UK consultation response to Commission Communication on Health Services

Summary

1. We welcome the opportunity to respond to the Commission's Communication on Health Services. This response takes account of the views of UK stakeholders that contributed to a consultation in the UK, and views expressed in the UK Parliament, following appearances by the Right Honourable Rosie Winterton MP, the Minister of State for Health Services, before both a House of Commons Standing Committee, and Sub-Committee G of the House of Lords European Union Select Committee.

   Minutes of the Commons appearance are available at the following web link:

http://www.publications.parliament.uk/pa/cm200607/cmgeneral/euro/070116/70116s01.htm

   Minutes of the House of Lords appearance will be published shortly at the following link:

http://www.publications.parliament.uk/pa/ld/ldeucom.htm#evid

2. This is an important piece of work. Member States face an increasing challenge in providing sustainable health services in the face of demographic ageing and globalisation. Cross-border healthcare, and non-regulatory cooperation, can add value to Member States' efforts in this field, provided that the fundamental rights of Member States for the organisation and management of their health care systems are respected.

3. Recent developments in the case law of the European Court of Justice, and the ensuing debates, have raised other, fundamental, issues:

   - The first is the underlying question of the wider impact of the Treaty on health systems. Here, we think it is important to continue the discussion that was started in the High Level Reflection process, and which was reflected in the Statement on Values and Common Principles that the EU Health Ministers agreed at the Health Council in June 2006. Further work is needed on how the impact of the Treaty might be managed to ensure that Member States continue to be able to discharge their responsibilities for the management and operation of the health systems of the European Union;

   - The second is the growing need now to address the tensions that are arising between the principles that underpin the long-standing EU Regulations in this areas (Regulation 1408, as recently amended) and the caselaw of the European Court of Justice. Although relatively few people are currently interested in going abroad from the UK in order to access treatment, there is considerable use made of other rules which

allow access to treatment while people are abroad. More work is needed, including at the Ministerial level, to ensure that this key practical benefit of EU membership is managed in a way that is financially sustainable for the longer term.

4. In that context the UK welcomes the Commission's launching of the debate on the specific issue of the terms under which patients access health care services when they travel elsewhere in the European Union, mostly at their own instigation, *in order to be treated*. There are some important specifics to get right in this area, and these form the main basis of our response to this consultation.

5. The Communication also flags the importance of non-legislative work in support of Member State action in the health care field (for example on centres of reference and on non-legislative guidelines for cross-border commissioning of services). The UK agrees that there is useful work to be done in this area, and endorses the Commission's view that this sort of non-legislative approach is more appropriate to this sort of work.

Detail

6. The UK is pleased to have the opportunity to respond to this Communication. The Communication essentially asks four questions, and we will respond to these questions in the rest of this document:

   - What is the current extent of cross-border healthcare / patient mobility?
   - What legal certainty is needed in this area?
   - What work can usefully be done through non-regulatory cooperation?
   - What sort of legal instrument would be appropriate?

What is the current extent of cross-border healthcare?

7. Whilst significant use is made in many Member States of the provisions under R1408 that allow EU citizens who are retired, working or travelling in other Member States to access healthcare in other Member States, the number of patients interested in going abroad specifically for treatment is relatively low in many Member States: in the UK, around 280 people went abroad for such treatment in 2005-2006.

What legal certainty is needed in this area?

8. The UK thinks that there are certain fundamental underlying principles that need to underpin, and be reflected in, any proposals in order to ensure a system of patient mobility that is manageable and sustainable in the long term, and also that respects the rights and responsibilities of Member State to organise and manage their health care systems:

   - The home health system in the individual Member State needs to be able to determine what health care services are offered to individual patients, and to manage the clinical decision about whether, given the

individual circumstances of the patient, 'undue delay' applies. In the UK this is done through referral processes as an integral part of the process of determining what health services will be offered to the patient. Such processes must be respected in any legislative proposals (this will require a development of the case law with regard to 'hospital' and 'non-hospital' services; see below).

