BMA

Response to the European Commission consultation on healthcare services

The British Medical Association is the UK's leading voluntary professional association of doctors with approximately 129,500 members. We represent 70% of practicing doctors in the UK.

The BMA welcomes the opportunity to contribute to the debate on the European Commission communication regarding Community action on health services. In light of recent debates around the Directive for Services in the Internal Market and the European Court of Justice rulings concerning patient mobility, increased legal clarification on the issue of patient mobility and safety is welcomed.

The BMA believes that future legislation on the issue of cross border patient mobility provides a unique opportunity to raise general standards of healthcare in the EU. However it is important that any future legislation fully takes into account a number of concerns that we highlight in this paper.

In principle, patients should and want to be treated as close to home as possible. However greater patient awareness of and demand for information on the availability of treatments abroad will lead to increased pressure on all providers (both sending and receiving) to improve their own standards to the benefit of all patients.

On the whole, the BMA supports the principle of patient mobility but believes that an appropriate balance must be achieved between legal certainty and maintaining Member State responsibility for healthcare.

- **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 system of uncertainty in which issues of patient mobility are decided on an ad hoc basis by the European Court of Justice is not conducive to the promotion of high quality healthcare in the EU. At the moment, the actual number of patients travelling abroad for treatment is negligible, however we should anticipate that with the advent of easier cross border information and communication services (facilitated by the Internet) as well as a greater awareness of patient rights, instances of patient mobility will increase.

When formulating any new legislation, the Commission should refer to current cooperation that already exists between border regions and which is already well developed. In the case of BMA members, cross border cooperation between Northern Ireland and the Republic of Ireland is well established. Currently there are limited agreements between the Health Authorities in the Irish Republic for 'public' patients to be treated on a planned basis in the other jurisdiction. An example would be either Renal Dialysis services or cancer treatment. In addition there are arrangements in place for ambulances to take patients to the nearest hospital which may be in the other jurisdiction. A considerable number of 'private' patients also opt to have planned maternity care in Northern Ireland as they live too far from maternity services in the Irish Republic. In addition there are close links between GPs on either side of the border and links between hospital consultants too. The European Commission should examine such existing examples of best practice in order to learn from the vast pool of experience on this issue that already exists across Europe.

- **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?**

The BMA believes that the European Commission consultation addresses a highly important but complex and inter-related set of issues. Legal clarification and practical information on a range of issues is thus required. For the purposes of this response, we have outlined below six key issues which we believe to be most pressing.

<u>Culture of care</u>

When choosing to undergo treatment in a Member State other than his/her own, patients must be fully aware of different cultures and traditions of care. Medical practices differ widely across the 27 EU Member States. Already a proportion of patient mobility is patients travelling 'home' for healthcare, despite having migrated to another Member State for all other purposes. This amply demonstrates the importance of culture of care when patients make a choice on where to be treated.

Practical issues to consider include the provision of hospital food and nursing care where in certain Member States these are seen as the responsibility of the patient's family. Treatment procedures may also differ from what is seen as the norm or culturally acceptable in a patient's home country. Patients' must be fully aware of these differences when they choose to be treated abroad.

<u>Patient and professional information</u>

Adequate information for patients is required in order to enable them to make informed choices about their treatment and to be aware of their rights. This includes practical information on treatment options and choice of provider. This type of information should be accessible to all patients including vulnerable consumers such as the elderly and those not digitally literate. Moreover, research should be conducted on the impact on patient safety of patient mobility.

Medical professionals also require a high level of information in order to enable them to advise patients on the best treatment options whether in their home country or abroad. The BMA is concerned about the possible extra workload that this may cause for doctors, specifically for GPs. It should be made clear that their role will be to direct patients to appropriate sources of information in order to allow patients to choose where to travel for care. GPs should not be expected to organise such cross border treatment.

The BMA thinks that the provision of information is essential and would support the Commission to encourage Member States to provide a comparable data set on the availability of treatment and on the quality of care and treatment outcomes. This would also need to address issues of different disease and specialty definitions across Member States. For Member States not to do so could be seen as a barrier to free movement.

<u>Undue delay</u>

The BMA believes that the concept of undue delay is not a helpful one. If the EU defines a threshold for undue delay it may have unforeseen consequences, namely by encouraging a lowest common denominator service provision. This could result in countries which currently have very short waiting times, reducing their overall quality of care by scheduling all treatments at the higher end of the threshold in order to save money or on countries

reducing their basket of care in order to avoid coming under pressure from those suffering delays before receiving more sophisticated treatment.

If a definition on undue delay is included in any future legislative proposals, it must be one of clinical judgment and specific to each individual patient. The definition must take into account patient needs and be based on independent medical advice in both the sending and receiving country.

