Translator's note: This text is similar to that submitted bv GGZ Nederland (translated as SANCO-2007-7042).

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Health services consultation
DG SANCO
European Commission
B232 8/102
B-1049 BRUSSELS
Belgium

Letter No
Nu/Roo

The Hague
31 January 2007

Subject
Health services consultation

Telephone
070 349 02 11
Email
nuyten@vno-ncw.nl

Dear Sir/Madam,

Please find enclosed the letter (our ref. 07/10.238/nu/Roo) which we sent you at 11.30 today by e-mail.

Yours faithfully,

Mr. M.E.M. Nuyten
Secretary for Health Care

Encl.

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Dear Sir/Madam,

Please find below our answers to the Commission's questions contained in the Consultation regarding Community action on health services[1]. We would like to take this opportunity to respond to the views given in the consultation document and have therefore kept to the structure of that document.

Who are we? The VNO-NCW is the largest central employers' organisation in the Netherlands, representing the common interests of 180 sectoral organisations with more than 115 000 affiliated companies. The five regional employers' associations affiliated to the VNO-NCW and Young Management represent 8 500 personal members. The VNO-NCW represents 90 percent of employment in the Dutch private sector.

High-quality health services for citizens are a priority for us too. We strive to ensure that they are used optimally, in order to avoid or at least limit worker absenteeism. This does not mean that employers are concerned only with their employees' health – after all, if an employee is absent to look after a sick partner/spouse or children, this also has an impact at the workplace. It is important to examine each measure to see whether regulation at European Union level offers the most efficient solution. We look forward to the Commission taking a position with regard to the development of a Community framework for safe, high quality and efficient healthcare services, the strengthening of collaboration between the Member States and the provision of certainty regarding the application of Community law to health services and healthcare.

To the Commission's view that that Community action should be founded on two pillars (*legal certainty* and *support for the Member State*s in areas where European action can add value to national action on health services), the VNO-NCW would like to add a third and a fourth pillar: the *health promotion* and the *health protection.*

Health promotion also includes support for initiatives of health insurers and treatment providers to facilitate cross-border treatment and, where possible, remove potential obstacles to cross-border patient movement. The latter aspect in particular offers patients the opportunity to benefit from collaboration between treatment providers and/or health insurers in the Member States.

It is also vital that, in addition to the availability of real freedom of choice for European citizens/patients, the *protection of public health* (currently governed by Article 152 of the EC Treaty) continues to be the basis for any developments.
Preventive public health policy and cross-border services have not been linked in the past, but this area could form the subject of research over the coming years. Awareness is growing about existing geographical differences in "healthy life expectancy" and the possible relationship with other factors such as socio-economic class, living and working in urban areas and other factors

[1] SEC (2006) 1195/4, 26 September 2006

which have an impact on health, whether cross-border or not. Health protection and promotion can therefore not be seen in isolation from patient mobility and the free movement of services, capital, persons and goods.

Question 1: what is the current impact (local, regional, national) of cross-border healthcare on accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

Local and regional levels
Citizens in the Euregios regularly cross the border for healthcare. Existing joint ventures, especially in the Euregios, show that, by way of good examples and cooperation projects, patients and care providers can get to know service providers in other countries, make comparisons and then make a choice, leading to an effective use of expertise and resources. As far as accessibility and financial sustainability are concerned, practical (bilateral) cooperation has solved many problems.

So far, the scope of the cross-border provision of services (i.e. providing a service from the territory of one Member State in the territory of another), such as telemedicine services, remote diagnosis and prescription and laboratory services, has been very limited.
There is also the more traditional use of services abroad, where patients go to providers in other Member States for treatment. Slowly but surely, more use is being made of this option. The European Health Insurance Card is a useful solution here.

Finally, the Commission understands cross-border healthcare to mean the establishment of a provider from another Member State and the temporary presence of professionals (whether or not in the context of a secondment). This is also fairly rare at the moment but could provide a solution for local shortages of care and care capacity. The impact on the provider's Member State of origin is not yet sufficiently clear. We expect to see an increase in the temporary presence of medical, paramedical and perimedical professionals in Member States other than the one where they were trained.

National level
At national level, maintaining legal certainty is important. The VNO-NCW therefore supports the Commission's view that health services provided for payment should be considered services within the meaning of the Treaty. This means that the relevant provisions of the Treaty regarding the free movement of services apply.

