EHMA
European Health Management Association

EHMA'S CONTRIBUTION TO THE CONSULTATION ON COMMUNITY ACTION IN THE FIELD OF HEALTH SERVICES

Introduction

The European Health Management Association (EHMA) welcomes the Commission consultation regarding Community action on health services. For many years, EHMA has argued that the Commission (and the Member States) should be taking the initiative in determining EU policy in respect of health services rather than leaving it to the haphazard process of European Court of Justice (ECJ) judgments and the evolution of the EU's internal market. This Communication is an important step in this process of recognising that the EU can no longer ignore health services under the convenient argument of subsidiarity.

An underlying issue that is not fully addressed in this Communication, but which nevertheless permeates the document, is the continuing tension between the internal market and the common values and principles in regard to health systems, as agreed in the June Council. Will patient mobility (and the decisions of the ECJ) strengthen the Council conclusions on common values and principles in EU health systems, or will it promote market forces in health care, possibly at the expense of some of those values? In truth, most healthcare systems are moving towards increasing use of market mechanisms in healthcare, and an accommodation will have to be found between our common health system values and principles and the application of market principles to healthcare. However, it will be important that any decisions taken as a result of this consultation process should take into account these significant political and ideological pressures.

A further underlying tension exists between individual and population health. Decisions on health services, both at national and at the European level, will differ greatly depending on whether the focus is on individual or population health.

In this response to the consultation, EHMA is answering directly to the nine questions posed.

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?

There is no single answer to this question, since the impact of cross-border care varies due to:

- Linguistic similarities / differences at border regions
- Ease of travel across borders / impediments to cross-border movements (mountains, seas)
- Increasing ease of access to information about treatments in other regions / countries, in particular through use of Internet
- Particular regions attracting specific populations (tourists, retirees, persons seeking specific types of treatments (spas, for example))
- Length of waiting lists (which are, in any case, diminishing in those countries which formerly had lengthy lists)
- Type of healthcare system – Bismarckian systems (i.e., systems primarily financed through health insurance) are more likely to contract either as marketing ploy or to take advantage of cheaper treatments, while Beveridge systems (i.e., systems primarily financed through taxation) may wish to resolve waiting lists or other problems by using bilateral agreements.

It should also be noted that the response to this question will vary depending on whether the country concerned is primarily receiving or sending patients.

Accessibility:
As a general principle, EHMA believes that Commission policy should emphasise that, wherever possible, patients should be able to access high quality care as close to home as possible. It should be acknowledged that in most cases this means treatment in their own country within their own health system.

Cross-border care has had a positive impact on accessibility

1. for private citizens who are wealthy and well-informed, and therefore able to access services on their own initiative;
2. for persons living in a country or region in which systems have agreed on bilateral terms;
3. for border workers for whom the 1408/71 system applies.

For the majority of citizens, however, there is little perceptible benefit and perhaps even negative consequences for those in lower socio-economic groups who have less ability to take advantage of these benefits. It is important that Community action in the field of health services should recognise the danger that cross-border mobility has the potential to create inequity, and should take whatever corrective measures are possible to diminish these risks.

Despite the risks of inequity, it is now widely recognised that citizens and patients should have greater choice. Patient mobility should provide the opportunity for the patient to choose treatment, hospital and physician but (with the exception of the "self-managed" patient) the insurer, sickness fund or purchases currently makes the choice and the citizen has to comply. If patient mobility is to provide real benefit to the citizen, choice of hospital, physician and treatment should be extended across borders. However, this would require considerably better information than is currently available.

The evidence is that the numbers involved in cross border mobility (at least, those that can be counted) are very small – involving less than 1% of healthcare budgets. It appears that most of the movement is currently at local border areas, with the exception of private treatments such as dentistry, cosmetic surgery or spa treatments, where patients appear to be willing to travel further afield.

Quality: Quality is difficult to define in relation to cross-border care. The focus could be on the delivery of reliable and predictable health services, based on agreed evidence-based clinical standards. It could also refer to services that are customized to take into account the specific personal history, age, social situation, co-morbidities etc of the individual patient.

