Health Consumer Powerhouse

Response to European Commission Consultation regarding Community action on health services

January 2007-01-31

In Europe, patient and care consumer mobility with cross-border care is starting to become a visible outcome of the European project: It offers the opportunity to access care not provided in your home country (or within a reasonable time frame). Likewise it improves choice to the consumer regarding providers and therapies. Mobility puts the healthcare systems under a healthy pressure to cope and deliver. Well-visited hospitals/service providers evidently have something to teach others. So there are lessons to learn from cross-border care. But reimbursement arrangements, outcomes measurement and systems transparency are key functions in modern consumer mobility markets and questions around these topics need answers.

The Health Consumer Powerhouse (HCP) views the cross-border developments as positive and worthy of support. We therefore consider the initiative to an open Forum very important and hope our answers are in some way useful for the Commission.

At present, the best way forward is to ensure the current information gap is closed. As pointed out in our 2006 Euro Health Consumer Index report: "There is less good availability of reports on the actual performance of healthcare systems, expressed in "customer value" terms such as quantitative and qualitative output, service and information levels and value for money spent. The statistics on European healthcare systems tend to focus on quantitative resource inputs such as staff numbers, beds and bed occupancy, and at best statistics on procedures such as "needle time" or "% of patients receiving trombolysis treatment."

This kind of information is inadequate for building and developing a good internal health service market. Increased transparency between systems and their outcome and the citizen's right to information must therefore be the primary policy concern.

1. 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?

The current impact of cross-border healthcare can be described in two quite different ways. The Commission's own papers estimate cross border care to just one percent of the healthcare costs and most of it concerns people getting sick while travelling. The other picture says that due to the huge

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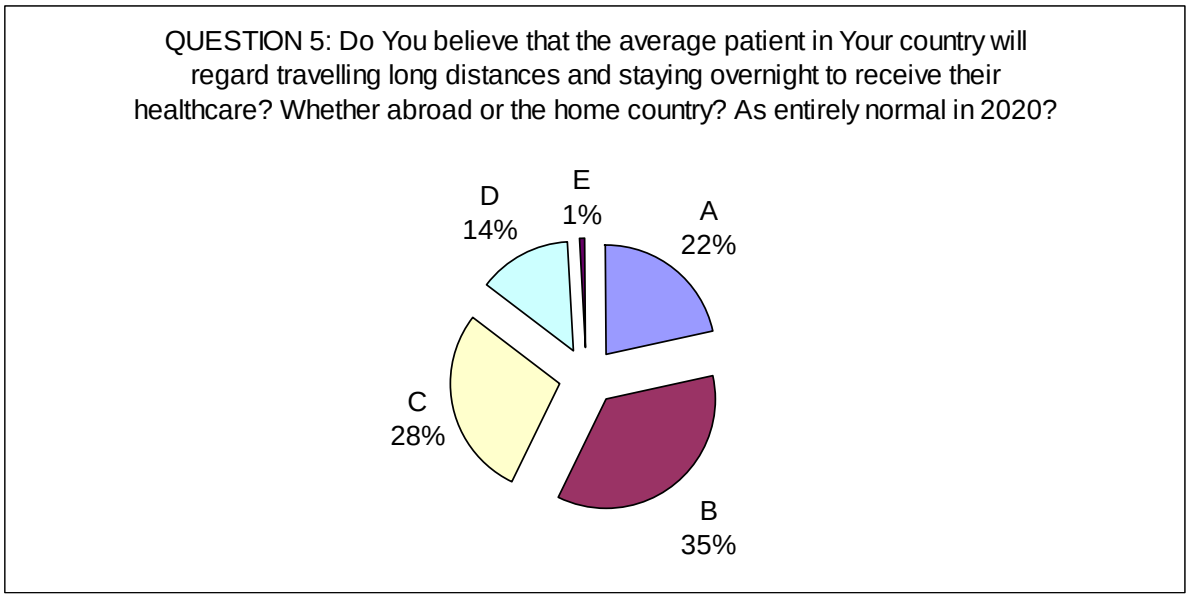
policy work generated by the relatively few cases of cross-border mobility this stream of people evidently has already reached a critical mass. We believe the trend has only just emerged, an assumption supported by the outcomes in our survey of patient organisations (to be presented in the HCP EU policy 2020 report):



A) Yes
B) Yes? But only in the case of surgery or a major interventional procedure.
C) Possibly? It depends
D) No
E) I do not know

Patient organisations clearly foresee a major change in attitudes with regards to cross border care. People talking about current opportunities will be acting upon them in the future. Probably not all would consider mobility a real option but many more than today.

