

European Community Consultation regarding Community action on health services NHS Confederation response

Summary

The NHS Confederation is responding to this consultation on behalf of the National Health Service in the UK. Our response is structured in terms of seven principles, which we would urge the European Commission to uphold when considering any action on health care.

The NHS strongly supports the EC's decision to bring clarity to the management of patient mobility, as conflicting obligations under the principles of subsidiarity and of free movement are of current concern to many NHS organisations.

We would urge the Commission to keep the interests of all patients central to its actions; not only those patients who are aware of their opportunities and who can afford to travel. To this end, no action designed to aid mobility should disadvantage the vast majority of EU citizens who receive care in their country of residence.

We strongly welcome the EC's recognition that the right of member states to plan, fund and deliver health care services to their own populations must not be jeopardised by unpredictable flows of patients to and from other countries. To this end, we believe that prior authorisation for both hospital and non-hospital procedures is a necessary tool to ensure financial sustainability of health systems.

1. Background

1.1 *About the NHS Confederation*

The NHS Confederation welcomes the opportunity to respond to this important consultation on behalf of the National Health Service (NHS) in the United Kingdom.

The founding philosophy of the NHS, and one that still applies today, is the provision of health care to the whole population which is free at the point of use. As such it is wholly publicly funded, principally through tax revenue. This is a principle that we would like to defend within the context of this consultation.

The NHS Confederation is a membership organisation covering all types of statutory NHS organisation, comprising over 90% of NHS organisations in the UK. These organisations are providers and commissioners of all health care services including acute, elective, mental health, primary and long term care services. NHS Employers is the arm of the NHS Confederation which represents and acts

on behalf of NHS organisations as employers (and collectively as the largest employer in Europe).

The NHS Confederation together with NHS Employers is active in European level health activity in three capacities:

- UK representative organisation within the European Hospital and Health care Federation (HOPE);
- member of the European Centre of Enterprises with Public Participation and of Enterprises of General Economic Interest (CEEP) (which represents European Public Sector Employers) and currently hold the Presidency of CEEP UK;
- Chair of the European Hospital and Health care Employers' Association (HOSPEEM).

1.2 Assumptions behind our response

In responding to this consultation, we assume that the main issues for clarification surround patients who choose to go abroad for treatment, or whose funding bodies decide to send them abroad. The issue of patients' right to redress is primary in this context.

Emergency care in another member state, care whilst travelling, as well as arrangements for retirees and pensioners, are covered in existing regulations and therefore will not be addressed in this response.

1.3 Collection of our members' responses to the consultation

This response is submitted on behalf of our membership of NHS organisations, the corporate views of which have been gathered via consultation events and written submissions. This document will refer to our membership as "the NHS" or "NHS organisations".

1.4 Characteristics of the responses

In general the idea of patient mobility is supported as an extension of patient opportunities to choose the most appropriate treatment or care for their problem. Patient choice is at the heart of current reforms in the National Health Service.

In addition, the potential opportunities for NHS providers to expand their business into Europe were welcomed. Increasing numbers of organisations may wish to take advantage of this mobility, especially as they are adopting a business model which gives them considerable freedom to choose to gain income in this way.

However, this support was tempered by concerns about:

- The risk of increasing inequalities by providing opportunities for faster access to those able to choose and afford to travel;
- the difficulties of practical implementation of widespread patient mobility to have the greatest benefit for the patient (not least in terms of risks to the patient in terms of safety and quality);
- the resource (time, staff and financial) burden that any large scale mobility out of and into the UK could potentially create for individual organisations;

- lack of mechanisms available for quality assurance.

The *Watts* ECJ judgement of May 2006 was a “watershed moment” for the NHS. It has left NHS organisations in “legal limbo”, where the Treaty of Rome’s free movement provisions and the principle of subsidiarity create contradictory obligations.

The NHS is clear that Community action should be limited to framework level only. This would allow member states to clarify their legal position, whilst retaining flexibility of application by member states on a local level.

1.5 *The current impact of EU patient mobility on the UK*

Scale of movement

During the financial year 2005-6, a total of 281 cases were approved under E112 provisions for treatment in other member states. Pilot schemes for orthopaedic and cardiac procedures have been carried out in the South East of England with 917 orthopaedic patients being treated in France, Germany and Belgium.

These figures are not reflective of the thousands of UK citizens who make the trip to Europe for treatments (especially cosmetic surgery) in private establishments each year, without claims against the NHS. As more people become aware of their rights to choose treatment abroad under E112 provisions, claims on the NHS for these types of treatments may increase.

