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Betreft	Comment: LHV (Dutch National Association of General Practitioners) and NHG (Dutch College of General Practitioners) on Consultation regarding Community action on health services of 26 September 2006. And: Answers to the nine questions in the Communication

A. Introduction

The Dutch National Association of General Practitioners (LHV) and the Dutch College of General Practioners (NHG) in this paper give their opinion on the EU Consultation Paper (SEC (2006) 1195/4. The paper is directed at possible EU actions such as legislation on reinforcing cooperation between Member States on the harmonization of the rights of EU patients to be reimbursed for health care services received abroad. Secondly it is directed at possible EU action on the rights of health professionals to deliver health care in another EU country on a temporary basis (legal certainty and clarity).

The EU asks to send responses to the communication by 31 January 2006.
The LHV and NHG are planning to send a reaction to the European Commission and to the Dutch Ministry of Health.
The Brussels based Standing Committee of European Doctors (CPME) will also send a reaction to the EU Commission. The Royal Dutch Medical Association (RDMA) is member of the CPME.

B. General approach LHV and NHG

We applaud the good and welcome initiative of the EU Commission to make efforts for more streamlined and better cross-border health care for patients and health professionals. The jurisprudence of the EU Court on the reimbursement of costs of care in another Member-State should indeed be incorporated in the legislation of the Member-States. This is not something temporarily passing by, but a phenomenon gathering volume by the day.

In this reaction we will deal primarily with the issue of health professionals crossing borders. This subject somehow seems to be snowed under in the communication and taken along with the codification of jurisprudence. It however was an integrating part of the so called Bolkestein Directive on Services. The European Parliament has decided to delete the item of health care services from the Services Directive and to regulate them in a separate Directive.

We also want to deal shortly with the European and Dutch perspectives on general practice, the definition issue, ending with answers to the nine questions posed by the Commission.

C. The European GP Perspective

We will start with the definition of the general practitioner, as published in 2005 by WONCA EUROPE, the European section of the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners.

The following is a definition of the role of the family doctor which puts the characteristics of the discipline described above into the context of the practising physician. It represents an ideal to which all family doctors can aspire. Some of the elements in this definition are not unique to family doctors but are generally applicable to the profession as a whole. The speciality of general practice/family medicine is nevertheless the only one which can implement all of these features. An example of a common feature is that of the responsibility to maintain skills; this, however, which may be a particular difficulty for family doctors who often work in isolation.

General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health, preventing disease and providing cure, care, or palliation. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care.

D. The Dutch perspective

The Dutch perspective regarding the issue of health professionals crossing borders is that they in the framework of the subsidiarity principle should respect the organisation of health care in the host country. As in other Member States with referral and gate keeping systems and well organised primary health care like the UK, Denmark we in the Netherlands believe these systems ensure that patients make informed decisions about care they should receive. As the British Royal College of Physicians states in its reaction to the Commission in referral and gatekeeping systems health professionals assume greater responsibility for helping patients with complex and often multiple disorders to navigate the health system. In the Netherlands for instance general practitioners deal with around 95 % of all health complaints. In around 5 % of all cases the patient is referred to another medical specialist.
We believe a system of direct access to the other medical specialists may contribute to waste and duplication, without achieving health gain. With the Royal College we believe that mechanisms should be established that will not undermine gatekeeping systems in Member States that use them.

A very important related item is that these systems while being based on the rights of patients to accessibility and quality of care contribute substantially to upholding the payability and the financial sustainability of national health care systems. It contributes to maintaining also the option of free choice. Another important element in these health care systems is the regulation of the manpower planning. Constant monitoring the education capacity is necessary as seen from the rights of patients for good care. Too extensive market-activity could result in an unhealthy surplus of health professionals, a disproportionate supply, unnecessary and/or double treatments and consequently unnecessary and avoidable costs and possibly damage.

The coherence within these national systems is a condition for their existence and therefore is an important issue. It is important to realize that changing some of the elements of them because of an EU reason very well could have the effect of removing one or two cornerstones. The whole building could be at stake and collapse.

So we believe that it is in the interest of the patient that health professionals temporarily crossing borders respect the health care system in the host country. The patients lifelong have to do with their national system. The health professional knows that and should act accordingly. His actions should fit within the continuity of care and the quality system in the country of the patient. Patients simply are entitled to it. Normally care includes precautionary care and follow-up care. Health professionals crossing borders should be fully alive to the importance of this. Isolated care does not exist. Guidance and showing the way to patients are important elements in gatekeeping systems not for the sake of the professionals but of the patients themselves.
As last item in this paragraph we believe that well functioning Primary Health Care and Gatekeeping Systems are very important conditions to the good functioning of Public Health.
From a European perspective this is not an unimportant item.