But - as highlighted in our report The Great Paradigm Shift – we still believe that there is a huge potential for the health care sector to develop and become a real growth service industry for Europe. Concerning the sustainability of healthcare systems we therefore believe it crucial that healthcare is treated primarily not as a cost but actually an investment and opportunity to society.

This idea is entirely in line with the cost evaluation research performed by KELA in Finland. (14) In this 1993-2003 study on asthma and allergy treatment, costs of drugs and GP visits actually doubled. But the disability cost savings (sick leave, in hospital stays et cetera) more than made up for that. Even discounting inflation the annual average cost saving per individual was EUR 300.

Moreover, a flexible healthcare market should contribute to lower costs but also to increased quality (good outcomes yield more patients) as well as efficiency, since for the first time there will be incentives for taking on more patients.

2. 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?

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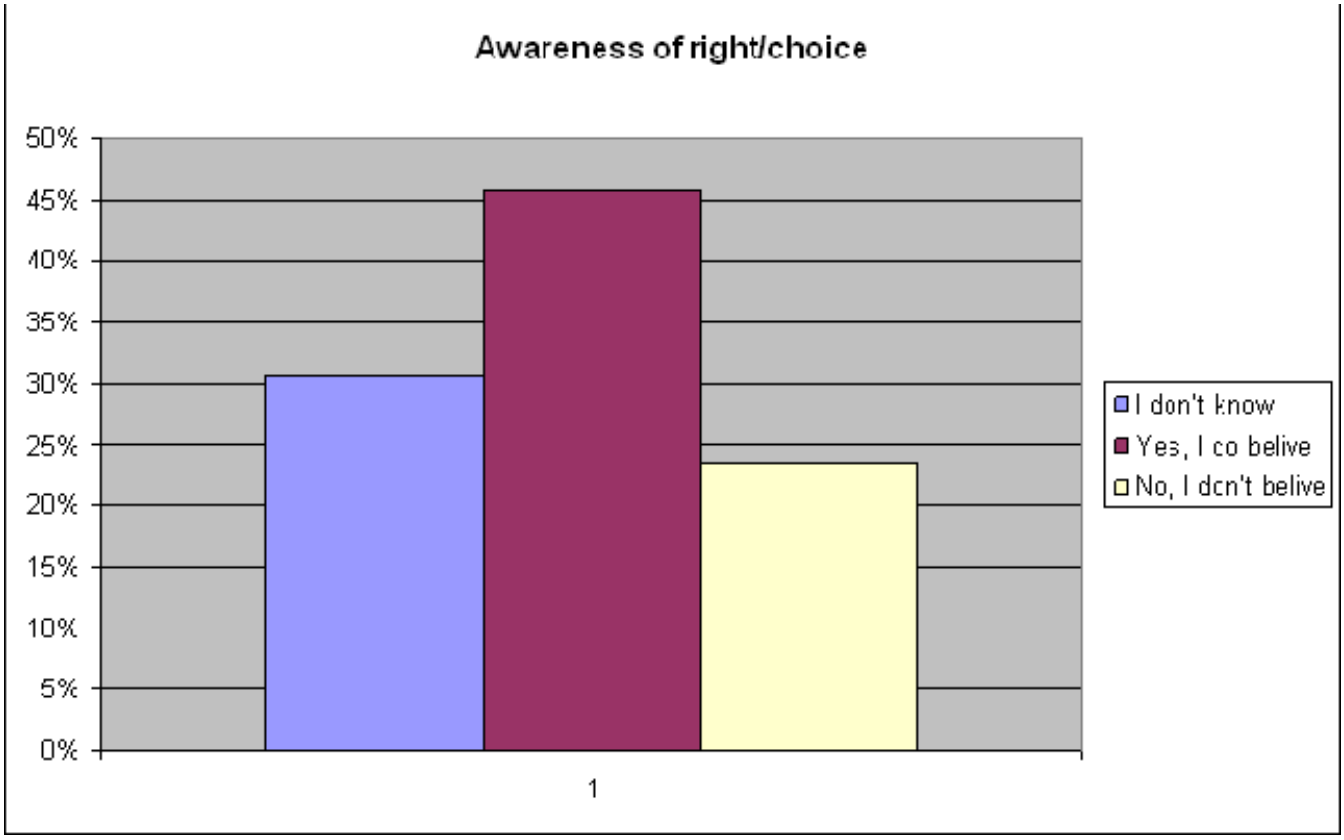
A free flow of information is crucial for a market to function. Hence it is important that the High Level Pharmaceutical Forum Working Group on Information to Patients finds a way to ensure that patients and consumers easily can access information from all parties involved in healthcare. In the UK a recent proposal has suggested to allow care providers to use the media to inform patients and consumers about their services. In Sweden such information is fully accepted.

