Overcoming Patient Access Barriers in Complex Conditions: Lessons From Schizophrenia for Broader Healthcare Applications

HSD81

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Objectives

To examine access barriers to CIAS care across eight European countries and identify system-level insights applicable to broader complex disease management.

Introduction

- Cognitive impairment is a core driver of long-term functional disability in schizophrenia, impacting employment, independent living, quality of life and social participation.[1,2]
- Despite its significance, gaps persist between research, policy recommendations and real-world implementation of CIAS assessment and treatment.[2–4]
- This study examines systemic, infrastructural and economic barriers to CIAS care to identify opportunities for patient-centred recovery and broader healthcare reform.

Methods

- A targeted literature review explored CIAS treatment pathways and barriers in European countries, guiding interview development and providing a comparative framework.
- Semi-structured interviews were conducted with healthcare professionals (HCPs; n=32) and health policy experts (HPEs; n=9) from 8 mid-sized European countries: the Netherlands, Belgium, Denmark, Sweden, Norway, Finland, Portugal and Greece.
- RREAL sheets captured key themes, monitored data saturation, and facilitated consistent comparison across countries, participant groups and HCP specialities.
- Transcripts were thematically coded using qualitative analysis software (Dovetail).

Results

- The typical care pathway for schizophrenia along with the major drivers and barriers of CIAS care is summarised in Figure 1.