E. Definitions

The EU must work with precise, clear and internationally workable definitions of hospital care and non-hospital care.
In the Netherlands for instance almost all other medical specialists other than General Practitioners have their premises within hospitals. In Germany and Luxemburg quite a lot of those other medical specialists have their own premises outside the hospital.
The costs of the consultation of a Dutch hospital based medical specialist include also some hospital costs, sometimes rather high. It however still concerns non-hospital care. These costs should off course also be reimbursed. The EU should as well address these kinds of problems in the coordination efforts.

The CPME already in 2004 has suggested a definition for hospital care, which seems quite adequate and seems to be workable whatever the differences between the national healthcare systems. "medical care under the supervision and responsibility of medical doctor(s) and provided in specific facilities where medical surveillance is available 24 Hours a day and which normally requires accommodation in the facility." In her comment to the Consultation the CPME states to intend to propose a revised definition.

Yet another suggestion: the Dutch National Health Care Board defines hospital care as care that includes staying in a facility during at least one night.

We propose to make a difference between hospital care where the patient stays in a hospital during at least one night versus non-hospital or outpatient care.

F. Health professionals crossing borders

The application of Community law on the activities of health care providers in another EU Member State in person or by e-mail should meet the next conditions:.

a. Conformation to the legislation in the host country, where the patient receives the service.
b. That legislation concerns competition law, tariff regulations, ethical issues, the treatment contract with the patient, the right to complain, disciplinary law etc.
   Aim is an identical position (rights and duties) of patients in relation to the health professional, whatever his nationality.
c. Notification to the Authorities in the host country when actually crossing the border in person. The Health Care Inspectorate should know who is acting in his country as a health professional.

d. So called mid-term quality guarantees concerning the abilities of health professionals is a delicate question. In the Netherlands we know the system of recertification of medical specialists every five years. In the case of GP's this in short implies a minimum amount of working as a GP (2 days a week on average during 5 years) and a minimum amount of hours of yearly extra education (40 hours per year) per every 5 years.
If a health professional wants to establish himself in another Member State, then his training history, such as basic and specialist training, are checked thoroughly. Although his continuing medical education (CME) history is not checked then, he or she will join the national recertification programs from that moment on. In the case of health professionals temporarily crossing borders there are no checks at all.
So some degree of harmonization on this point seems desirable. We believe it to be in the interest of the European population that there should be some kind of mandatory minimal system of CME and some kind of regular appraisal or certification.

The means to arrange this could be amending the new EU 2005/36 Directive on the mutual recognition of professional qualifications. As far as doctors are concerned this directive is limited to the qualifications of basic training and specialist training. Harmonization is a delicate question, as CME is a nationally inspired development. The United Kingdom for instance in the aftermath of the notorious Shipman case has dropped the system of regular recertification and mandatory hours of CME in favour of a system of regular personal appraisals with peer review. In Denmark there is no system of recertification, nor of mandatory CME, but only on a voluntary basis.

G. Answers to the nine questions posed by the European Commission

1. Nature and impact of cross-border healthcare

The effects on accessibility, quality and financial sustainability of national health care systems very well could be quite substantial in due time. Each Member State tries to limit the cost development of health care, but has to respect as well the consequences of the EU court decisions on reimbursing non-hospital and hospital care enjoyed in another Member State. Inclusion of that jurisprudence into the national legislation could effect more money and so could limit Member States in their cost containment efforts and in due time maybe also in maintaining a certain quality or a certain organisation of their nationally inspired health care systems. All this gradually could lead to more similarity between national health care systems and so to more harmonization. This however is not compatible with the EU principle of subsidiarity, that European action only should be allowed when a certain matter cannot be regulated at national level.
Possibly the hospital sector in the end will follow the non-hospital sector. For the sake of the financial sustainability of health care systems the systems maybe will have to grow to each other to keep them accessible and available for their own citizens. The subsidiarity here could be thinning.

As far as the quality of care is concerned we in the Netherlands believe that patients seeking care also in other Member States add to the problem as we call it of the "shopping" patient. The continuity of care and so the quality of care could suffer from this. This seems to plead at least for regulations or less infringing Community actions concerning duties for health care professionals crossing borders to inform the health professionals of the patient. One of these Community actions could be the starting of discussions on the admission to each others medical data and the promotion of their interchange.