Medical opinion

Definitions of healthcare and medically recognised procedures differ widely between the 27 EU Member States. What is considered healthcare in one Member State may be classed as social care in another. The concept of illness also differs between Member States. For example what is perceived as a health problem in one country and treated as such is not regarded as a problem in another Member State. This is true for low blood pressure.

Thus, both the decision to refer a patient abroad for treatment and the suitability of the treatment itself must be grounded in a valid evidence base. The BMA would seek to encourage the development of nationally agreed guidelines – independent of the commissioning authority and based on medical opinion – which would define the eligibility of patients to access such treatment both in the home system and abroad and would provide guidance on the types of treatment that could be reimbursed.

Privacy

The sharing of confidential patient health data raises issues regarding privacy. Standardised procedures and safeguards need to be developed for the cross border transfer of electronic medical records. There is currently a public debate on proposals for the sensitive use of the new patient record system in the UK which should be watched closely in order to predict the possible problems that may arise at the EU level for a similar system.

Continuity of care

Effective communication between clinicians and healthcare systems in both the sending and receiving countries must be ensured. Continuity of care should be ensured by a unified system of handover between clinicians as language problems and different decision making procedures may impact on patient safety. This exchange of information should be a two-way process, managed by and sensitive to the patient's home country. The BMA has concerns over the cross border treatment of certain illnesses such as mental health and chronic physical disability where the importance of the clinical relationship and knowledge built up over the course of several consultations cannot be overestimated. Patients must be aware of such concerns and they must be taken into consideration when opting for cross border treatment.

In addition, the issue of continuity of care is also important when providing treatments such as long term rehabilitation for conditions including neurological conditions, stroke rehabilitation and dementia. Here the definition of nursing care versus social care will be vital. With an increasing elderly population in Europe, we need clear agreements between all Member States on where responsibility for such treatment lies.

- **Which issues (e.g.: clinical oversight, financial responsibility) should be the responsibility of the authorities of which country?**

Continuity of care should be ensured by a unified system of handover between clinicians as language problems and different decision making procedures may have a negative impact

on patient safety. This system should respect and 'flag up' different cultures and traditions particularly regarding language. This exchange of information should be a two-way process with overall clinical oversight managed by the patient's home country.

Clarity is needed on who would be responsible for the provision of language support. It seems unfair to ask the receiving country to provide these services (interpretation, translation of medical notes). Should we assume that it is the responsibility of patients to ensure that they either speak the language of the country of treatment or that they provide the necessary language support?

The BMA strongly believes that the cost of authorised medical care should be the responsibility of the patient's home country. The level of reimbursement for that care should be provided at the same level as would be reimbursed at home for the same treatment. Otherwise, it risks seriously de-stabilising Member State healthcare systems. The cost of prescriptions and follow up care should also be reimbursed as these are part of the overall package of care. However, this raises the question of who would pay the difference if the treatment is more expensive abroad? It is clearly unsuitable for the Member State to reimburse at this higher level as this would be discriminatory against patients receiving 'cheaper' care at home. On the other hand, to ask the patient to pay the difference would introduce a barrier to free movement for those patients without the means to do so.

- **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?**

The concept of consent should be expanded to cover treatment and an understanding of redress. When a Member State authorises treatment abroad for a patient, the commissioning contract should stipulate what system of redress will be used in the case of patient harm. The system of redress should be a matter for bi-lateral agreement between the sending and receiving states but it should remain the responsibility of the sending organisation to ensure that an appropriate form of redress is agreed.

For patients making their own arrangements, the responsibility of ascertaining liability must lie with the patient itself. In these situations, redress should most likely be directed at the treatment provider.

In summary, the BMA posits that in the four principle situations regarding patient mobility, the following systems of redress should be applicable:

1. The first common situation, that of a patient requiring emergency care when visiting another EU Member State, is already adequately covered by existing legislation with the European health insurance card
2. The second situation occurs when an authority in one Member State commissions care from a provider in another. In this situation it should be the responsibility of the commissioning authority to ensure that an appropriate system of redress is written into the commissioning contract
3. The third scenario involves a patient making the decision to seek treatment abroad subject to prior authorisation from the relevant home healthcare authority. In such cases the patient should assume responsibility for confirming liability whilst the home authority should have a duty of informing the patient that this is the case
4. The final situation involves a patient receiving treatment abroad then seeking post hoc authorisation from his/her home authority. In this eventuality, it would be the responsibility of the patient to sue the healthcare provider under the jurisdiction of the Member State in which the treatment took place

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

Patient mobility must not jeopardise the provision of quality healthcare services for home-based users. This is particularly important in EU border regions and popular tourist destinations where high numbers of patients from abroad could de-stabilise the home healthcare system.