But before locating information about providers the patient needs to know about the right to choose. Within the EU this right is evidently far from given.

When asked if they knew that they had the right to go abroad for treatment in the Health Consumer Diagnose 2005 where citizens in Germany, France, UK, Poland, and Spain were polled it was very obvious that this is a very unknown right.



The 2006 Summary paper on Common principles of Care (from the Mapping Exercise of the High Level Group on Health Care Services) recommended that a national point of contact should be assigned in each country. We believe this to be a very good idea. Of course the European Union should not decide on how each Member State should organize that One Contact point. But the EU could very well demand that the member states appoint one point of contact for information about the rights and regulations around cross boarder care.

In terms of consumer safety regulations concerning medical records is a clear issue. In many national healthcare systems the lack of a right to access medical records in fact prevents the patient from getting a second opinion, i.e. to have a different doctor independently overlook prescriptions and medical procedures. This important procedure of course requires that the second opinion is fully aware

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of the patient's medical history. Such routines may serve well within a country but might be a big hurdle when you travel cross borders. Thus your medical history must be "portable".

The Data Privacy Directive in theory meets this need but as of today the directive is far from implemented in all member states, as can be seen both in the results of the EHCI 2006 and in the 2006 Summary Paper on Common principles referred to above. It is important that the Union now ensures its rapid implementation.

3. Which issues (eg: 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 oversights have to be monitored in the country of treatment. Therefore the practitioner also has to abide by the regulations of the host country.

The patient's insurance or country of residence should have the main financial responsibility. But the hosting country and the patient is not without responsibility. If a patient chooses to go to another country for treatment unavailable in the country of residence and is given that care it cannot be mandatory for the insurer or country of residence to pay-up. Either the caregiver or the patient then has to foot the bill.

In this respect the Nordic system works out quite well. If a Finn travels in Sweden falls sick Sweden does not bill Finland for the medical treatment costs. And vice versa. The result is lower administrative costs. And even if currently the economies of the EU are very different this is only a transitory phase. The financially weaker countries are catching up quickly.

For the future where one can estimate that most patients and consumers are covered by obligatory insurances, these policies have to follow the insured individual regardless of where in Europe she or he is located at a given moment. This requires that insurance companies be active in several countries and should not be allowed to limit the geographical scope of their business.

(Hence it is easy to see patient mobility as a cure for waiting lines in countries like Sweden and the UK. There is, however, also the problem with national citizens feeling pushed away by wealthy foreigners. We do not yet generally regard our neighbours and ourselves as Europeans when it comes to healthcare and hence we are not prepared to grant people from other countries access to our "own" healthcare institutions. The answer from one patient organization in our 2020 report shows this only too well. "Natives should be given treatment in their own country before it is offered to others from abroad").

4 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?

Generally we promote the idea of an implementation of non-malpractice insurance in each member state. The major issue here is not whom to address in case of error but the burden of proof incumbent on the suffering party. Of course then regulations and substititution levels et cetera of the country where the care has taken place has to prevail.

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5 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)?

Once again we refer to the Great Paradigm Shift report. The only way to ensure universal service is by building a well functioning healthcare service market.