- Patient mobility needs to be "cost-neutral" to the home health system: where patients choose to go abroad this shouldn't cost their home health system more than it would have done to treat them at home. Where the cost of treatment abroad is lower than at home, the home health system should only be required to pay for the actual cost of treatment.
- Clarification that, when patients request to go abroad in order to be treated (as opposed to services directly commissioned abroad), it is the standards of care, governance, and redress arrangements of the MS of treatment that apply: health systems can't take responsibility for the actions of providers they don't regulate or assess.
- A principle of transparency could be established making it clear what information should be made available to patients by providers before they travel abroad for treatment. This information should include: the nature of the service being offered; full costs; what is covered by consent; full details of what is included in the package; which systems of redress, care and governance will apply. What this means in practice may well differ substantially between Member States.
- That there is no 'requirement to treat' on MS receiving patients travelling abroad for elective treatment (in other words, that MS can prioritise their own residents above patients travelling to them specifically for treatment).
- The principles of equity and solidarity need to be respected with regard to patient mobility, thereby avoiding the risk of creating a system whereby those EU citizens who can afford to pay for services up front can access health care services faster than those with greater needs.

9. In terms of any specific legal action, it would need to be specific to three different types of patient mobility, and their practical handling:

    - Patient mobility where a patient goes to another EU Member State (MS) for a treatment that their insurer does not fund (e.g. cosmetic surgery), or their system does not provide (and is thus not entitled to reimbursement of costs).
    - Cross-border commissioning of services in one Member State by the health system of another Member State.
    - Patient mobility where a patient goes to another EU Member State for a treatment that their insurer will fund, or system will provide.

10. In the first case, where a patient is essentially self-financing, legal clarity on the standards, governance, and systems of redress that apply is needed; clearly these should be those of the MS of treatment. Any proposals could seek to clarify the information that providers are required

to provide to patients to enable them to make safe, informed decisions before purchasing health services from a provider in another MS.

11. For the second type of patient mobility, cross-border commissioning of services can be done mostly on an intergovernmental basis, although there may be a case for some limited European guidelines on this, e.g. reflecting the principle that national standards apply, and clarifying the duty of care that the commissioning authority has towards the patients it sends abroad.

12. Patient mobility where patients choose to go abroad specifically to receive treatment poses the biggest challenge. Although the current level of this sort of patient mobility is very low in the UK, this may not be the case in all the EU Member States. It may also be that this kind of mobility increases across Europe in the future. Any system that is put in place to facilitate patient mobility therefore needs to be both sustainable and flexible enough to take account of long-term developments.

13. We were surprised to see in the Commission's Communication the statement that the European Court of Justice has ruled that people may seek any 'non-hospital' care (to which they are entitled in their own Member State) in another Member State without prior authorisation. We do not agree with what the Communication says on this point. In fact the Court has said that it has yet to see a justification for a prior authorisation system for non-hospital care.

14. The Court has stated that prior authorisation systems were justified for 'hospital' services as they sought to ensure "*sufficient and permanent accessibility to a balanced range of high-quality treatment in the State concerned*"; that they assisted in controlling costs; and that they assisted in preventing "*any wastage of financial, technical, and human resources*". We think that this justification applies equally to some services that are delivered in a 'non-hospital' setting, as they require no less planning, funding, or careful management than 'hospital' services. Consideration should also be given to the drive in many Member States, including the UK, to move more services from being delivered in hospital to being delivered in a primary care setting.

15. European Court of Justice (ECJ) case law has stated that the decision as to whether a patient faces "undue delay" in accessing services should be based on "*an objective medical assessment of the patient's medical condition, the history and probable course of his illness, the degree of pain he is in and/or the nature of his disability at the time when the request for authorisation was made or renewed*" (*Watts,* para.119). The UK government is firmly of the view that this is a sufficient definition of the factors that need to be taken into account when assessing "undue delay". Any attempts to define the concept of "undue delay" further will contradict the logic of the ECJ case law, which is that it should always be clinically assessed against the needs and circumstances of the individual.

16. Any proposals on patient mobility should develop the existing case law on this point. In line with the key principles put forward in paragraph 8 of this response, the most effective way to do this would be to state the principle that prior authorisation systems are justified for treatments that are accessed on referral in the home Member State.

