Commission Communication on consultation regarding Community action on health services: Response of the Finnish Government

The Commission undertook in its 2007 Annual Policy Strategy to develop a Community framework for safe, high quality and efficient health services, by reinforcing cooperation between Member States and providing clarity and certainty over the application of Community law to health services and healthcare. For this purpose the Commission has on 26 September 2006 issued a Communication on consultation regarding Community action on health services (SEC 2006 1195/4).

In the following the Finnish Government answers the questions presented in the Communication. The responses have been prepared in the normal coordination process of European Union affairs, that is, they have been discussed in the EU Sections dealing with health and social issues as well as social security of migrant workers, the EU Affairs Committee and the Ministerial level Cabinet Committee on European Union Affairs. Certain bodies that participate in the EU Sections have also submitted their own views on the Commission Communication.

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?

On the whole, the effects of cross-border healthcare are minor in Finland. Annually only around 10–20 Finnish patients seek care in other EU/EEA countries or Switzerland on the grounds of the social security coordination regulation (E112). The Finnish health insurance system also reimburses costs for the treatment of patients, who without prior authorisation have sought care in a EU/EEA country or Switzerland. There are, however, no comprehensive statistical data on these cases. In some cases Finnish hospitals have also purchased services from other Member States, i.e. they have sent patients to receive treatment in hospitals in other countries. Usually such cases concern specialised medical treatment that is not available in Finland. The volume of such cases is also low.

To large extent the situation has remained unchanged during the whole of the Finnish EU membership. The low volumes of patients seeking care abroad are to a degree influenced by long distances, language problems, trust in the Finnish health system, etc. Finns are not eager to seek care far away from their homes even within Finland. For example, when hospitals have reduced their waiting times for treatment, they have offered patients care in other Finnish hospital districts (hospitals). However, over half of these patients refused to accept care in a neighbouring hospital district. Another example shows that around 90 per cent of elderly patients queuing for cataract surgery refused care in another hospital situated 200–300 km from their homes, even though they would have gained access to care more quickly than in their own hospital.

Respectively, annually around 10–20 patients from other countries seek care in Finland. However, there are a considerable number of persons, who reside temporarily in Finland due to work, studies or other reasons and who either live permanently or are insured in another Member State. The costs incurred by the treatment of these temporarily residing persons, who under the social security coordination regulation have the right to receive care in Finland, may have major impact on the economy of single small municipalities. This applies also to people living in the frontier (for example

present or former frontier workers) who due to linguistic reasons wish to seek care in Finland, which in turn causes considerable strain on the frontier municipalities. This situation is being redressed with national measures.

While the present national legislation enables foreign health service providers to establish themselves in Finland, the volumes are low even here. Only around one per cent of the health sector enterprises in Finland are foreign-owned. The majority of these companies deal with health products or technique and only a dozen companies provide services.

The mobility of health personnel is more significant. In the beginning of 2006 around 4.000 Finnish nurses and around 900 physicians worked abroad (the figures include also persons working outside the EU). In 2005 around 250 nurses and 65 physicians of working age moved abroad. A majority of the nurses and physicians working abroad return to Finland at some point. For example during the last two years, remigration of nurses has been slightly more popular than migration. Around 400 health professionals (physicians, dentists and nurses) from other EU Member States came to Finland in 2005, especially from Estonia (182 physicians, 17 dentists and 43 nurses) but the numbers decreased in 2006.

No significant increase in care demand abroad is projected for the next decade. This can be partly explained by the development of the national health system and the more swift access to care as a result of the 2005 provisions on maximum waiting times for access to care. Increased mobility of people in general and increased knowledge of the care possibilities in other Member States may, however, somewhat enhance patient mobility as well as encourage hospitals to purchase services from abroad. Also, health service providers are projected to establish themselves in other Member States slightly more frequently especially if the barriers for service provision are universally reduced.

From the Finnish perspective, Community action should promote access to safe, high-quality and cost-effective health services as close to the patient as possible. The right to medical care of persons moving around in the EU for various reasons (such as work, studies, tourism) should be realised in the regulated way and in the regulated extent. Cooperation between the Member States as well as Community action in the field of health services should be proportional to emerging problems. Also, sufficient resources for the Community's main public health task, i.e. health promotion and disease prevention, should be guaranteed even in future.

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

The Finnish view is that the legal ambiguity of the present situation is largely due to different ways of interpreting the existing Community legislation and case law. There are also issues, such as patient injury compensations, that are not at all covered by the Community legislation.

Improving the legal certainty and choosing the appropriate means for securing this certainty requires a thorough analysis of whether emerging problems are caused by legal uncertainty or by inadequate application of existing provisions, inadequate information, or by information that does not reach its target audience.

