Consultation response

Health and Consumer Protection Directorate-General
Health services consultation
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B-1049 Brussels
Belgium

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TO: European Commission
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ABOUT WHICH?

Which? is an independent, not-for-profit UK consumer organisation with around 700,000 members and it is the largest consumer organisation in Europe[i]. At EU level we are members of BEUC, the Bureau Européen des Unions de Consommateurs. We are entirely independent of Government and industry, and are funded through our membership and the sale of our Which? range of consumer magazines and books. 2007 marks our 50th anniversary.

INTRODUCTION

Which? campaigns on a range of consumer issues, one of which is health. Our aim is to put consumers' needs at the heart of everyday health care. Thus this consultation is of key interest to us as many UK consumers receive treatment abroad each year (both planned and in an emergency) and many health professionals from other EU countries practise in the UK.

Which? has consistently been a strong supporter of the opening up of the single market, including services. We have also supported the principle of access to cross-border medical treatment and therefore are keen to see robust Commission action to turn the legal rights of access established by the European Court of Justice (ECJ) into systems that are readily accessible, comprehensible, unambiguous, speedy, effective and inexpensive for consumers, with guarantees about standards of treatment and care. The ultimate aim should be that consumers can be confident that, if they choose to go cross-border for medical care, the overall treatment they receive, in both the medical and general sense, will be no less favourable than it would have been had they been treated in their own Member State.

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We recognise that the Commission's approach follows from the need to provide a coherent administrative structure to implement recent ECJ rulings. We regard the right to seek medical treatment abroad as important in itself, and also as a corrective mechanism and as a form of redress where services are failing patients. Beyond that however we see wider potential benefits to the EU and its citizens in improving choice, providing incentives for the improvement of national health systems, encouraging the efficient use of resources and developing centres of excellence in area of medicine which may be beyond the financial capacity of individual Member States.

Recent ECJ rulings have created a confused position that leaves consumers unsure about their rights to obtain funded healthcare in another EU country and how to assert them. At present, lawyers appear to be the group most likely to benefit from the ever-increasing body of ECJ rulings relating to treatment. The Commission has a responsibility to provide much greater clarity in this area so that consumers know their rights, and all sections of the community can equally assert these without fear of financial or clinical vulnerabilities.

The situation is particularly confusing for UK consumers because they do not have clear rights to treatment under the National Health Service (NHS), unlike many of their European counterparts whose entitlement to treatment or healthcare is often well-defined under the terms of their insurance fund. Added to this, the devolved nature of UK healthcare means that patients in each of the four countries of the UK (England, Scotland, Wales and Northern Ireland) can often expect different levels of treatment or care: for example, cancer patients in Scotland can be prescribed Bortezomib (Velcade) on the NHS, whereas those in England cannot. The current consultation does not provide sufficient clarity to see how an approach based on entitlements will operate in UK.

If consumers are really to benefit from cross-border healthcare the Commission must provide greater clarity and practical guidance to individual Member States about how they translate the ECJ decisions into the context of their health systems. They must also identify what needs to be done to safeguard the health and access to healthcare across the EU, particularly for the most vulnerable consumers. They must also ensure consistent monitoring of the impact of cross-border healthcare on the health systems, particularly on health inequalities as there is a real danger that those people with the greatest needs will be least able to seek healthcare elsewhere in Europe, especially as people are likely to have to pay their own travel costs or fund cross-border treatment upfront. There is also a danger under the UK cash-limited tax-based health system that patients who are unable or unwilling to travel may be further disadvantaged if their local

health authority has to fund significant numbers of patients who have sought cross-border healthcare without prior authorisation.

These tasks are especially challenging given the significant differences between the health systems of individual Member States, and their potentially limitless impact on European healthcare. Particular areas that need clarity are:

- Individual's rights and entitlements to cross-border care
- When and how they can exercise these rights
- What is hospital and non-hospital care
- Any costs the consumer must pay and when, and systems for reimbursement
- Quality standards
- Redress processes.

The Commission must explore ways of ensuring that all European consumers have access to good quality information to make informed choices about where to be treated.

The necessity (rather than the choice) of having to seek cross-border should be the exception rather than the rule. Our research indicates that consumers' over-riding preferences are for treatment close to home. We would not welcome moves to create a situation in which the element of choice was removed and where it would become normal for patients to be required to go to another Member State in order to receive mainstream treatments in a reasonable time.

Our response focuses on the implications for NHS patients, although we recognise a potential impact on the private health sector. We also recognise that the structural difference between the NHS and health insurance funds in other Member States raises some particular issues for the UK, including who is the insurer.

Q1: 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?

Current impact

Across the EU as a whole, claims for reimbursement of cross-border health care represent 0.1% to 0.2% of public spending on health care in the EU, and a study notes that levels of demand have remained stable[ii].

Member States and national authorities will be best placed to provide detailed figures on numbers of citizens coming from or going to other Member States for

treatment, and moving within Member States for the same reason, but the following illustrative figures may be of interest.

In 2002/03, of 445,263 inpatients and day cases in Northern Ireland, 1,722 (0.39%) were from the Republic of Ireland. In 2002, of 891,312 inpatients and day cases in Ireland, 902 (0.11%) were from Northern Ireland[iii]. In 2002 just fewer than 2,000 patients from the Republic of Ireland travelled to the UK for treatment and another 700 travelled to other Member States[iv].

