceiling caps and exemptions for vulnerable groups. Several examples of how this can be achieved were provided in the discussion.

- Access to medicines is a concern because co-payments are high; but countries can save money by cutting waste.

Availability of services

- Many different aspects of health services delivery have an impact on access. Particularly in this area, when designing reform policies, it is good practice to specifically assess (direct or indirect) impacts on access.

- Waiting times are both an operational and a political issue. Different Member States are using innovations such as e-booking, private sector resources or cross-border healthcare to address this challenge.

- Staffing changes are taking place in a number of Member States to boost accessibility and availability of services; for example, through the introduction of family nurses within GP practices and providing financial and training incentives for providers in rural or remote areas.

- Many Member States are aiming for a more structured approach to their health systems, e.g. by strengthening primary health care or by centralizing specialist care in a smaller number of hospitals. These structural policies can contribute to improved access.

The importance of good data and monitoring

- One fundamental question is how health care can be measured. The JAF health contains some useful preliminary indicators, as do other frameworks but they need to be interpreted correctly. Indicators are not an end in themselves but can be a warning of issues that need greater attention or further study in order to better understand the situation. Policy-makers should not jump from benchmarks to solutions, without analysis.

- Better monitoring of access barriers to health care is needed, allowing for more comparability. The recent opinion published by the EU Expert Panel on Effective Ways of Investing in Health on access to health care provides a set of valuable recommendations to improve the monitoring of access to health care in the EU. Data collection should aim for robust, relevant, comparable indicators disaggregated by region and sub-groups of people to discover who is not using services and why.

- Indicators should adequately reflect national situations and focus on unmet needs, utilization, user experience, financial protection and hard-to-reach people.

- Fundamentally, there is a need for context-specific policy analysis, because no one-size-fits-all solution is appropriate. For example, a number of Member States have regional healthcare structures which may demonstrate different trends and usage patterns. However, where good analysis exists, there is a basis for action.

- With regard to measurement and assessment of healthcare in terms of comparison between countries, it would be important that Europe promotes and produces shared and standardized procedures, allowing to get effectively comparable assessment systems. To this aim, it is important to put in place a close synergy among different groups, working at EU and international level.

- Data collection systems should be comprehensive and flexible enough to follow the organisational changes of the health systems, usually much faster than data gathering systems.