In cross-border situations patients, health authorities and service purchasers (such as local authorities) need information about other Member States' health service providers, waiting times, care practices, rights of patients, quality of care, costs paid by the patient, reimbursement of medical treatment and compensation for patient injuries as well as patients' possibilities to appeal decisions regarding treatment or costs. Also language issues must be considered when a patient receives care in another Member State. Successful treatment and commitment to treatment necessitate that patients receive service in a language they understand and in which they can make themselves understood. In addition, both the sending party/financier and the receiving hospital must be familiar with the responsibilities of each party as well as with the duration of these responsibilities. The follow-up and potential further treatment regarding medical care received in another Member State usually takes place in the patient's home country. Accordingly, it is of special importance that the data concerning the care received in another Member State is forwarded to the physician responsible for further treatment. With regard to individual patients, the necessary information should be transmitted between the Member States in as simply form as possible, ensuring however adequate data protection.

Health service providers (permanent presence or temporary cross-border service provision) need first and foremost information about the receiving Member State's conditions regarding establishment or temporary service provision. Also information about the reimbursement system is essential for service providers.

The information needs of patients, health professionals, health service providers and healthcare decision-makers can to a large extent be met by more effective cooperation and information exchange. At present each Member State collects data individually. Hence the data available in one Member State about the healthcare and reimbursement system in another Member State are not necessarily consistent or up-to-date because data collection takes time and effort. Therefore, the collection of essential data regarding cross-border situations should be centralised at the EU level. This should build on the existing information and for example on the Commission health portal as a portal for assembling and communicating information.

Not all issues can be solved with information exchange and cooperation only. Legal clarification is needed especially with regard to the responsibilities of each party in cross-border situations. Questions of responsibility should be clear from the viewpoint of the patient, service provider and service financier. In practice this could mean that the Community legislation would include a definition of which country in a given situation is responsible for the safety, quality, financing, etc. of care.

In case of patient injuries and malpractice, the patient should always have the chance to have his or her case examined. He or she should also be able to seek compensation from one of the countries involved.

Clarification is needed also regarding which cross-border situations require prior authorisation and which not. The EC Court of Justice has ruled that a prior authorisation can be required for hospital care but not for non-hospital care. This distinction is not unambiguous as hospital care has different connotations in different Member States. Defining healthcare and current care is intrinsically linked to the national healthcare culture, including the questions of what constitutes hospital care, non-hospital care, or hospital. In practice when granting a prior authorisation the party paying for the service applies its own legislation as it decides whether a patient can seek care in another Member State at its expense. At the same time it also takes a stand regarding the question what is hospital care and what is non-hospital care. If the acceptability of prior authorisation continues to be linked to hospital care in the

Community legislation, the definition of hospital care should be determined by the national legislation of the Member State granting the authorisation (and in the end, paying for the service).

When Community action is prepared attention should also be paid to improving of the compatibility and standardisation of health data systems, which would facilitate the transfer of patient records in cases of cross-border healthcare.

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?

At present, care is provided in accordance with the legislation and care practices of the country where the care takes place physically. This is an important principle and it should be retained also in future. Also, supervision of health services should be conducted by authorities in the Member State, where the service provider is active and where the care is provided.

Telemedicine situations are more complex. For example the responsibility for the technical quality of x-rays and laboratory tests is borne by all the parties participating in taking or handling the pictures or samples. Interpretation of test results is primarily the responsibility of the attending physician. Even for these situations there should be clear provisions that prescribe which Member State's authority in a given situation is responsible for ensuring and monitoring the quality of health services.

Health authorities or service providers purchasing health services from other Member States should ascertain themselves that the service they purchase is appropriate and of good quality. This requires sufficient information about health service providers in other Member States. Information can be exchanged even bilaterally for example between hospitals when agreements on purchasing services are reached.

The financial responsibility for treatment requiring a prior authorisation should mainly be with purchaser. The financier should not have to finance any other treatment than treatment, which is in accordance with the care practices prevailing in the patient's home country and which is reimbursable in the patient's home country.

As in many other countries, in Finland the patient's costs (reimbursement) depend on whether the care was provided within the public health system (in Finland for instance municipal healthcare; or in many other countries by a so-called contractor physician) or by the private sector. In order to safeguard the citizens' equity as well as the financing of health systems, it should be possible to apply these reimbursement principles and care practices even in cases where the patient himself seeks care in another Member State.

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?

Patient safety should be further improved both with national measures and through cooperation between Member States. The primary responsibility for ensuring safe care is borne by the health care unit/professional providing the care as well as by the country where the unit/professional provides the care. In situations where care has been provided in another Member State, either because it could not

be provided in the person's home country (due to waiting times, specialised medical intervention, etc.) or because the hospital has purchased the service, also the country sending the patient shares the responsibility for patient safety.

In case of patients suffering harm, it would be essential to increase knowledge of patients, health authorities and service providers of each Member States' relevant compensation systems. For example the Commission High Level Group on health services and medical care could collect this data. The data should be easily accessible for example via the Commission's health portal.

Finland views it particularly important that in cross-border situations patients have always the possibility to have their cases examined and to claim compensation for their injuries. This would require that patients had an easy access to information about the compensation system for patient injuries in their home country or in the country providing the care. From the service provider's perspective this means in Finland that a health service provider that establishes itself in Finland or provides services on a temporary basis must always have a statutory patient insurance.

