SUBMISSION BY THE DUTCH GOVERNMENT CONCERNING THE CONSULTATION REGARDING COMMUNITY ACTION ON HEALTH SERVICES

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1. Introduction

The Services Directive entered into force on 28 December 2006. The directive has been published and has taken effect. It aims to create a horizontal, statutory instrument to systematically eliminate barriers to the free establishment and free movement of services for transnational service providers. If free market principles were to be fully applied to healthcare, patients would be free to receive care in any EU member state and to be reimbursed by their insurer, and care providers would be free to provide care in any EU member state they chose. However, the relationship between healthcare policy and the European internal market is controversial, and that is why healthcare was left out of account when drafting the directive.

The European Court of Justice (ECJ) has already made clear in a series of judgments that the healthcare sector, too, must take account of internal market rules, irrespective of how it is organised in any particular member state. The Council and the European Parliament therefore asked the European Commission to present its own framework for healthcare services. This resulted in the Commission's communication on consultation regarding Community action on health services ('health services initiative').

The Netherlands believes that a health services initiative should cover both curative and long-term care. In addition to the health services initiative, the Commission published a communication on social services of general interest in late April 2006. Health services are included in its definition of social services of general interest. However the Netherlands believes that the entire healthcare sector, including long-term care, must be viewed in the framework of the health services initiative, to avoid a regime for the same health services being discussed in different places. The Netherlands also made this point during the consultations on social services of general interest.

The European Commission launched a consultation procedure on 27 September 2006. The aim is to obtain input from member states and stakeholders on the direction in which a health services initiative should develop. Below, the Dutch government explains its position on such an initiative and the areas of healthcare policy it should cover.

The Dutch response is set out as follows:

2. The internal market, health services and patient mobility

2.1 The Dutch healthcare system

To understand the Dutch position on a health services initiative, it is important to understand how the Dutch healthcare system is organised. The system consists of two pillars: curative care and care for the elderly, the mentally, sensorily or physically disabled, and psychiatric patients. A central role is assigned to principles widely accepted in Europe regarding the organisation and funding of health care, such as universal access to care and insurance, solidarity in cost sharing, and good quality. The Netherlands favours a healthcare system in which the general public, care providers and care insurers are given more freedom and responsibility, are more cost-conscious and are confronted with the consequences in terms of both care and insurance. This applies to the entire healthcare system, but is mainly reflected in the new Healthcare Insurance Act, which came into force in 2006.

Box 1: Key features of the new Healthcare Insurance Act

- Insurance obligation
  Everyone who lives or works in the Netherlands is obliged to take out health insurance.

- Acceptance obligation
  Every health insurer in the Netherlands who implements the Healthcare Insurance Act is obliged to accept everyone who applies for health insurance.

- Statutory basic insurance package
  Every insuree is entitled to the basic insurance package laid down by law.

- Care obligation
  Healthcare insurers are obliged to provide the necessary care themselves or reimburse the insured. Insurers may decide whether to provide insurees with care in kind, or whether to reimburse the costs of the care that insurees have chosen themselves.

- Freedom of choice for insurees
  People may choose any of the types of healthcare insurance that an insurer offers, and may change the type of insurance and their insurer every year.

- Solidarity-based premiums
  Premiums consist of a nominal part (paid to the healthcare insurer) and an income-related contribution. Healthcare insurers set the nominal premium, but it is the same for all insurees who have chosen the same policy with a particular insurer. Insurees up to the age of 18 are exempt from the nominal premium and people whose nominal premium is relatively high compared with their income are entitled to healthcare benefit.

- Risk equalisation
  Income-related contributions are distributed among healthcare insurers to compensate for any financial disadvantage resulting from the statutory acceptance obligation. Insurers receive a separate payment for the operational costs of providing coverage to insurees under the age of 18.

- Legal status under private law
  Outside of the rules that the government has set in the general interest, healthcare insurers are ordinary private-law enterprises which may make a profit and are subject to competition law.

- World wide cover
  Insurees are entitled to avail themselves of care services covered by the basic package anywhere in the world; the maximum reimbursement is the usual amount payable in the Netherlands.

As far as transnational healthcare is concerned, the level of the world wide cover is the most relevant factor. The system provides for reimbursement of healthcare expenses incurred in other countries, provided they are covered by the Dutch basic package. The maximum reimbursement is the usual amount payable in the Netherlands. Insurees with a 'reimbursement policy' may use the services of any care provider abroad. But insurers with a 'benefits in kind' policy are normally restricted to care providers who have signed a contract with their insurer.