2. Minimal information and clarification requirements to enable cross-border healthcare. What legal means and what practical information is needed?

Necessary in the field of legal clarification are:
- Clear definitions in EU legislation on hospital and non hospital care and undue delay.
- Clear legal texts in an EU directive on the core of the court rulings on the reimbursement issue and clear explanatory memoranda.

Necessary is on the field of practical information:
For patients:
- actual information on possibilities of care abroad by means of een clear unequivocal national portal.

For health care professionals:
- actual information on a certain, maybe limited set of rules and best practices and expected tasks and duties in the host country by means of a national clear portal in their own country.

For health insurers:
- actual information on prices and quality of care in other Member States.

For National Authorities:
- availability to foreign health professionals of actual information on national rules and best practices and expected tasks and duties to the health professionals crossing borders such as reporting to the National Authorities and the Health Care Inspectorate.

3. Identifying the competent authorities and their responsibilities. Which issues are the responsibility of which country?

- The host country as a duty to its own citizens should be responsible for the quality of care in a broad sense delivered on its soil. So also for cross border health service by a foreign health professional while crossing borders. Clinical oversight should be the task of the host country. Not only the whole range of health legislation in the host country should be respected, but also the organisation of the health care in the host country should be taken full account of. In the Netherlands for instance the role of the primary health care (PHC) and the central position of the general practitioner within the PHC and health care in general are key issues in the health care system and should be respected by health professionals crossing Dutch borders in person or by service only.
  Information of this kind should be easily available for health professionals in their own country.

- The host country in this case will have to reimburse the costs for the cross border service, but preferably along the lines of the national reimbursement system in order to safeguard the principle of equal treatment of civilians by governments.

- This off course is not applicable in the case of use of services abroad.
  The same is applicable in the case of permanent presence of a service provider in another member state. Then the rules of EU Directive 2005/36 are applicable. When he is recognized in the host country the host country has become the home country.

4. Responsibility for harm caused by healthcare and compensation arising from cross-border healthcare

Patient safety should at all times be the responsibility of the country on whose territory the service is provided. This is an obligation of the national state towards its citizens. This should be extended to non nationals staying in their country. Member States have to cooperate to enable each other in realizing this responsibility.

The second half of question four asks for suggestions on how redress for patients should be insured, if patients suffer harm.
We believe that it should be the duty for all health care professionals to be insured properly for their liability, whether their patients live in their own country or abroad. This should be the responsibility of the Member State of origin. Promoting this very well could be a subject for the system of the open method of coordination between Member States. Maybe one should be prepared to consider the means of an EU Directive on this point.

5. Ensuring a balanced healthcare accessible to all

The question for what action is needed to ensure the financial sustainability of well balanced national health care systems in countries where much health care is delivered to patients from other Member States is primarily the responsibility of those countries themselves. Possibly they can build into the tariffs for patients from other Member States some kind of extra compensation to the benefit of the sustainability of their own system.
EU citizens will be crossing borders more and more and so the need for medical services abroad will grow. The same could go for crossing border medical services. The open method of coordination possibly could stimulate Member States to join forces on possible scenarios for the future. Eyes should not be shut, but wide open.

6. Other issues not already addressed by Community legislation?

This question partly is answered in the answer to question 3:
In case of cross border services delivery we have addressed duties such as the respecting of the legislation and the health care system of the host country. Directly connected to this is the problem of the upholding of this kind of obligations. What kind of sanctions could be optional? Which Member State should be responsible therefore? We wonder if these sensitive questions could be subjects for non legislative options, to be discussed in the High level Group on health services and medical care.

7. Other issues.

No remarks

8. Support to Member-States?

As stated in the answer to the first question we believe one should be aware that active European action in helping Member States in dealing with consequences of cross border healthcare very well could contribute to some kind of harmonization of health care systems.
As one has to face facts we nevertheless we would suggest the High Level Group on health services and medical care to map out the main problems and go on identifying areas for non-legislative options. Secondly the High Level Group could also elaborate on the possibility of a more formal framework as a possible alternative.

9. Options for European instruments?

We believe that tackling at EU level the different issues relating to basic rights and duties of individuals, should be in the form of legislation, accompanied by a clear explanatory memoranda. Less stringent means should be applied like the stimulating of discussions on coordination and common frameworks in order to help Member States in looking forward to and preparing for more integration of nation health care systems.

Sincerely yours,
also on behalf of the NHG,

osmalen, MD, GP
ubstitute General Manager
Dutch National Association of General Practitioners