Financial implications

It is difficult to obtain figures for numbers of EU citizens receiving care and treatment from the NHS not covered under reciprocal EHC agreements (and for which the NHS makes claims from another MS). However, in 2005-6, total UK claims against other member states totalled £35m.

As increasing numbers of UK citizens take advantage of cheap flights for holidays in Europe, and more pensioners choose to retire in other member states, the UK’s bill for treatment abroad under E111 and E112 provisions is rising rapidly. In 2005-06 this stood at £463.1m, and the Department of Health estimates that this figure will rise to around £641m for 2006-07.¹

The impact of EU citizens coming for treatment in the UK is principally felt by NHS organisations in London and close to principal ports of entry. One organisation with hospitals near to a major airport reported that they have incurred substantial deficits due to unpaid claims against other countries (both within the EU and outside) for treatment they have provided.

Some organisations have reported that the process for gaining recompense from other member states is particularly unclear and would welcome some form of overarching agreement that could be agreed prior to referral with the “sending” organisation. This could be facilitated by prior authorisation and “preferred provider networks” outlined in section 2.2 on subsidiarity below.

Impact on quality and accessibility

¹ Figures in this section obtained from Department of Health’s written evidence to *House of Commons Health Committee, Public Expenditure on Health and Personal Social Services 2006*, London: TSO, 21.11.06, s. 3.3.3

The aim of any European action on health care must be to improve the experience and outcomes for the patient, but this action must not compromise the quality of care for any other patient, particularly in the case of vulnerable groups who are less likely to be able to exercise choice.

At present NHS organisations are concerned that an increase in patients coming to them for treatment from the EU will undermine their efforts to improve their performance, particularly in terms of waiting times. There should therefore not be an obligation placed upon providing organisations to give treatment or care to citizens from other member states in the case of planned care. Patient mobility has the potential to improve quality of care only where there is spare capacity in the “receiving” organisation.

From the point of view of the patient seeking treatment in another member state, the decision carries with it a number of risks which inevitably are to the potential detriment of patient experience and outcomes and therefore to quality of health care. These are outlined under point 2.1 below.

2. Proposed principles for Community action on health care

These are the principles which the NHS would like to see upheld when the European Community is preparing action on health care.

The central issue to be addressed in this consultation is the reconciliation of free market principles with the right of member states to plan, fund and maintain the sustainability of their health care systems.

We would suggest that the Commission should be guided by the fundamental principles outlined below:

- 1 Acting in the best interests of patients
- 2 Upholding the principle of subsidiarity through prior authorisation
- 3 Upholding the principle of *caveat emptor*, “buyer beware”
- 4 Ensuring equity of access
- 5 Ensuring transparency
- 6 Ensuring sensitivity to differences between conditions and treatments
- 7 Limiting financial and human resource impact on member states

2.1 Acting in the best interests of patients

The “sending” health care systems and the patients themselves should only opt for treatment abroad after weighing up the potential risks and benefits. Although for some elective surgical procedures with low risk of complication, there will be benefits to individuals in terms of speed of access and perhaps presence of relatives for support, there are substantial risks to patient mobility. These are firstly risks of increasing health inequalities (see 2.4 below), and secondly personal risks to the patient.

We would urge that “undue delay” for treatment not simply be classified in terms of time. Clinical advice regarding level of pain, quality of life, likely prognosis and other clinical factors should inform decisions about whether “undue delay” has occurred. This clinical need must also be balanced against the risks of travelling to receive treatment.

At present there is a substantial risk of poorly informed patients experiencing a lower standard of care or treatment than they had expected; this situation has been documented by UK couples travelling abroad for fertility treatment. Communication problems and cultural differences may not only lead to a difficult experience of care but more importantly to significant safety risks.

Inappropriate discharge and negative impact on continuity of care are other risks that the Commission should consider. Problems of fitness to travel after treatment may also arise.

2.2 Upholding subsidiarity through prior authorisation

NHS organisations felt that the principle of subsidiarity must be upheld to ensure the financial sustainability of member states' health systems as well as equity of access to health care for home citizens. Their right to plan the prioritisation of resources within a cash-limited system can only be protected if a strict process of prior authorisation is applied.

