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Response to the Commission consultation regarding Community action on health services [SEC (2006) 1195/4]

The responses below are not intended to be complete answers, but to identify some issues in addition to those widely known and accepted.

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

1. In assessing this it is important to consider indirect as well as direct effects. The actual number of patients with Community law rights to migrate, and the total cost of this, may not be huge (see answer to question 5). One might therefore tend to think that the impact is moderate. However, public healthcare institutions are often risk averse, and fearful of legal uncertainty or challenge. Therefore their reaction to migration rights may be disproportional to the actual migration taking place or likely to take place.

   This reaction may be of one of two forms; either institutions may become defensive, and attempt to use legal or other tactics to block the rights (the case law concerning Dutch patients is an example of this) out of a fear of 'opening the floodgates'. This may undermine both the position of patients and Community-Member State relations in this area. Alternatively, institutions may attempt to adapt to Community law, which may in fact entail fairly radical restructuring. For example, any successful mobility of patients scheme will require accurate and fair pricing of medical treatments (see answer to question 7), and the separation, at least administratively, of payment from provision. Incorporating this into integrated national health systems based on bulk pricing and the vertical unity of the system can itself have radical liberalising effects.

   The structural adaption necessary to make migration system-consistent is however independent of the actual numbers of patients wishing to migrate. The institutional desire to maintain internal consistency may therefore lead to surprisingly significant results given the low numbers of actual migrants.

   Philosophically, many systems are based on inclusiveness and closure. Internalising the very idea that patients may be able to opt-out and receive

reimbursement is a challenge to this way of thinking and self-image which is likely to have knock-on organisational effects. The UK is likely to be a good example of this. Once the NHS is perceived as a 'payer' rather than primarily as a 'provider' the public and political (and business-led) pressure for further liberalisation will be great.

2. It is a common myth that markets lower prices. In healthcare the evidence is that market-like systems, or healthcare systems making major use of private providers, provide good care at high cost compared with more nationalised or centralised systems, which often provide good value for money, but at the price of waiting lists and limited ranges of treatment. (e.g. the US or Germany, compared with UK or the Netherlands)

   Thus if Community law has the knock-on effects of tending to cause health systems to restructure to become less centralised, and make more use of diverse and private providers, then this may well improve patient care but at the cost of increasing health budgets.

   This trade off of care against cost is highly political, and there needs to be a serious assessment of whether free movement law is an appropriate means of imposition of a particular choice, even if that imposition is indirect (see also the answer to question 5 below).

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?

1. The principles of the case law are clear, but no doubt some national institutions would be grateful for details of what they entail. This might involve e.g. lists of treatments which cannot be refused because they are 'unapproved' nationally, indications of what is 'undue delay' for particular conditions and so on. On the one hand, there is no reason why approved treatments or acceptable delay should vary from state to state, since both are to be based on medical science rather than national organisational preferences, and the Court has indeed rejected the idea of 'national science' and affirmed the international and scientific objectivity of these matters. On the other hand, any Community document setting out details might well be seen as unacceptable intrusion into national competence and incompatible with subsidiarity. See answers to questions 8 and 9 for possible approaches.

2. The extent and nature of the application of the free movement of services (the basis of most of the cases) to private insurance companies and medical providers is legally not entirely clear. To the extent that these are involved in carrying out a public mission to ensure health care to the population there is a good argument that they are subject to Article 49 EC. However, as the range of private actors involved in health care increases and the nature of their relationships with the state and patients become more diverse attention will need to be given to this point. Legislation might be useful. While Article 49 is generally applicable to public or quasi-public organisations, legislation

achieving the free movement of services can also impose obligations on the private sector.

Attention needs to be given as to whether such obligations would be desirable, as an interference with market freedom. However, ignoring the private sector might raise the possibility of states radically liberalising provision and insurance and their populations thereby largely being deprived of free movement rights. Prima facie, a private insurer who offers insurance on the basis that a patient goes to one of five private hospitals with whom they have contracted is not subject to Article 49. A patient with public insurance however does have rights to choose an out-of-state provider. The policy question is whether such disparities, which may grow, are problematic.

3. There is a need for certainty on when free movement may be stopped. The Court has made clear that if the costs were to reach a point that they threatened the stability of the national system, this would justify restrictions. This is clearly sensible, but very difficult to assess or measure. Clarity on the conditions under which an authority may legitimately claim that it simply cannot fund cross-border treatment would be very useful. On the one hand, there is the potential for serious misuse of this idea – 'our budget is used up, sorry, we have no more money'. On the other, realism demands an acceptance that if a financially hard-pressed health system risks crisis as a result of migration the law needs to take this into account. This is not an entirely unrealistic scenario given the increasing motivation to migrate that may go along with enlargement, and the pressure on national budgets that might result from states demanding repayment for treatment provided.