17. The basic principles of the system by which patients can access medical treatment in another EU Member State by way of entitlements under Article 49 of the Treaty differ from the basic principles of the system of referrals under Regulation 1408/71 ('E112 referrals'). This has the potential to cause confusion, particularly to patients (e.g. the reimbursement principles for the two systems are entirely different). One simple way of addressing this confusion for the circumstances where patients ask to go abroad would be to make the use of the E112 referral system optional for Member States. In the long term, the principles developed in the Court's case law (e.g. that reimbursable costs for mobile patients are restricted to the level that the treatment would have cost in the home Member State) seem a more sensible and sustainable basis to handle requests to go abroad for treatment.

18. In areas other than cross-border healthcare there are two issues relating to professional mobility that could be dealt with in legislation:

    - A duty on regulatory authorities to share information about current professional status on a proactive basis wherever possible, on health professionals moving between countries, in line with the "Crossing Borders" Edinburgh Agreement.
    - Clarification that Member States can require health professionals from overseas to be proficient in the language in which they will be working.

What work can usefully be done through non-regulatory cooperation?

19. The UK believes it would be appropriate to consider developing further the work of groups such as the Commission's High Level Group on Health Services and Medical Care, so that there will be a standing mechanism of Member State experts who can advise the EU institutions on the implications of EU activity and proposed legislation for the health systems of the EU.

20. The UK believes that there is much benefit to be gained from EU-level networking of clinical and health management professionals, and from facilitating the exchange of good clinical practice.

21. Cross-border commissioning of services, as referred to in paragraph 11 above, may be a fruitful area for developing information sharing systems, in order to promote intergovernmental cooperation. This kind of information sharing will also help to promote continuity of care in patient mobility, which is a key concern.

22. The UK is concerned about the risks of over-ambition in the area of the role of IT in cross-border healthcare. IT clearly has an important role in supporting the delivery of cross-border healthcare, and we support strategic development of the options that will enable this in the future.

23. However, it is important to understand that there are some very difficult problems to solve which are not directly related to the use of IT. These are evident, particularly in relation to ensuring confidentiality and security, and also in adopting common standards and clinical technologies. It is essential that we proceed cautiously and in full consultation with the appropriate clinical professions. Where IT is used to support cross-border care it must be effective, transport reliable and accurate patient information, and deliver real benefits to citizens moving between Member States. It must also take full cognizance of the legitimate concerns of citizens about the privacy of confidential health information. In particular, we see no case for a central data warehouse of information about patients.

24. When discussing the development of IT, the potential costs and benefits of any proposals must be very carefully considered.

What sort of legal instrument would be appropriate?

25. We can see potential value in legislation in this area provided that it helps health systems to manage requests to go abroad effectively, and provides legal certainty to patients: in practice, this means not just writing out the case law, but dealing with some of its underlying ambiguities.

26. It is important that any proposed solution is proportionate to the demand from patients. Whilst significant use is made in many Member States of the provisions under R1408 that allow EU citizens who are retired, working or travelling in other Member States to access healthcare in other Member States, the number of patients interested in going abroad specifically for treatment is relatively (very) low in many Member States: in the UK in 2005-2006 around 280 people went abroad to receive treatment in this way. However, this may grow: any system that is put in place to facilitate patient mobility therefore needs to be both sustainable and flexible enough to take account of long-term developments.

27. In the context of 27 different health systems, and in accordance with the statement of Values and Common Principles that EU Health Ministers endorsed in June 2006, the detailed implementation of any systematic approach to patient mobility will differ. The key aim for any EU-level proposal should be to ensure that such implementation does in fact happen, in accordance with the key principles listed in paragraph 8 above. Any proposals should be based on these high-level principles, and should not attempt to construct an overly-detailed system that would prove unwieldy or unworkable.

28. There would be very limited value in a proposal that simply transposes ECJ case law into legislation. There are real uncertainties that arise from

the existing case law that need to be addressed, for example the question of ‘hospital’ and ‘non-hospital’ care mentioned above. Clarifying these uncertainties is in the interests of both citizens and those planning and managing services.