- Existing gate-keeping structures for referrals (in the NHS, this is principally the General Practitioner) must be respected. If referral abroad is recommended, specialist input may then be required to make sure that this decision is in the clinical interests of the patient.
- If citizens of a member state are not entitled to receive a particular treatment or intervention paid for by their home health system, they should not be entitled to receive it in another member state.
- Recent ECJ judgements have established that the prior authorisation process is only merited in the case of a person seeking hospital care in another member state. We would propose that prior authorisation requirements be extended to non-hospital health care.
- There are many packages of care which involve components outside of hospital, and many treatments which do not necessitate inpatient care but that can be defined and priced. With medical advances, increasing numbers of procedures can be carried out on a day case basis and in non-hospital settings, but these are not without risk and must be deemed clinically necessary through the prior authorisation process. Examples include angiography and scans involving large amounts of ionising radiation (such as whole body scans). Free access without authorisation to such treatments would constitute a serious financial threat to health systems and would undermine their ability to plan resources.
- The decision to approve a citizen accessing both hospital and non-hospital care in another member state should be taken jointly by the funding body of the "sending" country and by clinicians involved with that case, as well as the patient who has been furnished with all information regarding the risks involved.

The prior authorisation of treatment is in the patient's best interests as it offers an opportunity for all parties to come together to set out and agree the following:

- a. The potential risks to the patient;
- b. what the funding body can expect from the provider in terms of the exact contents of the package of care and the costs;
- c. quality assurance for patient and funding body and the outcomes they can expect;
- d. what the patient can expect to happen at different stages of the care pathway, and fees for which they may be liable;
- e. the responsibilities and liabilities of all parties in terms of safety, quality, outcome, after care, redress and complaint.

Preferred provider networks

NHS organisations felt that while it may be desirable, a contract for each patient's treatment prior to referral would not be practicable. The prior authorisation process could be facilitated more efficiently through funding organisations defining a "preferred provider network" across other member states. This would enable publication of information about this limited number of providers to inform patients and funding decisions. In this way the process would become transparent and responsibilities and liability defined at the outset.

2.3 Responsibility and liability

NHS organisations hope that the European Commission will provide confirmation that it is the legislative framework and systems of regulation, standards of care and governance, and codes of safety, of the country of treatment that would apply. There should be no redress for patients against home health care systems as long as a prior agreement with a preferred provider had set out liabilities before referral (see above).

The "sending" health organisation should have some mechanism to ascertain the quality of services available in the "receiving" provider - particularly when selecting preferred providers. Rather than formal standards and regulations on quality, we would welcome the development of EU wide quality benchmarks within an evidence based framework. Rather than enforcement by inspection against standards, this benchmark approach would allow providers to give quality assurance through demonstrating achievement of these benchmarks. This may act as an incentive for improvement. Whilst the NHS would support such benchmarks, it would not support the development of any type of EU-wide health regulation system.

In cases where complications arise after return home as a result of treatment received abroad, there should be a means of the patient's home system claiming compensation for any remedial action they need to take as a result. There may be a case for contesting the appropriateness of discharge.

Any agreement between funding body and provider should make clear the responsibility for follow up and after care. Not making arrangements for this before referral would risk the patient not being followed up after return home.

Some clinicians are concerned about the point at which their duty of care for a patient would stop, if they were referring them for treatment abroad. It was felt that a situation in which patients had redress against a referring clinician

or organisation when things go wrong would be untenable and that clinical responsibility lies with the provider of treatment.

2.4 *Maintaining equity of access*

NHS organisations strongly argue that their ability to provide the best possible service to UK citizens based on their clinical need, not their ability to pay, must continue to be the fundamental principle upon which they organise and prioritise care.

European Community action must not unintentionally result in a system where free movement and quick access to health care can be achieved by those most able to research their choices and those most able to afford to travel. In the UK, some hospitals with spare capacity that is not being purchased for UK citizens are concerned about the ethics of accepting patients from other member states who would essentially bypass waiting lists and be seen before UK citizens, regardless of clinical need.

2.5 *Ensuring transparency for the benefit of patients*

Over-arching agreements between funding organisations in the “sending country” and a network of “preferred providers” in other member states would facilitate greater transparency. Becoming a “preferred provider” would entail providing information about services available, standards, care package contents, liability and responsibilities. Information should also be provided about the regulatory and legal framework under which such organisations operate.

Exchange of patient information between “sending” and “receiving” countries presents issues of confidentiality as well as the potential for confusion. An expensive EU-wide IT system would not be the best way to solve this problem and it may well be that information exchange has to happen on a case by case basis between clinicians. Such information requirements could again be part of the agreement between sending and receiving organisations.

2.6 *Sensitivity to different considerations for different conditions and treatments*

“Health care” is a complex and highly differentiated function; different conditions and different treatments would require separate consideration under any EU guidance. This is not limited to the present differentiation between hospital and non-hospital care.