There is no evidence that cross-border care has as yet had any impact on the quality of provision, although one might speculate that competition in countries where there is spare capacity (such as Belgium) might drive up quality.

The possibility of charging different tariffs for foreign patients than for local residents poses both ethical questions and the risk of creating two-speed systems within countries, with greater access and/or greater quality for the higher-paying, foreign-driven systems. It is therefore important, within the context of this consultation, to examine potential inequities that could rise from the elimination of (certain) borders in the provision of health services.

Financial sustainability: Again, the impact on financial sustainability is likely to be greater in countries with both spare capacity and Bismarckian systems in which hospitals are privately managed, though usually not-for-profit. Such impact is likely to be felt in specific regions (e.g., tourist or border regions) rather than at an aggregate national level. It is possible, though unlikely, that under such competitive circumstances, a hospital at a border region might face major financial problems if it is seriously uncompetitive compared with a neighbouring hospital in another country, and if the sickness/health insurance fund is prepared to transfer significant numbers of patients to the lower-cost hospital in the neighbouring country.

There is no evidence in NHS-type systems that the financial viability of the healthcare system is under threat.

Patient mobility may carry the risk of a growing two-tier system (with greater access to those who can afford to pay for care in another country). Safeguards (such as disallowing opt-out from the public healthcare system) may have to be considered to prevent the longer-term development of a growing trans-national parallel private system, which would leave the public system (as in the US) providing care primarily to those who cannot afford private care.

Furthermore, the role of private, for-profit care providers in the development of a European framework of health services needs to be considered and examined. While many health systems reforms are recognising the potential of privatisation and are increasingly relying on it in some form, Member States have attempted to do so within the confines of their national borders. A number of the private, for-profit health care organisations (some of which have multi-national operations) are significantly interested in the developments outlined in the consultation document and should be consulted. This exercise undertaken by the European Commission should therefore be all the more welcomed as it may enable a more coherent and consistent management of a process that, if left solely to poorly-regulated market forces, could threaten the values and principles on which individual European health systems are founded. It is therefore imperative that the private for-profit health sector be consulted as one of the main stakeholders.

The impact of cross-border mobility in relation to for-profit healthcare services is as yet unknown in terms of its effects on quality and financial sustainability of the public sector. This is an unknown that needs to be investigated (and managed well).

A guideline that might be useful in examining the role of the private for-profit health sector is to make the distinction between the privatisation of services otherwise delivered by public institutions and the commercialisation or 'commodification' of health services: the former is 'merely' a change behind the scenes of normal health services provision while the latter suggests a search for lucrative markets at the expense both of a true population health approach and of individual patients whose diseases might be the source of profit.

Future evolution: It is widely accepted that the majority of patients will continue to prefer to seek treatment as close to home as possible, and certainly within national boundaries. However, the trend of patient mobility will probably increase:

- In the case of rare diseases, for which state-of-the-art care might not be available in the Member State of residence, the patient might have no choice but to travel to receive care.
- Given a certain 'commodification' of health and wellness through, for example, the increasing availability of outpatient services (dentistry, cosmetic surgeries, spa treatments, and a growing plethora of travel/wellness packages), we ought to consider the possibility of increasing numbers of 'self-managed' patients taking their health into their own hands (sometimes dangerously so, for lack of proper regulations applying to these types of centres).

As EHMA have stated in the past, it is very likely that the phenomenon of professional mobility will have far greater consequences on health systems than patient mobility. We analyse this impact further in response to Question 6.

Some health professionals might choose not to move while providing services across borders – the increasing use of information and communication technologies enables this, as images, files and information are transferred digitally within and across borders. The case of Sweden sending images for interpretation by Spanish radiologists is just one among many examples. Telemedicine and second opinions are a few of the other services provided across borders with no mobility of either patient or professional required. Proper safeguards must be enforced to ensure that privacy and confidentiality

are protected, that responsibilities and liabilities are defined, and that claim and redress procedures are clearly stated.