Insurers can sign contracts with care providers both in the Netherlands and in other countries. People with a "benefits in kind policy" can therefore receive care abroad from any care providers who have a contract with their insurer. Nevertheless, the law also allows insurees with a "benefits in kind policy" to turn to non-contracted care providers at home or abroad. In such cases, the insuree is not always entitled to full reimbursement of expenses. In the event of long-term care, freedom to choose care abroad is limited at present.

In the Netherlands' opinion, this satisfies the need to allow scope for patient mobility, as provided for by ECJ case law.

2.2 Patient mobility

An important element in the free movement of health services, is patient mobility. In the Netherlands' opinion, the freedom of patients to choose between care providers helps to improve the quality of care, since patients take quality differences and waiting times into account when choosing their care provider. This freedom of choice may be limited only in special circumstances.

At the same time, the Netherlands has the opinion that the healthcare market is unlike other markets. Its organisation is partly a public task and continuity is necessary to ensure that sufficient, affordable, quality care remains available in the longer term. To a certain extent, this justifies restrictions on the free movement of health services. For the Netherlands, reconciling patients' freedom of choice with the financial and organisational viability of national healthcare systems is a core concern.

The Netherlands also takes account of the freedom of choice of patients who want to receive health care in another EU member state (cross-border health care). It believes that patients should be given ample scope to receive care in other countries. But what was stated above regarding freedom of choice at national level, is even truer here: freedom is subject to constraints. After all, national governments have their own responsibility for organising and safeguarding accessible, high-quality healthcare with secure long-term funding. The vast majority of patients receive healthcare in their own country and sufficient care must remain available. Patients, too, ultimately have an interest in a high-quality, financially sustainable healthcare system at national level.

This is one of the reasons why the care sector has been excluded from the Services Directive. The Netherlands believes that specific conditions regarding patients' freedom of choice may be laid down.

In the Netherlands' opinion, ECJ case law allows member states to achieve the right balance between the patients' freedom to receive healthcare where they choose and restrictions to that freedom in the interests of the national healthcare system.

Box 2. Elements of ECJ case law that the Netherlands considers important

- The principle that patients who choose to receive healthcare in another EU member state normally receive a maximum reimbursement equal to the amount the same treatment would have cost in their own country.
- A healthcare system may only refuse to reimburse patients for using healthcare services in another member state if there are reasonable alternatives in their own country (including waiting times that are medically acceptable) and if it is shown that patients using care services in the other country will cause disproportionate damage to the viability of the healthcare system in their own country in the longer term.
- In the case of residential care, patients' freedom of choice may be further limited than in the case of non-residential care. (NB: the Netherlands believes that a fundamental debate is required on the viability of the concepts 'residential' and 'non-residential' as distinguishing criteria for the level of reimbursement.)

The Netherlands believes that the health insurance system it has put in place, strikes the right balance between facilitating patient mobility and safeguarding the system's overall viability.

In practice, however, friction still exists because national systems are not fully compatible, which means that it is sometimes difficult for patients to use healthcare services in other EU member states. The Netherlands endorses the importance of member states being free to design their national healthcare systems as they see fit. But member states also have a responsibility to minimise administrative and other provisions which may make it more difficult for patients to receive healthcare in other member states. The Netherlands thinks that member states first need to ensure coordination at bilateral level in relation to the most common problems involving patient mobility in border regions, in order to eliminate obstacles to patient mobility. The wide range of practical problems may be difficult to place in a general Community framework.

2.3 Quality and patient safety

In the case of cross-border care, the Netherlands sees patient safety and quality of care as the key issues in the debate. Internal market rules mean that both patients and care providers are free to use or offer healthcare services in another member state. But this must not undermine the quality of the care provided or patient safety.

As regards the quality of cross-border care, the Netherlands takes the view that the quality level in the receiving country is the decisive factor. The quality of care and patient safety are also important for the patient's own country, e.g. because it will have to deal with the medical consequences of treatment abroad. The Netherlands is of the opinion that efforts must be made to improve the general quality of care in Europe. Without detracting from member states' responsibility for organising national healthcare systems, the Netherlands is in favour of working within the framework of the health services initiative to ensure comparable quality standards throughout the EU, so that patients know what level of care to expect when opting for treatment in another member state.

As regards legal liability in the case of cross-border care, there appear to be no legal problems in practice. The rules of international private law indicate the legal system that applies in specific cases. For patients and professionals, however, it may be unclear which rules apply in which cases. In the Netherlands' view, clarifying this matter could also form part of the health services initiative.

2.4The impact of patient mobility in Netherlands

The impact of patient mobility in the Netherlands is limited, if we view it only from a quantitative macro perspective. Although reliable statistics are lacking, it is estimated that about 1% of curative treatments undergone by Dutch patients take place abroad. Figures from care insurers show that this percentage can rise to about 5% of treatments in border regions. In these regions, cross-border care is an essential part of the healthcare infrastructure.

