


sotsiaal ministeerium

European Commission
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Teie

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Public consultation on Community action on health services

Please find hereby the position of Estonia, approved by the Government on 1.02.2007, in relation to the Commission Communication on the Community action on health services (26.09.2006, SEC (2006) 1195/4).

The impending health care initiative has to take into account the diversity of health systems in the EU, the need to ensure their financial sustainability and a proven need for common measures in this area. The scope of the planned legislation on health services has to be considered very carefully and it should be proportionate to the problems in the area of cross-border health care. Questions related to the matters of reimbursement of cross-border health services should be regulated in the Regulation on the Coordination of Social Security Systems, as other issues should be settled in the directive, enabling thus more flexibility in the implementation of those legal requirements.

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?

1.1 Costs of cross-border health services

Cross-border healthcare activity in Estonia involves mostly patients coming from neighbouring countries. Taking into account the fact that patient mobility is quite limited at the moment, it cannot be described as an important factor influencing the availability of health services in Estonia. According to data based on E125 and E126 forms, health care was provided to 1435 foreign patients in 2005.

In 2005, the Estonian Health Insurance Fund (*hereinafter referred to as EHIF*)[1] provided insurance coverage for 1 271 354 persons, 985 of them received necessary care when staying in another Member State (hereinafter *referred to as MS*) and 53 persons received planned care in another MS – this concerns altogether 0.08% of insured persons and 0.4% of EHIF budget costs. In 2004 these costs were 0.05% and in 2006 January-September 0.22%. The rise of reimbursable cross-border care costs is forecasted 10% per year in the next 4 years.

[1] In Estonia health insurance is compulsory insurance, where benefits are provided by EHIF (a public legal body) in accordance with the relevant legislation. EHIF funds are pooled from social tax. Approximately 6% of population is without insurance coverage, being entitled to emergency care financed directly from the state budget.

The statistics reveals big differences in the prices of health services among different MSs. In 2005 the average cost per case of an insured person residing in Estonia and receiving treatment in another MS was 11 497 EEK, whereby the average cost per case of an insured person from another MS receiving treatment in Estonia was 3 151 EEK.

As the statistics covers only a few years period, starting from 2004, and does not encompass cases where the health services received in another MS were paid by the patient or covered by private insurance, it is not possible to give a full overview on possible trends.

However, it can be said that if the amount of patients coming from another MSs to receive planned care or specific health services would grow considerably, it could influence the availability of health services for Estonian citizens because of longer waiting lists. This concerns particularly the specialties with few patients.

1.2. Mobility of health professionals

The principle of free movement of workforce in the EU is on one hand beneficial in enhancing the quality of health services by exchanging best practice, but on the other hand it causes the "brain drain" of qualified health professionals and endangers thereby the availability and sustainability of health services provision.

According to the data of February 2004-October 2006 of the Health Care Board of Estonia, 873 health professionals have taken out the certificate on professional qualification enabling them to apply for the recognition of the qualification in another MS, i.a :

- 512 doctors, i.e 9% of all registered doctors,
- 91 dentists, i.e 7% of all registered dentists,
- 264 nurses, i.e 3% of all registered nurses,
- 6 midwives, i.e 1% of all registered midwives.

This statistics does not however mean that all of those who have taken out the certificate on professional qualification have left from Estonia to work temporarily or permanently in another MS. We note that there is a lack of appropriate data (a common problem across MSs) which would enable to get overview of the actual mobility of health professionals.

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

2.1 From the legal point of view we find it necessary to introduce the principles of reimbursement of cross-border health services, deriving from the ECJ decisions[2], into the Regulation No 883/2004 on the Coordination of Social Security Systems, with appropriate practical clarifications (such as delineation of hospital and non-hospital care, reimbursement rates etc).

2.2. At the same time many questions and problems arisen in practice can be solved by enhancing practical cooperation and better dissemination of information.

[2] Kohll and Decker 1998, Smits and Peerbooms and Vanbraekel 2001, Müller-Fauré/van Riet and Inizan 2003, Leichtle 2004 and Watts 2005.

Regulation No 1408/71 on the Application of Social Security Schemes and its implementing Regulation No 574/72 identify clearly the competent bodies responsible for social security sectors and its parts. The experience of EHIF as one of the competent authorities in the implementation of these acts has been positive and there have been no problems in identifying the relevant competent authorities in other MSs.

In order to further enhance the practical cooperation and exchange of information a network of competent authorities should be created. This network would enable competent authorities, for instance, to consult one another on the possibilities and conditions of a particular care in other MSs (like length of waiting list, price of the service, patient co-payment conditions etc) in planning treatment in another MS.

It is also important to facilitate the availability of information to the public on the systems and conditions (i.a co-payment conditions, health service providers, procedures when patient suffers harm and complaint mechanisms etc) of health service provision in other MSs. This could be done by establishing a relevant health portal, which would contain information from all the MSs on the possibilities, conditions, rights, obligations and responsibilities of patient when receiving treatment in a MS. However, generally the first source of information for patient on the possibilities and conditions of getting treatment in another MS is the referring health service provider.

Every MS should be responsible for ensuring that information on the principles and conditions of cross-border health services, including national procedures would be available to its citizens.