In terms of systems, Bismarckian systems are more likely to take an entrepreneurial approach, seeking price or marketing advantage, and are thus more likely to use the openings afforded by cross border mobility. Indeed, some sickness funds/ health insurance organisations may seek to expand their business opportunities by operating in Member States other than their own.

It will also be necessary to consider the possibility that some countries may decide to restrict their own "basket of services" specifically to prevent patients from travelling abroad in order to receive more rapid care and subsequently claiming reimbursement from their home system.

If information about best practices across the European Union improves, this will lead to increased patient mobility as citizens opt for best practice treatment. Patients may also wish to travel to receive treatment where clinical trials and experimental procedures are being carried out. The implications of the Peerbooms judgement that "authorisation cannot be refused because a treatment is not "normal" in the home country if it is accepted by international medical standards" will have to be considered in this context.

The current ECJ rulings leave it to the patient's physician to determine what is an "undue delay". This has the potential to create inequities between EU citizens, since physicians will inevitably determine undue delay within the context of their own healthcare system – physicians working within the UK context with waiting lists will have a different concept of undue delay than German or French physicians where waiting lists are relatively rare or short. Such differences may encourage citizens, who are aware of these differences, to travel abroad to obtain treatment more rapidly.

There is also the potential for the aware citizen to exploit the differences in definitions (hospital care v. ambulatory care / inpatient v. outpatient) between Member States in order to obtain treatment in another Member State. Some treatments can be inpatient in one country and outpatient in another. At present it is unclear whose definition would count.

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

National authorities:
Legal clarification:

- Clarification on citizens' entitlements to treatment abroad
- Clarity on terms such as "undue delay" and "hospital, non-hospital based" care: It may be necessary to redefine these (and other) terms in relation to patient mobility.
- The rights of a Member State to limit the number of patients treated either in a particular hospital, or for a particular condition. It should be recognised that there are potential unintended negative consequences of patient mobility within Member States, for example the possibility that Member States may decide to restrict entitlements in order to ensure that citizens do not avail of services in other Member States.

Practical information:
Accurate information on the numbers of patients availing of cross-border care: This problem cannot be overcome by further research. Rather, it is now up to the Commission to decide which data is needed, and then to require Member States to provide this information. A harmonised process of data collecting and reporting is long overdue and should urgently be agreed upon. The type of information that needs to be collected on a regular basis in order to understand the use of health services by citizens of other Member States might include:

- The number of people who are resident in another Member State and who have registered for health services;
- The number of citizens referred by their sickness fund/insurer/purchaser for treatment in another Member State;
- The number of citizens travelling for treatment without referral from their sickness fund/insurer/purchaser;
- Categorization of the reasons that citizens travel for treatment (waiting list, cost, unavailable services in home country etc.)

Purchasers:
Legal clarification:
- Clarification on citizens' entitlements to treatment abroad
- Clarification on liability issues
- Clarification on data protection rules
- Duty of care to the patient – is the purchaser required to check the provider's competency?
- Compensation rules and claim procedures for patients when problems occur

Practical information:
- Quality of providers (accreditation)
- Where are the *genuine* reference centres – the institutions which have specialist departments or clinicians to which patients with rare diseases can be referred across borders?
- Range of services offered by providers
- Language of discharge notes

Providers:
Legal clarification:
- Clarification of the rights of citizens from other countries to be treated
- Clarification on liability issues
- Clarification on data protection rules
- Compensation rules and claim procedures for patients when problems occur

Practical information:
- Clarification on reimbursement procedures
- Timely transfer of patient records
- Language of discharge notes

Patients:
Legal clarification:
- Clarification on citizens' entitlements to treatment abroad, including considering self-managed patients, i.e., those persons who seek care / treatment of their own initiative, and who therefore do not fall within the context of arranged contracts (see also our response to Question 3)
- Clarification on liability issues
- Compensation rules and claim procedures for patients when problems occur