   Without guidance, at some point we may expect states to over-rely on this exception, undermining free movement. Further, assurance that under extreme conditions it is possible to limit movement would be reassuring, and might encourage a greater acceptance of free movement under normal situations.

   The problem is that assessing when costs threaten the stability of a system is both subjective and economically, politically and organisationally complex. This may be however be in itself a reason to give attention to it. Possible mechanisms are discussed in the answers to questions 8 and 9.

Question 3: which issues (e.g. clinical oversight, financial responsibility) should be the responsibility of the authorities of which country?

1. Any sustainable migration system can only operate if the state of insurance/residence/primary governance of the individual is also the one responsible for the costs of their treatment. The alternative will be a growing distortion of finances as migration grows, particularly in an EU of wide cost and income disparaties. On the one hand, patients from poor countries receiving treatment in rich ones may often entail a subsidy from rich to poor, which is perhaps not unacceptable. However, it is likely to occur in such a random and un-thought-through way that these accidental subsidies should not be left to happen. Some states will incur significant burdens, and other none.

The allocation of financial responsibility is the primary issue in making cross-border health care practical.

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 service accessible to all (for example by means of financial compensation for their treatment in receiving countries)?

The law needs to be based to a greater extent on actual economic assessments of the impact and extent of patient migration. These need to consider not just the current position, but dynamic factors: increasing migration, and integration generally, may increase public awareness of the possibility and produce feedback effects, as may institutional adaption which makes migration easier.

Currently the law is largely based on the application of simple free movement principles by courts. This is not morally objectionable, but over-simple for such a complex and important area as healthcare which requires ongoing management. The precise extent and terms of migration rights should not be assessed until social and economic research has established what flows and costs will result in the short and medium term.

Research should also be institutional: how are states and institutions likely to react to the possibility of patients 'exiting' their provision, and what feedback effects may this have? Institutional behaviour has a dynamic and logic of its own which is often ignored in the context of free movement, with its legal-principle-led bias. This risks creating unrealistic law and unpredictable effects.

On the other hand, there is always the possibility of leveraging organisational effects to achieve Community goals. The organisational imperative is to sustain itself. A structure for migration which includes it within the domain of national institutions, rather than undermining this domain, or which provides entrepreneurial opportunities for the institutions, might result in them embracing it. I leave it to the political and organisational scientists to work out how to do this.

Question 7: are there other issues where legal certainty should also be improved in the context of each specific health or social protection system?

1. Patient information is an important issue. Cultures and practices vary widely with respect to the extent of information provided to patients, and the extent to which they are expected to defer to professional judgment. In particular, information about risks, and alternative treatments, may vary.

   Without attention to this we may expect some painful stories, as patients from high-information states expect the same approach abroad, and are then later shocked to discover possible side-effects or that alternative treatment might have been a better choice.

   Similarly, the rights of patients to know the details of the treatment they have received, and any errors that may have been made, will vary significantly, and

patient assumptions are likely to lead to tears. The patient from an open Scandinavian state who attempts to discover what went wrong during his treatment in a less open state (most of them) will no doubt be distressed and disappointed.

Given the importance of medical care, the information inequality between provider and patient, and the variation between states, the case for some kind of 'consumer legislatinon' for migrating patients is far stronger than it is in the context of goods – where such legislation exists.

2. Migrating patients create the need to think about continuity of care between states. A patient may migrate for a treatment or operation, but will often (usually) not remain in the host state for full after care. If complications or problems arise weeks or months after treatment, these are likely to be addressed in the home state

Some surgeons are reluctant to provide aftercare to patients who have had their surgery elsewhere. There is anecdotal evidence of patients returning to the Netherlands from treatment in Belgium or Germany to face doctors reluctant to help them (short of emergency treatment) because they were not treated by them, or in their institution, or even within their medical system.

There may be psychological, but also economic and organisational factors at work here. Is aftercare financially rewarding, or is payment (as in some systems) primarily or totally for the operation, with aftercare included in the package price? In this case a doctor is penalised if forced to care for a patient treated elsewhere.

Continuity of treatment also entails the question of cross-border information. It is not always normal practice to provide patients with medical notes. Will their doctors at home always have access to full information about the treatment they have received.

