

The **Women's** Health Council
Comhairle Sbláinte na mBan



Submission

EU Commission Consultation

Community Action on Health Services

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The Women's Health Council

The Women's Health Council is a statutory body established in 1997 to advise the Minister for Health and Children on all aspects of women's health. Following a recommendation in the Report of the Second Commission on the Status of Women (1993), the national *Plan for Women's Health 1997-1999* was published in 1997. One of the recommendations in the Plan was that a Women's Health Council be set up as 'a centre of expertise on women's health issues, to foster research into women's health, evaluate the success of this Plan in improving women's health and advise the Minister for Health on women's issues generally.'

The mission of the Women's Health Council is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland. Its membership is representative of a wide range of expertise and interest in women's health.

The Women's Health Council has five functions detailed in its Statutory Instruments:

1. Advising the Minister for Health and Children on all aspects of women's health.
2. Assisting the development of national and regional policies and strategies designed to increase health gain and social gain for women.
3. Developing expertise on women's health within the health services.
4. Liaising with other relevant international bodies which have similar functions as the Council.
5. Advising other Government Ministers at their request.

The work of the Women's Health Council is guided by three principles:

- **Equity based on diversity** – the need to develop flexible and accessible services which respond equitably to the diverse needs and situations of women
- **Quality** in the provision and delivery of health services to all women throughout their lives
- **Relevance** to women's health needs

In carrying out its statutory functions, the Women's Health Council has adopted the WHO definition of health, a measure reiterated in the Department of Health's 'Quality and Fairness' document (2001). This definition states that

'Health is a state of complete physical, mental and social well being'.

Introduction

The Council welcomes the consultation on Health Services and the European Commission investigations on how to best integrate them within a European perspective in order to maximise the benefits for patients. While we see the potential for great improvements in the access and quality of care from many of the proposals suggested in the consultation document, it is paramount that patients' interests, such as their safety, their ability to access information, supports, and redress remain at the forefront of any initiative stemming from this consultation process. In this regard, we have some concerns directly linked to a number of the specific questions listed in the document, but we also wish to raise some issues which have not been addressed but which also require close attention in the implementation of any new proposals, such as the need for gender mainstreaming in health services provision and administration.

Legal Certainty

Question 1 – *What is the current impact of cross border healthcare on accessibility, quality and financial sustainability of the health systems, and how might this evolve?*

The Council wishes to bring the attention of the Commission to the very insightful report by Rosenmöller, McKee and Baeten (2006) which illustrates a number of diverse case studies on cross-border health initiatives throughout the European Union (EU) as well as providing very clear recommendations for their future development. Because of their relevance and evidence-based approach, we feel it is worth reiterating them:

- Patient mobility should be managed, i.e. it cannot be left to market forces but requires the input and engagement of national health care providers.
- Patient mobility requires trust. In order to foster trust it will be necessary to establish some mechanisms to ensure adequate standards of health care quality across the EU.
- Patient mobility should clearly define specific arrangements necessary to support the mobile patient, in relation to matters such as transport, language and accompanying persons.
- Patient mobility should ideally be integrated into larger forms of cooperation involving providers of both countries. Referring providers may need to assume responsibility for care prior to and subsequent to travel.
- Patient mobility should be based on prices set in a manner that is transparent and which minimises incentives and distortions to the market.
- The competent authorities or purchasers should define explicit eligibility criteria for patients who go abroad specifically to obtain treatment.

Closer to home, in the same report, an analysis is also provided of cross-border care in Ireland by Jamison, Legido-Quigley and McKee (2006). They found very limited evidence of cooperation despite official approval for it at government level on both sides. Their recommendations included the following:

- greater clarity on the objectives of improving cooperation and the obstacles to be overcome in achieving this improvement.
- Both jurisdictions to have funding flexibility and the capacity to facilitate it. They found that the funding system in both jurisdictions currently carries no incentive to good performance.
- Cooperation should be mainstreamed at national, departmental and local level.

- Research is needed in this area and priority for funding should be given to projects comparing the effectiveness of the two systems.

On a smaller scale, a study on the impact on the border on women's health is being conducted by Derry Well Woman in conjunction with the Institute for Public Health in Ireland and due for publication in May 2007. The findings of this study could provide useful information in term of the practical implications of cross-border healthcare.

Question 2 – *What specific legal clarification and what practical information is required by whom to enable safe, high quality and efficient cross-border healthcare?*

The priority in setting up new proposals for cross-border care should be to provide very clear indications as to what “undue delay” and “medically accepted waiting time” mean. These were the phrases used in the European Court of Justice ruling on the Watt case. However, as the case proved, these concepts can be interpreted differently in different countries and thus do not provide a transparent concept for patients. Of course, each clinical case is different and strict guidelines cannot be issued; however, patients should be able to access information as to what “undue delay” and “medically accepted waiting time” might mean in relation to the most common conditions as well as in the different European jurisdictions.