It is time to consider this matter from a market perspective. Twenty years ago no one would have believed that we could afford IT/mobile phones to the extent that we are today. By taking the service industry approach - expanding access rather than rationing the use of care - we would be able to improve healthcare as well as economic growth.

Our ageing population gives another example why you should look at care with different glasses. For many years this issue has been treated as a cost problem. Today, we know that regardless of the age we reach it is still the last couple of years which call for costly care. And that the older we get the cheaper the intensive care during the final years tends to be as well. This tendency might be supported by preventive work (CVD/Anti-diabetes/Vaccines). Alas, there is a need to look upon care in a different way than just a cost problem.

6 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?

A European Service Directive for Healthcare that makes it clear that the providers are obliged to follow local regulations and law.

7 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?

Why differentiate between non-hospital and hospital care? Care develops constantly and what is non-hospital care varies country by country. There is no need for a system where therapy areas are kept from developing into non-hospital ones due to for example a government wish to keep patients from the right to cross borders to seek care.

The right to privacy / personal integrity is important. How can one dare to visit the doctor for diseases like mental illness, HIV, venereal diseases et cetera without ensuring that the patient and her doctor are alone in accessing the medical records? The EU ought to ensure the right to privacy in this field.

8 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?

Today the pharmaceutical business among the EU is given support and consideration. The service parts of healthcare should be given as much attention, exploiting the potential of the total healthcare system to become a competitive European service industry.

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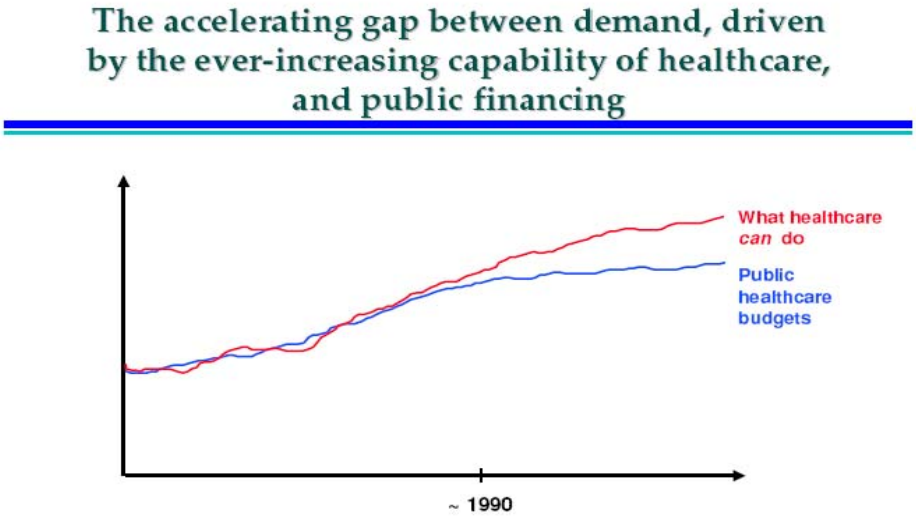
9 Question 9: what tools would be appropriate to tackle the different issues related to health services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

A market depends on information. If information is limited there is no way for the consumer to make good choices. Therefore it is unacceptable that certain countries have bans on care providers right to communicate with the consumer via third parties. Nor should the citizens be banned from seeking and digesting certain types of information. Here the legislation on EU level should improve.

The EU directive 2001/83/EC banning pharmaceutical advertising should be amended to allow for information on diagnostics, treatments and medicines available, including direct communication between citizens, care providers and pharmaceutical companies. Any amendments to the Directive must take the freedom of information of all stakeholders into account, and any limitations be clearly justified and defined.

But the transparency issue also needs to be addressed:

"Many European hospitals still receive revenue in proportion to the number of patient bed-days. If providers are exposed to the fundamental principle above, one vital effect appears. This effect is present for all goods and services providers in "free" markets. This effect is: *It is always fundamentally good to produce and sell a lot, and cost less."* Great Paradigm Shift, page 31.



The community should direct its non-legislative efforts into output-focused research, to support entrepreneurs within the healthcare service sector and strive to change the attitude that healthcare is a cost burden into a positive supportive industry environment.

Thank you again for this opportunity to contribute to a more consumer friendly internal market for healthcare!

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