Practical information:
- Reimbursement of medical costs
- Reimbursement of additional costs (travel, accompanying relative)
- Quality of institutions (and professionals) – Accreditation

Some form of Europe-wide accreditation is a possible consequence of patient mobility in the medium term. Both purchasers and patients will need to be satisfied that the treating hospital meets acceptable quality standards. This is *not* a suggestion that the Commission should set up a new European accreditation process, but that the Commission might ensure that the national hospital accrediting agencies(where they exist) meet agreed international accreditation standards – i.e. accrediting the accreditation agencies. A useful spin-off from such a system would be that national accrediting agencies would be able to award a European accreditation certificate (and perhaps a recognisable

symbol, such as a plaque with the EU flag) that would identify that hospital as meeting European standards. Alternatively, a system might be established to ensure that citizens have access to reliable information on accreditation systems in other countries and what they mean.

It must be recognised, however, that accreditation does not exist in some countries (such as Sweden), and that there may be fears that accreditation might limit the potential to strive for excellence rather than merely meeting accreditation standards.

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:
The 'Bolkestein' Services Directive illustrated very effectively the problems that are caused by the "country of origin" principle. Without question, the country in which healthcare is provided must exercise clinical oversight of the services being provided, since these services will be offered in hospitals and by professionals of that Member State. It should be up to the purchaser, however, to ensure that the contract with the provider specifies the quality standards required.

Financial responsibility:
The extent and locus of financial responsibility depends on the type of cross-border healthcare, but in the majority of cases there should be a contract between purchaser and provider which should specify where financial responsibility lies. Such a contract should apply to bilateral agreements between countries, or to agreements between sickness/insurance companies in one country and provider(s) in another. It is the responsibility of purchasers and providers to ensure that they have a contract with the necessary provisions to cover the financial risks that may occur.

The problem in relation to financial responsibility relates to patients who, like Mrs Watts, travel to another country on their own initiative rather than through an intermediate purchaser. Such people do not fall under the E111 or E112 process, nor are they covered by contractual agreements between purchasers and providers. They are seeking treatment in another Member State on the basis of the rights accorded to them by the Internal Market. For such patients, there is a need for protection in case they experience medical problems on their return home as a result of treatment abroad. The risk is that either the patient or the patient's purchaser (even though that purchaser may not have been involved in the purchasing of care in the other Member State) may be expected to pick up the costs of treating the patient, perhaps as a result of inappropriate treatment in the other Member State. A major problem, however, will be to define whether subsequent medical treatment is directly related to the treatment received abroad or whether the medical problem could be regarded as a different discrete problem. There is a strong probability that such issues will lead to litigation unless the European Commission provides greater clarity but, even with greater clarity, it is likely that there will be disputes about cause and effect.

In addition to issues concerning medical problems after treatment abroad, clarity is also required concerning the provision and financing of normal treatment following a procedure carried out abroad. If a patient elects to be treated abroad, is the patient's normal purchaser required to provide and pay for follow-up treatment, even if this treatment is not normally provided by the country (or region) of residence?

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?

In circumstances in which the purchaser is purchasing care on behalf of patients, the purchaser should bear legal responsibility for ensuring patient safety and for ensuring redress for patients. In these

circumstances, the purchaser should enter into a legal contract with the provider, stating clearly where responsibility lies and for what. Given the variety and complexity of healthcare, the potential for European legislation to take account of every circumstance is extremely limited. However, it might be helpful to provide a template for purchasers in Member States to use as a framework.

In situations where the patient establishes direct contact with a provider (rather than going through an intermediary purchaser such as a sickness fund), it must be the responsibility of the cross-border provider both to ensure safety and to provide redress for the patient. European legislation may be required in order to ensure clarity in this respect.

When the patient accesses private care in another Member State through a commercial organisation (e.g. private intermediaries offering dental services in Hungary), such commercial organisations should assume legal responsibility on behalf of their clients, in the same manner as sickness/health insurance funds.

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)?