There is a good case here for a European code of conduct on treatment of patients who have been treated elsewhere, a system for the transfer of information, and attention to the financial and organisation issues raised.

3. It was suggested in the answer to question 5 that no migration system can work unless home states pay. Further, no system can work unless the price is fair and accurate. There is an urgent need for pricing transparency. On the one hand, if prices are set too low, this will distort flows of patients and represent a burden for host states. It may also represent a distortion of competition where undertakings are involved. On the other hand, if prices are too high then states may be effectively exploiting other states' health budgets. Further, if it is difficult to establish exactly what prices are then neither states nor patients will be able to plan or use migration possibilities effectively.

All of the above are likely to be problems. Many states operate complex systems in which insurance pays a price for treatment that is not in fact the true total cost, because the providing institution also receives other forms of

subsidy or public assistance. The price may represent the marginal cost, or a percentage of cost, or simply a politically acceptable cost calculated more with an eye to insurance company and patient behaviour than true reimbursement. Insofar as private institutions receive payment for health care from both patient/insurers and public sources, the patient/insurer price will be below true cost. This makes the institution competitive in the international market, and enables them to attract migrants, who are then effectively partially paid for by the host state. The dynamic is the same as in higher education, where foreign students pay a below cost fee, but the university receives additional per student funding from the state, making it attractive to have foreign students, even though their up-front fee is low.

These kinds of problems distort competition and/or undermine budgets and represent arbitrary inter-state subsidies. Yet establishing fair and transparent prices is likely to be very difficult in structures not fully adapted to thinking in per-treatment-costs, or doing so accurately. How to establish these costs is likely to be controversial, and exposing true per-treatment costs may be very confrontational for a number of systems. For example, the UK NHS is relatively opposed to patient migration. It may well be possible to argue that in fact UK per-treatment costs are high, so that migration is often a money-saver. There will however be arguments against this too. The issue is a complex and controversial one, but ignoring it is dangerous, and will lead either to exploitation of free movement or unfair allocations of financial burden.

A final technical issue will be how prices are calculated and defined. If one state/system/insurer pays a given sum for an entire ‘package’ consisting of operation, aftercare as necessary, and medication, while another state/system/insurer pays per hour, or per act, or per consultation then transfer between systems is likely to be effectively impossible. For example, if insurance policy X offers up to 1000 euros for a given ‘treatment’ (carpal tunnel treatment), while provider Y in another state offers an hourly rate of so much, an operation fee of Z, and expects the patient to buy their own medication, then the calculation of whether treatment is covered will be so uncertain and complex that we may expect patients to avoid migration.

Market behaviour may solve these problems, as providers become flexible and adaptive to foreign patients. This is something for experts in the funding of health systems to consider.

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? AND 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?

The issues addressed in 2 and 7.3 above are best suited to an initial soft-law approach. The diversity of systems means there is a need for a gradual coming together, and a feeling for where problems may lie. It may be that in fact problems are solvable by consensus and adjustment. The Commission can

perform an important role in defining the problems, providing a forum for discussion, and indicating to Member States what it understands their obligations in these areas to be, as a matter of free movement and competition law, and asking them to indicate whether they already comply, how they propose to comply, and what problems they see in the context of their own systems. 2.2 may, at some point, require legislation, depending upon the situation in the states. The legal issues here are complex.

It is suggested that there is a good case for legislation on the patient information and continuity of treatment issues raised in 7.1 and 7.2 above. This is, in essence, consumer protection legislation within the market for services, and an internal market legal base would be appropriate. This is an important market, both socially and economically, a growth market, and one where the consumer is vulnerable, and the costs of error and confusion are high. In the context of goods the argument has been made that if the consumer does not feel safe and secure and assured of basic rights throughout the internal market he will not engage in cross-border transactions. That seems *a fortiori* true of the market for cross-border healthcare.

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Sources

The text above draws on ideas developed in the following publications, by the same author:

'The process and side-effects of the harmonisation of European welfare states', Jean Monnet Working Paper 02/06, www.jeanmonnetprogram.org

'Competition, free movement and consumers of public services, (2006) European Business Law Review 95-104

'The effect of Mrs Watts' trip to France on the National Health Service' (2007) 18.1 Kings' Law Journal (forthcoming)

'Higher Education, Equal Access, and Residence Conditions: Does EU Law allow Member States to Charge Higher Fees to Students not Previously Resident in that State?', (2005) 12:3 Maastricht Journal of European and Comparative Law 217-230