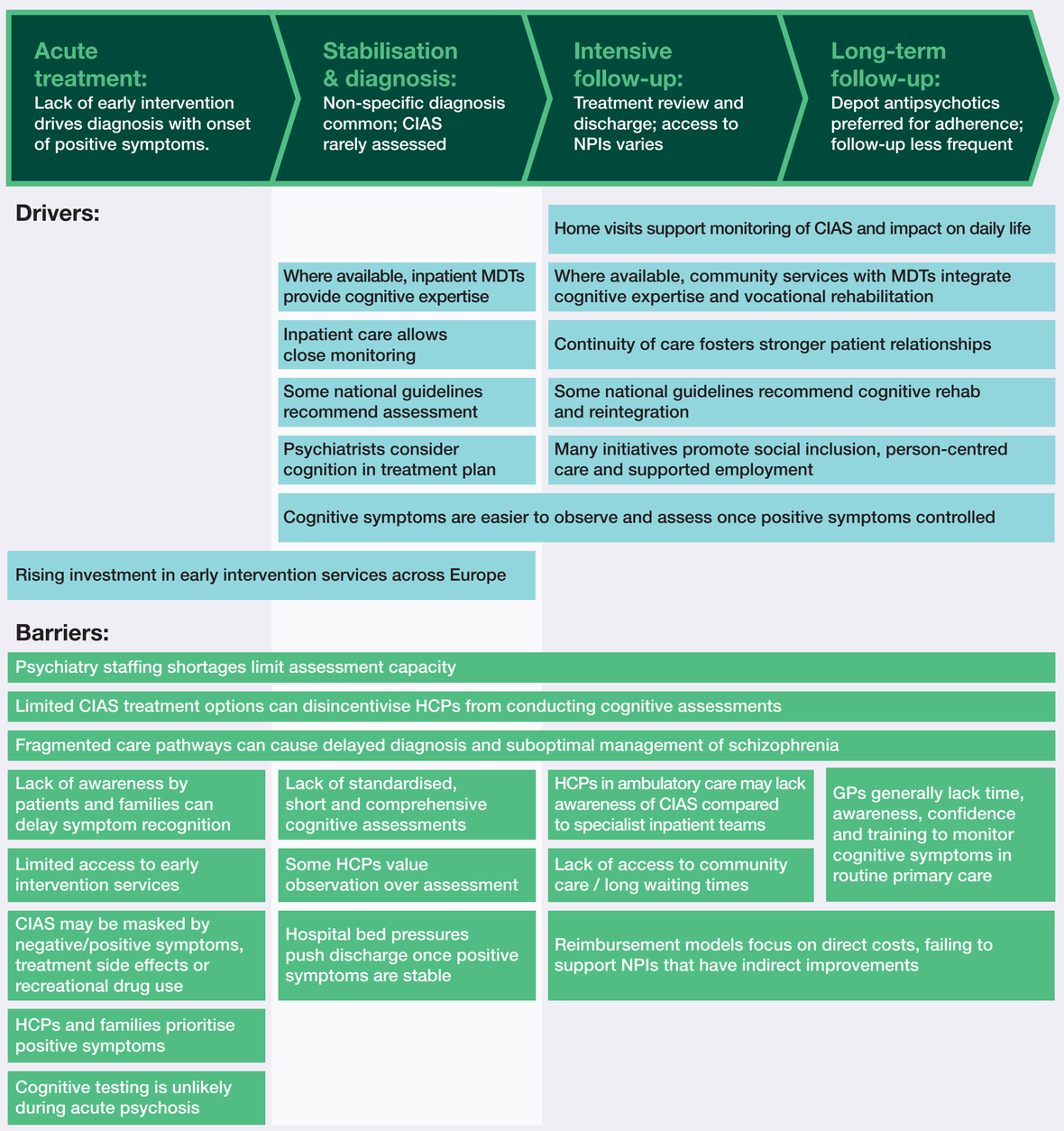

Figure 1. Schizophrenia care pathway with major drivers and barriers.

- Based on comparative analysis of the interviews, two distinct archetypes of countries were identified. While all countries are trending toward greater emphasis on community care and social reintegration, the two archetypes reflect differing rates of progress (see Figure 2).

	Community mental health services	Policy emphasis	HTA perspective	Access to NPIs	Example countries
Group 1	Limited development	Clinical recovery takes priority over social / vocational outcomes	Healthcare payer/sector perspective	Patchy, locally driven; often funded by third-sector	Belgium, Finland, Greece, Portugal
Group 2	Well-integrated with early intervention services and FACT teams	Strong national commitment to social / vocational reintigration	Societal perspective (considers indirect benefits)	National policy support, yet access varies locally	Denmark, Netherlands, Norway, Sweden

Note: The archetypes are intended to highlight broad patterns in CIAS care integration. In practice, most countries combine features of both models, and national differences are more nuanced than this simplified grouping suggests.

Figure 2. Summary of country archetypes.

Insights & future directions

- Across the eight European countries examined in this study, a consistent finding emerged: **existing healthcare systems are insufficiently structured to address the full complexity of conditions like schizophrenia**.
  - Care focuses on acute psychotic symptoms, neglecting recovery, psychosocial function and relapse prevention.
  - Structural barriers – such as lack of training, tools, funding and mandates – result in fragmented, inconsistent care.
- Gaps in CIAS care mirror those seen in other chronic conditions – including oncology, chronic pain, metabolic disease and rheumatoid arthritis – where clinical care often fails to address patient-centred functional outcomes and coordinated, holistic management is lacking.
- To address these challenges in healthcare, the following should be considered:
  - **Prioritising early identification**, such as OPUS early intervention service for psychosis in Denmark and Scandinavian national cancer pathways[5,6]
  - **Practical, accessible assessments** and interventions that promote patient-centred recovery like PROMs and simplified batteries for assessing CIAS
  - **Integrated multidisciplinary care can reduce fragmented pathways**, improve continuity and enhance patient-centred outcomes
  - **Expanding community-based and peer-driven support systems**, such as Clubhouse International and cancer support networks, to focus on continuity, recovery and real-life functioning[7,8]
  - **Reforming reimbursement and policy to reflect functional and societal impacts**, particularly to support NPIs that provide indirect benefits
- While recommendations overlap, access strategies should reflect each country's policy and funding context. Group 1 countries should expand integrated care, while Group 2 should enhance NPIs and specialised services, including youth-focused programs.

Conclusions

Gaps in CIAS assessment and management reflects broader structural limitations in healthcare systems, showing a persistent misalignment between patient-centred needs and current care models.

Our analysis yielded a novel archetype framework demonstrates how community infrastructure and HTA perspectives shape patient access.

Addressing access barriers requires proactive, multidisciplinary, community-based care that is tailored to the structural characteristics of individual healthcare systems to enhance feasibility and scalability.

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Abbreviations

CIAS, cognitive impairment associated with schizophrenia; FACT, flexible assertive community treatment; GP, general practitioner; HCP, healthcare professionals; HPE, health policy expert; HTA, health technology assessment; MDT, multidisciplinary team; NPI, non-pharmacological intervention; PROM, patient-reported outcome measure; RREAL, Rapid Research, Evaluation, and Appraisal.

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