There is, once again, a distinction between Bismarckian and Beveridge systems. In Bismarckian systems, sickness funds will only engage in cross-border arrangements if the financial mechanisms are advantageous. It can be left to these sickness funds to ensure appropriate financial compensation.

Beveridge systems are likely, as the UK has done in the past, either to enter into bilateral agreements which take account of the financial implications, or to use the existing Regulation 1408/71 process, which already possesses financial provisions.

In general, however, there is little evidence that – thus far – patient mobility has had any marked negative impact on the provision of a balanced medical and hospital service accessible to all, with the exception of certain tourist areas (such as Andalusia or the Veneto region) where there may be a very marked seasonal increase in populations. While the additional costs incurred may be regarded as an investment in the tourism infrastructure (or as a loss leader), efforts should be made to ensure that reimbursement of costs is made to the institution that has incurred these costs, rather than remaining with the central administration. In some countries, this appears to be a flaw in the operation of the 1408/71 procedures.

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?

The movement of professionals is likely to become an issue of far greater significance than patient mobility, with poorer Member States suffering a loss of professionals to wealthier countries which can attract professionals with higher salaries, and with smaller Member States suffering a disproportionate impact to their health services if even a few professionals move to another Member State. Such losses may have a far greater impact on the provision of a balanced medical and hospital service than patient mobility. However, the principle of the free movement of people within the Internal Market is so firmly established that it is inconceivable that healthcare workers can be excluded from these provisions.

If the problems of professional mobility are, indeed, not amenable to Community legislation, perhaps the best that can be done is to develop a code of ethics concerning recruitment of professionals from

other Member States, which could be adopted through the Open Method of Coordination. While codes of practice for ethical recruitment already exist, and the European Federation of Nurses (EFN) has adopted a European good practice guidance on recruiting and retaining international nurses, there has been little effort either at national level (with some exceptions) or at a European level to ensure that these good practices are adopted. At some time in the (not too distant) future, Europe may become the "victim" of recruitment from other continents. Member States will then wish that they had upheld more ethical recruitment practices.

Professional mobility is also a global issue which may become significant in the context of WTO agreements. This would therefore require careful coordination with DGs Trade and External Relations.

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 determining future policy, it is important to recognise that in some countries all health and social care services fall within the authority of health services while in other countries the responsibilities are shared with social care. These differences will have consequences for cross border care, and these will have to be analysed country-by-country in order to ensure that any negative consequences are mitigated.

There is also a need to clarify the health and social welfare rights of citizens who transfer their residence to another Member State but then decide to return to their original country of residence, only to find that they have lost their entitlement to health and social services.

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?

A central (European Commission) process should be established to assess the impact that *potential* EU legislation might have on health services – an early alert system, and a coordinating centre for other health-related DGs (such as "Employment & Social Affairs", "Enterprise & Industry", "Research", "Market", "Information Society & Media", "Competition", "Trade"). Clearly, the requirement that the EU should make sure that a high level of health protection is ensured in the definition and implementation of all Community policies and activities is extremely important, but it is also very important that the Commission should analyse how Community policies and activities might impinge on the delivery of health services.

While the Commission formally relates to national Ministries of Health, an increasing number of countries are devolving responsibility for healthcare to regional governments or organisations. The European Commission should develop better mechanisms to enable regionalised healthcare systems (perhaps defined as regional healthcare systems which have their own Minister of Health) to have their voice heard at the European level. In particular, when the Commission or the Council addresses issues which impinge upon their mandate, the regions should be involved and consulted.

While some Member States might find this challenging, the European Commission should view and explain patient mobility as a benefit of EU citizenship.

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?

With the wide range of issues that need to be addressed, a package of tools will be required, including:

- legislation, to clarify previous developments (e.g., the ECJ rulings) and to draw the skeleton of the necessary framework;
- soft law and policies, such as data collection, early assessment of the potential impact of policies on health/health systems, the application of the Open Method of Coordination, accreditation; and
- direct communications with citizens.