The Commission rightly states that the cost of healthcare systems to public funds has risen significantly faster than inflation in recent years. It must be pointed out that forecasts of this kind are very sensitive to changes in the (cost) price of a given package of services. We agree with the Commission's starting point that, in order to keep health systems financially sustainable, it is vital to manage costs and increase efficiency, in conjunction with appropriate prevention policy and health promotion measures to maximise healthy life expectancy.
We therefore assume that the European objectives of universal access to high-quality healthcare on a financially sustainable basis, founded on the principles of equity, equality and solidarity, will continue to be respected.

The economic, social and health impact of cross-border healthcare for citizens and for health and social security systems will increase. There is an impact not just on the "receiving" countries but also on health provision once patients have returned to their country of origin, e.g. higher costs as a result of bacterial infections (such as MRSA) and complications caused by treatment in other Member States which have to be solved in the Member State of origin. We agree with the Commission that the lack of information on treatment possibilities in other Member States stops some people going abroad for treatment, even where this would be a good idea.

Question 2: What specific legal clarification and what practical information is required by whom (e.g.; authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?

Citizens, as potential consumers of treatment, and care providers and health insurance companies, as service providers within the care sector, need clear procedures and conditions which must be met for cross-border healthcare to be a viable option. This means, first of all, legal clarification, which the Member States must provide. As far as practical information is concerned, treatment providers and health insurance companies also play an important role. Patients, patient organisations and providers all need appropriate information in order to make choices between different treatments and providers in other countries. In this way, patients can be referred on where necessary.

Moreover, existing procedures need to be simplified so that the costs incurred by treatment providers can be reimbursed quickly and properly. This includes the conditions for the competent bodies (e.g. health insurance companies) to give permission to policyholders/patients to go abroad for treatment. Clarifying and simplifying these procedures is primarily a task of the Member States. The European Union must supervise this to make sure it actually happens.

As far as the application of the internal market rules is concerned, it must be clear which country is responsible for supervising (the implementation of) health services.
Specific issues which must be dealt with include continuity of care when patients go abroad for a specific treatment and are then returned to their own country, or when the treatment is provided by health professionals operating temporarily in another Member State.

Clarification is also required as far as the tasks and responsibilities of providers in the Member States are concerned. More particularly, the tasks and competences of providers, the conditions for establishment and admission set by national and regional government workers, and the quality standards that apply in the legislation of the individual Member States must be clarified. More detailed product specifications are needed in order to meet the quality requirements that patients expect in the Member States of the EU.

Question 3: Which issues (e.g.: clinical oversight, financial responsibility) should be the responsibility of the authorities of which country? Are these different for the different kinds of cross-border healthcare described in section 2.2 above?

Clinical oversight must, in principle, be the responsibility of the country in which the treatment is actually provided. Supervision by the national inspection authorities of the quality of care in the country where it is provided must be guaranteed.

The financial responsibility for treatment requests is incumbent mainly on the authorities of the system to which the patient belongs – this may vary for the different types of cross-border treatment.

In the event of the cross-border provision of services from the territory of one Member State to the territory of another (e.g. telemedicine), the clinical oversight must be performed by the Member State from which the treatment takes place rather than the Member State where the patient is located, as it needs to be associated as closely as possible with the provider who is actually performing the treatment and/or is primarily responsible for implementing it. Otherwise, the principles laid down in Regulation 1408/71 and, after its introduction, the new Regulation 2004/884, can continue to apply.

Question 4: Who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm, how should redress for patients be ensured?

It must be clear who guarantees patient safety for cross-border treatment, how patients are to be offered redress for harm and, in the event of error, whose liability rules apply and what follow-up can be expected. Where treatment is offered under standard or supplementary insurance, it is up to health insurance companies to make clear agreements with the provider abroad. The *restitutiepolis* (refund policy) can also contain clear instructions, so that policyholders know in advance what to do if safety-related problems arise.

As far as intensive are and urgent treatment is concerned, it is for the Member States to make agreements on safety for cross-border care.
The system of Member State of origin, to which the patients actually belong (and usually where they actually live), must make appropriate arrangements to provide redress for any direct harm caused.