Question 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?

Supervision of the health services has to be done by the competent authorities of the MS where the service is provided. The responsibility areas and obligations of different authorities are determined nationally. In Estonia the type of cross-border health care is irrelevant when defining these authorities. Information on the competent authorities and their obligations could be available in the above-mentioned health portal, so that patient could contact directly the relevant supervision authority.

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?

Every MS defines nationally the principles of health care provision in this country. Guaranteeing quality and safety of cross-border health services and compensation of harm to patient has to take place according to the legislation of the MS where the service was provided. All MSs have adopted appropriate legislation and mechanisms to guarantee and control the quality of services. However, in order to ensure the same level of protection of patient interests as regards the compensation of harm we find it necessary to establish an compulsory professional liability insurance requirement in all MSs (it is already a legal requirement in many MSs).

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)?

Access to health services has to be guaranteed for everyone on equal basis. It would be discriminative and inconsistent with the principle of free movement of services to establish different prices for country's own citizens and foreign patients for the same service. We consider the limited health service provision capacity and "brain drain" of health professionals a possible cause for the decrease in the availability of health services. The problems related to the availability of health services could be prevented and solved by close cooperation between MSs, like exchanging information on waiting lists and cooperation on border areas.

Estonia does not support the creation of a compensation fund for managing the problems rising from the settlement of accounts between MSs competent authorities, as the relevant questions and the deadlines for payments, i.a rules on sanctions, are provided in the Regulation No 883/04 (were not regulated on a satisfactory level in the Regulation No 1408/71).

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?

There is already Community legislation on the recognition of professional qualifications of doctors, dentists, nurses, midwives and pharmacists in Directive 2005/36/EC. These rules do not concern re-certification and continuous professional development, leaving this to the national competence (either voluntary or obligatory rules in MSs). As far as we know there is no common approach on behalf of professional organisations at European level to harmonise it. We note that obligatory re-certification does not necessarily guarantee a higher quality of health services.

We rather see a need for an efficient cooperation between competent authorities, especially to exchange information on the migration of health professionals, and if appropriate, legal measures on data collection, because data at Community level is inadequate and does not enable to follow the trends in the EU:

At the moment we do not consider it necessary to put in place rules on health service providers establishment, as it has to take place according to the legislation of the country of establishment.

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?

The ethical principles of medicine belong to the national competence. It is up to the MS to decide which health services can be provided in its territory (SPUC vs Grogan (C-159/90)).

EHIF as one of the competent authorities of the Regulation No 1408/71 has had only positive experiences in the implementation of this regulation so far. EHIF, however, recognises the necessity to review the content of statistical data and its collection as regards the patient mobility and cross-border health care, because statistics based on E-forms does not reflect the actual situation in the EU. Another improvement in ensuring better quality of cross-border health services and their continuation would be the creation of a European e-Health application.

The objective of health service providers is the provision of health care. Access to cross-border health services depends on the availability of information, including how and where this information is disseminated by the provider. It is in the interest of service providers to simplify the regulations and availability of patient health data (for example by developing e-Health). The primary health data of patient should be available in an internationally understandable form.

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?

Estonia attaches a special importance, among the topics mentioned in the Communication, to the idea of centres of reference. However, we think that practical cooperation in this area might not be sufficient enough and there might be a need for a binding legislation. This legislation should tackle in addition to legal and financial questions the issue of access to services of centres of reference. Access to the services of centres of reference has to be on an equal basis, based on transparent and clear treatment indications and the criteria for keeping waiting lists.

In addition to the areas mentioned in the Communication attention should be paid to the improvement of the European Health Insurance Card and making it more functional. Consideration should be given to the development of a scheme which would enable the health service provider to obtain access to primary health data of the patient in an internationally understandable form (e.g patient is unconscious or there is a language barrier).

MSs also need common principles of data processing in health area, to guarantee the same level of data protection and quality of data. These principles should guide MSs in the implementation of the Directive 95/46/EC on the protection of personal data as regards health data, and in the building of the e-Health systems.

Action at Community level is also necessary for the development of e-Health applications, such as e-Health record, e-Registration, digital images and e-Prescriptions in Estonia, in order to facilitate cross-border health services, their quality and continuation.

Finally, the European Commission should facilitate and support the cooperation between MS competent authorities in relation to the recognition of prescriptions of pharmaceuticals (for example online database on prescription formats in MSs, operative exchange of information on the health professionals authorised to write out prescriptions etc).

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?

It has to be born in mind that creation of a new legislation is not always the best solution and does not necessarily ensure the results which were hoped for. We consider it necessary to codify the questions related to the reimbursement of cross-border health services in the Regulation No 883/2004 on the Coordination of Social Security Systems. Other areas which need legislation, such as centres of reference, statistics, compulsory professional insurance, should be regulated in a Directive, which enables more flexibility in the implementation and transposition of Community rules. This directive should probably be a framework directive, where the legal norms could be further refined and adapted by MSs, taking into account the organisation of a specific health system and the legal order.

Many questions could be solved by close practical cooperation between MSs, as described above in the text (for example network of competent authorities, health portal, e-Health).