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## Access to Medical Technology Differs Across Europe:

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**Survey Shows Variety of Causes for Discrepancies Between Guidelines and Practice**

**The practice of cardiovascular medicine differs from country to country despite commonly accepted management guidelines. Discrepancies persist, even when comparisons are based on investigations of the proportion of patients with a defined disease offered a particular treatment modality.**

Surveys disclose that adherence to European guidelines for the management of different parts of cardiovascular practice may be unsatisfactory. Recent surveys show that prevention of people at high risk and those with previous cardiovascular disease manifestations is unsatisfactory across Europe.

Differences in educational standards may be one reason for discrepancies between guideline recommendations and practice. Other potential reasons may relate to traditions and cultural differences. Another clear cause for divergence relates to funding and reimbursement of cardiovascular practice and for making new medical technology, including drugs, available to patients and physicians.

**A Task Force Report**

A task force within the framework of the ESC Cardiovascular Round Table gathered relevant information to study reimbursement as an obstacle to meeting recommended treatment standards. In the report, published in the European Heart Journal, attempts were made to study funding and reimbursement in various European countries and to look at the transparency of the process of introducing new technology.

This editorial summarises the most important findings of the investigation, which was based on a review of existing European and national systems for healthcare funding and reimbursement and a questionnaire distributed to 47 national cardiology societies. Some recent experiences during the work with the European Heart Health Charter is included here.

**Funding of Healthcare**

The amount of money spent across Europe on healthcare varies, as expressed by the percentage of the Gross Domestic Product (GDP). Funding for healthcare is mostly derived from public sources, taxation and/or social health insurance, and only to some extent from patient charges. Private health insurance is, in the vast majority of countries, only a small part of funding.

Countries within the EU may be grouped according to their sources of funding. One group receives funding predominantly from taxation; another from social health insurance and a third uses a combination of tax and social health insurance. Sources and amounts of funding for healthcare vary significantly. The investigation did not permit a detailed analysis on how these different patterns influence patient access to medical technology, but it made it reasonable to assume that the different funding mechanisms play a potentially important role.

Thus, an increased demand from those insured, in one way or another, for the best possible return on direct or indirect investments may improve access to new medical technology. It seems less likely that such demands would improve inequity between countries. Still, increased public and medical professional awareness of the domestic reimbursement system and the amounts invested in the healthcare sector might be an important way towards better utilisation of available resources and to improve funding.

The reimbursement systems are, however, complex, underlining that not only individual physicians but also organisations representing the medical profession should be actively engaged in these issues, something the questionnaire indicated not always to be the case.

**Reimbursement and Availability**

The investigation revealed that the reimbursement system and available healthcare resources influenced the accessibility of medical technology. Equipment considered expensive, for example coronary stents and cardio verter defibrillators, were introduced earlier and more frequently in countries with a social health insurance system.

During the work with the European Heart Health Charter, meetings were held with representatives of the cardiovascular profession from all EU nations. There was a universal acceptance that prevention should be high on the future agenda of cardiovascular practice, but that it would be difficult to live up to the set standards.

#### Prevention Not Satisfactorily Practiced

Recent surveys show that prevention is not satisfactorily practiced. When this discrepancy was discussed during the launch of the Charter it was repeatedly underlined that health insurance systems do not reimburse preventive efforts to the extent needed for a proper management of patients at high risk or with already manifest cardiovascular disease, promoting therapeutic rather than preventive activities.

Looking at the questionnaire, a majority of the national cardiac societies replied that reimbursement related factors limited the availability not only of new but also more established technology and that this related to drugs as well as devices.

Cost-constraints in combination with high patient co-payment were reasons mentioned. It may then seem surprising that less than half of these societies declared that they took an active part in reimbursement issues, mostly in an advisory role and only rarely in lobbying. Moreover, few of them collaborated with the industry on this issue.

#### The Role of Professional Organisations

The investigation indicates that knowledge on reimbursement systems is variable and not infrequently limited among the professional societies. Indeed, about half of national societies replied that they did not believe that funding or reimbursement barriers limited the use of medical technology, an opinion not supported by the investigation.

Moreover it was a common opinion that medical devices are available as soon they have a CE mark. However, a CE marking does not take into account financial and economic constraints. The replies clearly indicate there is no isolated European solution to the problem with reimbursement and therefore availability.

Such issues have to be addressed at a national level and adapted to local conditions and constraints. In the future one would like to see a more consistent and transparent European reimbursement sys should tem based on patient needs, clinical evidence and practice guidelines.

#### Concluding Remarks

It is likely that the involvement of the profession, perhaps best accomplished by activation of national cardiac societies, is mandatory for accomplishing an improved, more transparent system for making new medical technology, including drugs, available, that does not include inequity between countries. With regards to funding and reimbursement of medical technologies there is no single European model.

Each healthcare system has developed its own approach within the context of the cultural, political, economic and historical environments from which it evolved. Nevertheless each government clearly wants to maximise the health of its citizens and provide equitable access whilst at the same time controlling expenditure. It is this balance that needs to be considered and made fair and transparent. The concern that the economical system may be used to ration medical technologies that are useful and approved must be counteracted.

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