Health information in general must be disseminated by the European Commission. The Commission should continue to encourage Member States to participate in data gathering and research aimed at producing comparable statistics easily accessible to all European residents. In this regard, ongoing projects such as the European Community Health Indicators and Monitoring (ECHIM), the European Health Interview Survey and Examination (EHIS and EHES) should be strengthened to ensure participation by all Member States. Comparable data must also become available in relation to health systems performance to promote best practice and aid mobile patients in their choices. An information campaign aimed at communicating European residents their rights and entitlements in relation to health care abroad must also be organised.

As mentioned above, the issue of prior and after care is also one of key concern to ensure patients' trust in patient mobility measures and well as their safety. In terms of liability, clear and transparent procedures must also be in place to ensure that patients can access reviews and redress promptly and without undue bureaucratic and legal complications.

Finally, the issue of payment is also one of concern. The current arrangements, which entail the reimbursement of out of pocket expenses, clearly act as a barrier to access to foreign care by the less well off and more vulnerable. The new proposals should ensure that the financial arrangements in place do not discriminate access to care according to socio-economic status, gender, age or any other criteria, but ensure that all European citizens are able to avail of cross-border care when needed.

Question 5 – *What action is needed to ensure that treating patients from Member States is compatible with the provision of a balanced medical and hospital services accessible to all?*

The Council is pleased to note that the EU Commission supports a commitment to “providing high quality health care accessible to all” by Member States (European Commission, 2007), and note that according to EU policies “low income or lack of money should not bar anyone from obtaining the health and long-term care that he or she needs” (ibid.). In light of the reform process taking place in many EU Member States in relation to healthcare provision, the Council wishes to highlight some key trends which have been identified through international research. There is substantial evidence that taxes and social insurance schemes provide the most equitable basis for health care financing (Health Evidence Network, 2005). Other schemes, such as private insurance and direct out-of-pocket payment, are likely to increase inequities, particularly in access to care and health-seeking behaviour and this may affect women more, as they generally have fewer financial resources. These findings are highly significant both in terms of the need for cross border health care to be ‘managed’ as recommended earlier, and of the financial arrangements for them, i.e. out-of-pocket arrangements are likely to increase health inequalities and should therefore be discouraged for mobile patients.

Support to Member States

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?*

One of the Council’s key concerns in relation to the issue of patient mobility is the need to take gender into account in any proposals that will lead and regulated this sensitive area. The European Commission has shown continued commitment to the issue of gender equality and for the first time it included the realm of health as one of concern in terms of gender in the *Roadmap for equality between women and men 2006-2010* (2006). In its Conclusions on Women’s Health, the Council of the European Union also emphasised the need to take gender into consideration in all aspects of health (2006). Hence, it is crucial that a gender sensitive approach is adopted in drawing up any new proposals in the area of patient mobility.

This is particularly important due to evidence which suggests that women are currently discriminated in terms of access to proper care in Europe (European Parliament, 2005). Irish evidence also points to the fact that, for instance, women who suffer heart attacks wait longer to be assessed, admitted and receive treatment than men with the same condition (O’Donnell *et al.*, 2005). Similar discrimination has also been identified in relation to dermatological and ophthalmic care (European Parliament, 2005).

Moreover, research dealing specifically with waiting times for total joint arthroplasty (TJA) (i.e. hip and knee replacements) carried out in Canada revealed some further evidence of gendered patterns of care: despite reporting greater pain and disability than men, women more often wait longer to be referred to orthopaedic surgeons, and to be referred to surgery (Jackson, Pederson and Boscoe, 2006). Hence, how ‘wait time’ is defined obscures the differences in men’s and women’s ‘patient journey’ through the health care system. Gender-sensitive diagnostic and referral tools must be developed and implemented to ensure that the women and men who need



medical intervention receive it in an equitable manner. Clinicians must also receive gender training to develop their knowledge of gender patterns in care-seeking, symptoms presentation, and prior and post-interventions needs.

The Council looks forward to the establishment of the EU Gender Equality Institute in Vilnius and wishes to reiterate the need to include health within its remit. The Institute could then monitor patient mobility initiatives to ensure that they are implemented in a gender-sensitive way and sponsor research in this field, such as the one mentioned above. It could also promote the introduction and strengthening of gender training modules in European medical schools to increase clinicians' awareness of gender-based issues. Finally, the Institute could support the introduction of gender budgeting in the realm of health care to ensure that national and European investment in this field does not discriminate along gender lines. The Women's Health Council's expertise is at the disposal of the Institute and the Commission in relation to any gender-based or women's health issue affecting either patient mobility or any other area of their work.



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