The impact of patient mobility on long-term care is also limited. It is estimated that only 0.1% of the entire budget for long-term medical care is spent on patients who receive care abroad.
For further information on the specific problems surrounding cross-border care, we refer to the contributions that the EU regions will provide as part of the consultation process. The Netherlands is working with the regions to identify the problems.

It appears that the number of Dutch patients travelling to neighbouring countries for treatment is far higher than the number of patients from these countries who come to the Netherlands. This could be mainly because the Dutch healthcare insurance system offers more scope for using healthcare services abroad than the healthcare systems in neighbouring countries. The effect of this one-sided migration of patients has so far not been studied.

Since the number of treatments undergone by Dutch patients abroad is fairly limited, no research has yet been done on the implications of cross-border care for the organisation and financial viability of health care at national level. It is expected that most patients will continue to want to receive care in their own country. This means that estimating the consequences of a major increase in the use of healthcare services abroad for the organisation of health care, is as yet a purely theoretical exercise.

When the importance of patient mobility is viewed from the perspective of individual patients, the impact is far greater. A patient's welfare may be enhanced if he or she is treated at the place of their choice. Viewing the impact of patient mobility from this angle is also in the interest of the EU's citizens agenda. The EU can show that it offers individual citizens specific benefits on this issue. The Netherlands considers this positive message to be very important at a time when many people are uncertain about how European cooperation really benefits them.

3. Professional mobility

The internal market gives service providers and professionals the right of establishment anywhere in the EU. The Netherlands believes that this freedom must in principle also apply to healthcare service providers and health professionals. However, the specific nature of health care, especially as regards patient safety, justifies setting further requirements for care providers.

For professionals, these further requirements are largely regulated at Community level, especially in Directive 2005/36 on the recognition of professional qualifications. This directive sets rules governing the recognition by member states of foreign professional qualifications for access to and the exercise of a regulated profession.

Recognition is based either on the general system, which involves comparing the content of training courses and the period of training (combined with work experience and subsequent training), or on the system of automatic recognition, which applies to specific professions, provided the minimum period of training is satisfied.

The Netherlands is of the opinion that this fleshes out the main conditions for the mobility of health professionals at European level. It does, however, believe that ongoing efforts are needed to improve the system of automatic recognition and to set minimum quality standards for continuing education and training.

Box 3. What is regulated in Directive 2005/36?

- Article 5 (3) states that a service provider is subject to professional rules of a professional, statutory or administrative nature which are directly linked to professional qualifications applicable in the receiving member state. Disciplinary rules form an integral part of this.

- Article 8 (2) states that the competent authorities must ensure the exchange of information necessary for complaints against the service provider to be correctly pursued.

- Article 22 (b) states that the member states are free to set conditions for continuing education and training.

- Under article 56 (2), information is exchanged on disciplinary action or criminal sanctions likely to affect the pursuit of professional activities.

The Netherlands does not pursue a conscious policy of recruiting foreign health workers. It is more common for foreign health workers to work in the border regions of the Netherlands. However, the number is low in absolute terms. The Netherlands' policy is to exercise restraint in the proactive recruitment of health workers from outside the EU, such as developing countries and countries with a shortage of health workers, in accordance with the EU ethical code of conduct.

4. Other initiatives (support to member states)

In the consultation document, the Commission mentions 'support for member states in areas where European action can add value to their national action on health services' as one of the two pillars of the health services initiative. This can include a wide range of measures, such as ICT cooperation in the healthcare sector, research and innovation, networks of specialists and hospitals, etc. Not all these measures are new, of course. The Commission wants to place these activities in a common framework.

The Netherlands is in favour of cooperation between EU member states. At present, cooperation takes place in various working groups of the High Level Group on health services and medical care, for example. The Netherlands believes that European cooperation currently has added value with regard to the following themes in particular.

Better information provision and exchange

Patients considering going abroad for treatment, care providers and care consumers all need information. In the Netherlands, care insurers possess a great deal of information. The Netherlands believes that the EU should seek to establish a readily accessible information system to help patients make choices concerning cross-border care. This could include information on quality, prices, reimbursements, payments by patients, waiting times, liability law and complaints procedures. In addition, care providers need to improve the way they exchange medical information on patients who have received cross-border health care.

Quality supervision

The Netherlands is in favour of exploring the possibility of setting minimum standards at European level for the quality of care. One reason for doing so is to promote patient safety. This argument also plays an important role in the case of patient mobility. Furthermore, member states need to work more closely together, e.g. through national inspection bodies, in areas such as the exchange of information on the quality of care within particular institutions or on particular care providers. It would be better if institutes for the recognition and certification of healthcare products and institutions were to observe a single European standard.