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)?

The rights of patients from other Member States to care are primarily defined by national legislation and the social security coordination regulation. With regard to this, provisions exist also for compensations between Member States.

Patients seeking care in other Member States on the grounds of free movement can, depending on the system and volume require extra resources in the receiving country or assist in utilising the available capacity. Finland has enforced maximum waiting times for access to care as well as uniform national criteria for non-emergency care. A patient residing in another Member State is in the same position as patients residing in Finland with regard to assessment of non-emergency care.

Community action must enforce the principle of equity, and such situations should be avoided where a person seeking care in another Member State is in a privileged position compared to patients residing in the receiving country, or where the costs incurred by patients seeking care in another Member State deteriorate the status of patients who want to receive care in their home country. Hence, in cases where patients seek care in another Member State, the sending country should compensate the costs incurred by the care, unless otherwise agreed between these Member States.

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?

Finland considers that there are already fairly comprehensive and satisfactory provisions on the movement of health professionals in the Directive on Recognition of Professional Qualifications, the implementation of which is currently being prepared in the Member States. In practice, problems have emerged e.g. due to an employee's lack of language proficiency or due to the requirements on a physical examination of the employee. The employer can, however, set preconditions regarding language proficiency and physical examination. This is of particular importance in the health sector

where these preconditions have significant impact on patient safety. Exchange of information between Member States can promote good practices on these issues. In order to prevent malpractice, information exchange between authorities should be intensified with regard to loss of or restrictions on professional qualifications.

The Finnish health system is relatively open to service providers from other Member States. Private service providers need a licence issued by a State Provincial Office. The State Provincial Office must grant the licence if the prerequisites prescribed by law are fulfilled. In many EU countries, a number of preconditions exist for service providers from other Member States. Health service providers need sufficient and accessible information on these preconditions. The Member States should also be obligated to examine the practices and formalities that Member States apply to the establishment and carrying on health service business as well as to simplify them where necessary. The prerequisites should also be non-discriminative, necessary and proportionate to the set goals.

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?

The Finnish Government views that the issues introduced in the other questions include the most essential issues regarding cross-border healthcare.

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?

Finland considers it important to further support the network for health technology assessment with Community financial instruments. Finland views that a similar approach should be considered for the assessment of the clinical value of new drugs (relative effectiveness of medicines). Finland also supports the improvement of health systems impact assessment. In addition, the possibilities for cooperation should be more thoroughly mapped out regarding the promotion and utilisation of health innovations. In Finland, we have for example developed mobile services that enable people to book appointments with the dentist or the health centre online or by mobile phone.

The alternatives for developing the networks of centres of reference should be considered further so that appropriate solutions could be found. The assessment should even consider the entire Community health policy package as well as the appropriate allocation of resources.

Finland views that the eHealth cooperation should be further developed so that enterprises, Member State health systems and patients could get the maximum benefit out of it. The most central element of health technology, the electronic patient record system, has been introduced in most of the Member States. However, the full implementation of the system will take years. It is projected that in a few years another wave of technological development will emerge signifying a transition to more modern technology applications. As there is no EU level agreement on electronic patient record standards, there are no Community level eHealth markets that would benefit the EU economy in general and bring competition gains to health systems. In order to get prepared for future developments, an agreement on

electronic patient record standards and reference terminology should be reached at the Community level.

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?

Finland views that many issues relating to cross-border healthcare can be settled with better and more uniform application of the existing provisions and principles and with cooperation between the Member States. Legislative tools should be considered in case of such cross-border healthcare issues that were mentioned above and where there clearly exists legal uncertainty from the perspective of patients, health professionals, health service providers or decision-makers (such as which actor is responsible for what, which Member State's legislation is applied in a given situation, what are the prerequisites for a service provider to operate in another Member State).

Finland considers that a directive as a possible legislative instrument might in general work better in this field than a regulation as it would better take into account the differences between national health systems. The choice of the legislative instrument is, however, influenced by the contents and legal basis planned for the rules regarding health services. There is no exhaustive analysis in the Commission Communication regarding a potential legal basis. Finland views that such an analysis is necessary and that it should cover the applicability of not only Article 95 of the Treaty but also for example the articles on free movement of services to the rules regarding health services. In any case the rules should be based on the common values and principles that underpin the Member State health systems. That is, the rules should enable the existence of national health systems characterised by solidarity, universality and equity.

It does not seem possible to solve all the open issues relating to cross-border healthcare with the existing provisions such as Regulation 1408/71 on the coordination of social security. The regulation concerns the social security rights of persons exercising their right to free movement, including the right of patients to seek care in another Member State and receive reimbursement for it as well as compensations between Member States in such situations. The regulation does not apply to the right to seek care in another Member State that is based on interpretations of the Treaty and case law. The Finnish view is that combining these elements into one and the same legislative instrument is not without problems.

Finland highlights the necessity of an extensive and thorough impact assessment, economic impact assessment in particular, in connection to the preparations for health service rules. The impact assessment should examine the effects of Community legislation on various kinds of health systems.