Healthcare is based on the spirit of universality, accessibility, equity and solidarity. Healthcare provisions should be equal for all EU citizens regardless of whether they have the ability to travel abroad for treatment. Patient mobility must not just be for the wealthy and educated - equality of access must be guaranteed.

In the UK, the ability of NHS-funded patients to secure treatment abroad has implications for equity. Effectively, patients placed lower down a waiting list for reasons of clinical priority who are willing to be treated abroad might not only get treatment more quickly than those higher up the list who prefer to be treated in the UK, but - depending on the financing arrangements - might even delay the treatment of those patients.

A further aspect of equity is that, under current NHS arrangements, patients in one part of the country are not free to seek treatment, as a matter of right, in another part where waiting times are shorter. Yet they are able to seek such treatment in other EU countries. This can be viewed not only as an anomaly, but also as inequitable to those who might consider treatment elsewhere in the UK but who are denied that option by UK rules, and who for whatever reason will not contemplate seeking treatment abroad.

Before any future legislation on cross border mobility is proposed, the potential financial impact on Member State healthcare systems should also be carefully examined in order to ensure the long term sustainability of healthcare provision in the EU.

- **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?**

Representing the professional interests of doctors, the issue of professional mobility is of great importance to the BMA.

The BMA believes that the Directive 2005/36/EC is no longer fit for purpose due to the nature of changes in modern medicine. It is essential that a system is introduced which has an emphasis on a healthcare professional's continuing fitness and suitability to practice in the receiving country. Basing a decision on their fitness to practice on the length of time they have trained rather than on the skills they have acquired is not suitable for the continued development of a modern healthcare system.

Whilst the BMA does not advocate a system which acts as a barrier to migration, it does insist upon a system to safeguard the quality of care by providing a higher level of qualification standards. This would include safeguards which specified:

1. Appropriate length of training
2. Appropriate national competency based assessments
3. A means of confirming a professional's eligibility to do the job

Member States should share their respective regulatory data and should be able to verify the eligibility of professionals to practice. This could be in the form of a certificate confirming an individual's good standing and fitness to practice.

In a modern healthcare system with an increased emphasis on patient safety, it is desirable to demonstrate that Member States and healthcare authorities have fulfilled the appropriate safeguard criteria. Thus healthcare providers must fulfil the regulatory requirements in the practicing country rather than in their country of origin.

The Commission will also want to consider the logical conclusion of professional mobility with potentially one region's health system being severely depleted by doctors moving to work in another member state.

In addition, there needs to be clear rules on professional insurance – will doctors be covered by their 'home' insurance if they perform work overseas or will health professionals expose themselves to new liabilities if they treat patients abroad?

Clear ethical guidelines are also needed in order to avoid the possibility of doctors travelling abroad in order to perform a dangerous operation that they are not allowed to carry out in their home country.

- **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?**

The gatekeeper system of healthcare as exists in the UK is an issue of subsidiarity and is essential to the functioning of the NHS system. The function of a gatekeeper has been developed as the basis of patient care in the UK and should not be challenged in order to harmonise the UK with other European healthcare systems.

As such, Member State referral processes should be respected – where a referral from a GP is needed to access a service in the UK, patients should need a similar referral from a British GP to access that service in another EU Member State.

- **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?**

The BMA supports initiatives that would provide economies of scale to social security systems and improve exchange of information between national systems. However, these actions should duly respect the principle of subsidiarity and the competency of the Member States to organise their health systems and to take the necessary national political decisions on the future of their own systems. The development of quality standards should be encouraged in a way that does not jeopardise the principle of subsidiarity.

The European Commission should oversee the collection and publication of comparable health data from across the EU. However, as it is difficult to reduce health to a sole economic activity, analysis of the data collected should respect and reflect the differences in national health systems. Moreover, all EU actions should take into account the principles of data protection and of medical confidentiality.

The Open Method of Coordination, which would include the full involvement of stakeholders, would be a useful tool in allowing healthcare authorities to learn from each other.

- **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?**

In order to give legal certainty to patients, rules on free movement of patients and on compensation systems should be addressed in a binding legislative instrument act (a Directive). This binding legislative framework should cover the issue of patient mobility, professional accountability and regulation and all financial aspects related to patient mobility.

The BMA is happy to liaise with the European Commission on which issues should be dealt with in a Directive and which issues are best dealt with through other tools.

In conclusion, the BMA is in favour of the principle of patient mobility. However in view of the diversity of healthcare systems across Member States, the appropriate balance must be achieved between legal certainty and maintaining Member State responsibility for healthcare. If this cannot be guaranteed, national systems run the risk of destabilisation (with resulting costs to national governments and patients). In this case, the BMA would favour a more restrictive approach.

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