European networks of centres of reference

The Netherlands believes that cooperation between care providers in the form of networks is invaluable. The High Level Group's work in this area should be extended. The Netherlands is as yet not in favour of physical centres of reference in a limited number of locations.

E-health

The Netherlands believes that e-health will become an increasingly important part of mainstream healthcare in the years ahead. The potential problems with cross-border care may certainly play a role in e-health. The Netherlands therefore advocates close cooperation in this area, first and foremost in order to establish European standards. The Netherlands requests the Commission to guard against a fragmented approach in which e-health is tackled by multiple working groups from different directorates. The development of an electronic EU health insurance card is an example of cooperation. The Netherlands requests the Commission to encourage member states to learn from good examples and pioneering projects. In this regard, the Netherlands suggests taking a closer look at the standards it has developed for electronic patient files.

Information exchange on long-term care

In the framework of the Social Protection Committee, information is being exchanged on long-term care services through the open method of coordination. This is felt to be useful and should be continued.

5. Choice of instruments

The Netherlands is of the opinion that the instruments chosen to flesh out a possible health services initiative, must help solve existing problems. In this we should be guided by the aims we want to achieve. The Netherlands does not rule out any instruments in advance. Legislative instruments, too, such as a directive, are open to discussion as far as the Netherlands is concerned, provided they help solve widespread problems.

The Commission mentions in its consultation document that achieving legal certainty on the scope for cross-border healthcare is one of the two main pillars of a potential health services initiative. The Netherlands, too, is in favour of legal certainty. However, it feels that ECJ case law sets out a clear line on patients' entitlement to reimbursement in the case of cross-border care and the restrictions that member states may place on it.

The Netherlands is not yet convinced that codifying case law in a directive will automatically clarify matters. This is because legal uncertainty is present not so much at European level, but at national level where member states do not incorporate case law into national legislation. The Netherlands believes that complying with case law is important because it contributes to striking a balance between the interests of individual patients and those of healthcare systems as a whole. The Netherlands believes that member states should incorporate case law into their national systems. It has done this in designing its own new healthcare system. Where other member states incorporate ECJ case law insufficiently, the primary solution seems to be for the European Commission to institute infringement proceedings against them or, if necessary, to draw up a manual or guidelines.

If, however, it is decided to codify ECJ case law in a directive for other reasons, the process must not be used to place restrictions on the line laid down in that case law. A directive must not unnecessarily limit the freedoms of European citizens. Any directive should therefore take the form of a framework directive, giving member states the latitude to implement specific measures as they see fit.

Finally, it should be noted that the EU has already taken a variety of measures to regulate many aspects of patients' rights and duties in cases where they receive health care in other member states. For example, EU social security regulation 1408/71 includes rules on the use of healthcare services during a stay abroad and on how to settle the ensuing costs.

At present, a proposal to modernise social security regulation no. 883/04 is under discussion. The proposal already codifies a great deal of ECJ case law. The Netherlands believes that, where codification takes place, maximum effort must be made to achieve a clear set of rules on patient mobility.

6. Conclusions

- **Patient mobility**
  Cross-border patient mobility can help to increase the efficient use of health resources and the welfare of patients. The Netherlands attaches great importance to this. Given the special nature of healthcare, imposing restrictions on patient mobility may be justified. ECJ case law provides clear guidelines for determining the extent to which restrictions are justified. The case law must be incorporated in member states' healthcare systems. The Netherlands is not yet convinced that a directive is the necessary instrument to achieve this.

- **Quality and patient safety**
  In the Netherlands' opinion, quality of care and patient safety are two of the key issues in the debate on cross-border care. As part of the health services initiative, the Netherlands advocates the establishment of comparable quality standards in the EU to create transparency and ensure that patients know what level of care they can expect in another member state.

- **Impact of patient mobility**
  Patient mobility is limited in absolute terms, but significant in border regions. From the perspective of individual patients, the impact is great. In the Netherlands' opinion, this justifies looking for solutions to concrete problems that may obstruct patient mobility in practice. These solutions should preferably be found at the most practical level possible.

- **Professional mobility**
  The Netherlands is in favour of mobility for health professionals and of care service providers having the right of establishment. In practice, many important conditions for the establishment of health professionals have already been harmonised and there is little need for further Community action at present.

- **Support to member states**
  The Netherlands believes that cooperation between member states can be further strengthened, especially as regards information provision and exchange, quality supervision, European networks of centres of reference, and e-health.

- **Choice of instruments**
  The Netherlands believes that the choice of instruments must depend on the goals set and rules out no instrument in advance. A directive is one possible way of incorporating ECJ case law into member states' healthcare systems, but is not the only one and not necessarily the best one.