NHS organisations would urge that any guidance or legislation drawn up at Community level must recognise the very complex nature of “health care” as a function. Unfortunately the decision to view health care as a service to be bought and sold has led to a dangerous tendency to assume that all types of intervention and care provided under the health care banner can be subject to the same assumptions and rules.

Different conditions and different modes of treatment may need to be considered separately in guidance and legislation, in close consultation with experts in each field. If one considers the differences between two conditions,

the need for this sensitivity in the processes surrounding patient mobility will become clear.

The care and treatment provided for a person with a hernia and for a person suffering severe depression both fall under the label of “health care”. However, a hernia repair is most often a simple defined procedure (one on which there is not much disagreement between surgeons from different countries). It can be dealt with in day case surgery with perhaps one follow-up appointment, with full recovery expected within a few weeks. As such, the implications for the patient of treatment abroad would not be great

Severe depression may be a lifelong episodic condition requiring different levels of intervention at different stages in its progress, and long-term follow up and preventive work is likely to be required following an acute episode. In contrast to the hernia repair, models of care are not uniformly agreed between two psychologists in the same clinic, let alone in different countries.

Rather than being based on undisputed evidence, choice of model of care often depends on the personality of the patient, the standpoint of the clinician, and the prevailing government policy at that time. When it comes to agreeing care packages and prices for such interventions abroad, it can be seen that this situation is much more complicated and variable than that of the hernia repair.

Such considerations would apply to other mental health conditions and many chronic conditions such as diabetes.

2.7 Limiting financial and human resource implications for member states

Finance

As the EU does not pay for health care, it should not take action which will have significant financial or human resource implications for health systems or individual health organisations.

Proportionality must be maintained when action on a European level is considered. Even if the estimate of 1% of health care spending overall being on treatment provided in another country is accurate, any action intended to clarify the management of this 1% must not have any unintended adverse consequences for the remaining 99%.

Any move to support increased patient mobility must be accompanied by stringent and enforceable processes for “receiving” organisations to be paid; if these are not in place with penalties for late payment, financial stability of health systems is severely compromised.

Some believe that the effects of patient mobility are likely to have far less impact on member states’ health systems than professional mobility. Work on developing core competencies for different professional groups across the EU is underway.

Human resources

In terms of human resource consequences of Community action, it must be borne in mind that training of any health care professional is a long process and represents a substantial investment on the part of governments.

Cross border health care will raise significant issues around the training and resourcing of health care staff. Any significant increase or decrease in the numbers of patients in any member state could cause serious problems in managing the workforce.

Many EU countries participate in ethical recruitment policies which encourages health care professionals to remain in their country of training, particularly where there are shortages in that country. Through membership of HOSPEEM, the NHS Confederation / NHS Employers is working together with other European hospital and health care employers and the European Federation of Public Service Unions (EPSU) in the Hospital Sector Social Dialogue Committee to find solutions to the problem of recruitment and retention of staff that some countries (particularly the accession states) are experiencing.

An increase in the numbers of patients seeking treatment in other member states will also raise issues around the communication and the training of staff. If staff can not speak the language of the patients they are treating then this may lead to an increased need (and potential increased cost) for language and interpretation skills. Staff may also require increased training and new skills in order to better treat patients from different cultural backgrounds.

We feel patient safety is paramount and that some action will be needed to ensure that dangerous professionals can not cross borders and that incidence of professional misconduct or criminal behaviour by health care professionals should be accessible across the EU.

Conclusion

The NHS is strongly supportive of the principle of patient mobility when it is clinically necessary and in the best interests of the patient. NHS organisations can also see future opportunities to start to provide high quality care in other countries.

We have suggested ways in which patient mobility can be facilitated in the best interests of patients whilst allowing health systems to continue to provide timely and appropriate care to home citizens. We have argued that avoiding unnecessary risks to individual patients as well as protecting the financial sustainability of health systems will be greatly aided by upholding the seven principles described in our response.

The importance of ensuring equity of access within member states, provision of transparent information about risks and about providers, and clarification that responsibility and liability for regulation, standards and redress lie with the member state hosting treatment, are central to this response. We have also outlined practical considerations such as the expansion of the prior authorisation process and the concept of preferred provider networks.

Perhaps most importantly the NHS would argue that any European level action should be restricted to guidance and framework level legal clarification only, so that member states may appropriately apply such frameworks to their different circumstances.

NHS Confederation

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