Question 5: What action is needed to ensure that treating patients from other Member States is compatible with the provision of a balanced medical and hospital services accessible to all (for example, by means of financial compensation for their treatment in 'receiving' countries)?

To ensure that treating patients from other Member States is compatible with the provision of balanced medical and hospital services accessible to all, financial compensation for treatment in the "receiving" country which corresponds to the real cost of the treatment in that country can be agreed. The principle should be to offer patients as much freedom of choice as possible and for providers to be reimbursed the actual price of the treatment.
In this context, it should be possible for providers to add a surcharge to their normal charges for patients from other Member States. This surcharge must be structured in accordance with the European Court of Justice's Ferlini judgment.

Question 6: Are there further issues to be addressed in the specific context of health services regarding movement of health professionals or

establishment of healthcare providers not already addressed by Community legislation?

Some medical conditions and their treatment are subject to cultural factors, for example the treatment of low blood pressure, for which, in the Netherlands, there is no treatment or method. There are also ethical issues where Member States differ about the treatment they wish to provide, e.g. fertility treatment and the reimbursement or provision of abortion services (for instance the abortion ship). Our starting point is that Member States should be allowed as much freedom as possible to make their own laws and rules concerning quality standards, medical-ethical issues, etc.[2] In order to maintain a high level of health protection, in accordance with Article 152 of the EC Treaty, Community action may well be necessary if health and safety are in jeopardy (e.g. in the event of infectious diseases or pandemics).

Question 7: Are there other issues where legal certainty should also be improved in the context of each specific health or social protection system? In particular, what improvements do stakeholders directly involved in receiving patients from other Member States – such as healthcare providers and social security institutions – suggest in order to facilitate cross-border healthcare?

In this context, we would like to highlight in particular the need to maintain and, where necessary, improve the freedom of choice of patients in the Member States.
Legal obstacles that sometimes stop patients going abroad for treatment should be removed as far as possible by the Member States. Going across the border for treatment can be simplified above all by making the application procedures as simple as possible and settling the treatment costs directly.

Question 8: In what ways should European action help support the health systems of the Member States and the different actors within them? Are there areas not identified above?

Using European measures such as the open method of coordination. The VNO-NCW expects the various actors to be faced with as little red tape as possible and for patients' freedom of choice to always be the underlying principle in the promotion of cross-border healthcare.

In some health services, such as those dealing with rare conditions, a concentration of resources or expertise may be required. The European Union can promote this by linking reference centres with each other at European level.

One of the main challenges facing health services is dealing with innovation and making sure that treatment is based on the best possible scientific research. Setting joint criteria at European level would create a sound scientific basis so that Member States could make the best possible use of new technologies, treatments and techniques.

Another point for attention is the application of the rules concerning European

[2] This means that the requirements for health professionals or providers to demonstrate that they have not been found guilty of a disciplinary of criminal offence will have to be the same for all treatment providers.

tendering for healthcare institutions, whereby European tendering rules for government services cannot be applicable in those Member States where, within the basic insurance system, competition between (private) health insurance companies and private treatment providers has been chosen (as is the case in the Netherlands).

Question 9: What tools would be appropriate to tackle the different issues related to health services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

Legal certainty in Europe can best be guaranteed through a binding legal instrument for all Member States for matters which can be considered to be of common interest, in the form of a regulation or a directive (e.g. based on Article 95). However, binding legal instruments could curb innovation in healthcare, so care will need to be exercised in their application.

Recommendations, communications and guidelines are also suitable tools, not to optimise legal certainty but to support Member States in areas where measures at European level can add something to the national health services policy and to encourage health promotion and protection.

If the Commission were to clarify the case law of the Court of Justice (e.g. in an interpretative communication), this would throw more light on the subject..

In the light of the ongoing reforms of healthcare systems, a mechanism to update the instruments and rules is also needed.

We would also call for the existing experiments in the Euregios to be encouraged and for the legislation to be brought into line with the provisions of the Council of Europe. Bilateral collaboration agreements (and treaties) boost further experimentation in the Euregios, and the EU should support these initiatives (financially, too, for example by way of the seventh framework programme).

We hope that the above will prove to be a positive contribution to the consultation and would be pleased to liaise with you in the next phase.

Yours faithfully,

R.A. Nieuwenhoven
Director for Social Affairs