Extent of cross-border healthcare between England and Wales 2001-2003[v]

		2001-2002	2002-2003
No. of Welsh patients treated in England	Emergency	12,200	11,500
	Elective	21,100	20,000
	Total	33,300	31,500
No. of English patients treated in Wales	Emergency	8,300	8,700
	Elective	2,800	2,800
	Total	11,100	11,500

While at least one Member of the Scottish Parliament has complained about residents of Northumberland using Scottish health services (although of course Scottish citizens may use health services in England), we would agree with the response of one Scottish citizen that "I expect to be able to use hospital services in neighbouring health board areas if it's convenient for me and the NHS and I see no reason why bureaucratic boundaries like the Scotland-England boundary should get in the way of this"[vi]. In our view, health systems should serve the needs of patients, not vice versa and the same principle should, as far as possible, apply across borders within the EU as well as within those of Member States.

However, current figures on cross-border medical treatment are limited and need to be treated with some caution. We suggest that major steps must be taken to improve the quality of the available data, but also it would be useful to disaggregate them in order to identify the different types of situation most commonly arising. For example, UK citizens who are resident in Spain and who

require non-emergency medical treatment which may be funded by the NHS should not be regarded as seeking cross-border treatment: in these cases it is the payment, not the patient, that is moving cross-border.

The reasons why people choose to seek medical treatment abroad, which of course include quality, specialisation, or the location of the nearest suitable hospital as well as undue delay (as in the case of Yvonne Watts) are well-established. It would however be helpful if the Commission were to undertake some further research into individual patients' experiences of cross-border medical treatment and of any problems arising as a result, and also to identify the reasons why people may have chosen *not* to seek medical treatment abroad when they might have been able to do so.

We have seen no evidence in the UK that internal cross-border movement has had any impact on the quality of services. There have been reports of some financial impact on individual health authorities within the UK where the cross-(internal) border figures were greater than budgeted for, although this may point to poor planning and/or inflexibility in budgetary and administrative systems rather than the actual levels of demand.

In any case, we do not see cross-border movement as a zero-sum game: "The use of foreign health care expands the accessible volume of care. Furthermore, it frees capacity within the national system. If patients on waiting lists receive treatments abroad which require extended hospital stays, more patients in need of shorter treatments can be treated at home. Patient mobility thus has a double effect on waiting lists and capacity as more patients gain faster access to care within and outside the system"[vii].

How this may evolve?

A survey for Which? in February, 2004 shows that UK consumers are positive towards going to another EU Member State for medical treatment. We found 45% said that they would be very likely to accept treatment for a non life-threatening health condition, which was affecting their quality-of-life, in another European country if it was paid for by the NHS and meant that they could be treated sooner, and a further 27% said that they would be quite likely to do so.[viii]

Nevertheless, we do not see a likelihood of very significant cross-border patient mobility from the UK, at least in the short term, largely for cultural and linguistic reasons, unless there is a dramatic change in NHS provision. There are for example relatively low levels of patient movement even between Northern Ireland and the Republic of Ireland, where language is not a barrier. The

Commission's own surveys of services in general shows that many consumers are not yet confident about using services generally from other Member States.

However, we do not underestimate the scope for growth in the longer term as understanding of new rights and procedures develops, including among health professionals. Nor would we underestimate the implications for smaller Member States where access to some specialised treatments may be limited and the costs of sending patients abroad for treatment may be significant.

At the same time, we see that there could be a very positive effect for *all* patients, as health service providers would have a strong incentive to tackle inefficiencies in the domestic supply of services, including between regional health authorities within individual Member States, and between public and private providers. This would in turn reduce the need for individual consumers to exercise their rights to cross-border treatment under EU law.

Q2: 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?

Legal clarification

Patients will need a clear statement on the circumstances in which they might be eligible to receive treatment abroad at the expense of their own health service provider or insurer, together with the detailed practical information discussed below.

A fuller statement summarising the relevant ECJ case law and giving guidance would be useful to assist patients' organisations, general practitioners, advice bodies and others. The ECJ judgment in *Watts* implies that health authorities should have a legal framework setting out the criteria for allowing or refusing authorisation of an application, and we hope that the Commission will give greater clarification in its legislative proposals to terms in ECJ rulings such as "normally available", "undue delay" and in particular what will constitute an "objective medical assessment". We suggest that a medical assessment will need to be independent if it is to be objective.

It will be also essential to define what constitutes a "fair appeals procedure". Any appeals procedure must be open and involve a strong element of independence.

While it will remain for Member States to interpret the new legislation, we would encourage initiatives to develop detailed memorandums of understanding by the Member States, at an EU level, to provide the maximum clarity and, as far as possible, consistency across the Community.

Clarity will be needed about where responsibility for any medical treatment rests while a patient is in transit to or from medical treatment in another Member State (which may not necessarily be planned, or related to the original condition) and for any related treatment once the patient returns to his or her own country. Which? strongly believes that if patients suffer complications or medical errors, they must automatically be provided with any necessary immediate treatment or rehabilitative care that is required, and must not get caught in any wrangle over whose responsibility between their funding authority and the overseas provider of healthcare.

The Commission must also clarify the definitions of hospital care and non-hospital care, where different legal principles apply to the need for prior authorisation. If consumers are entitled to that care in their home country, they may seek non-hospital treatment in another Member State without prior authorisation. This is likely to be particularly difficult as there are no clear-cut definitions of what constitutes non-hospital treatment, or indeed of what is a 'hospital'.

What types of healthcare are currently provided in non-hospital settings can vary significantly both between and within countries. Some procedures that may be carried out in non-hospital settings in some countries or areas are only carried out in hospitals in others, and vice versa. Similarly, some procedures or treatments may be carried out in both hospitals and community settings, such as dentistry or physiotherapy, depending on the complexity of the case and the skills, equipment etc. of the primary care professional or local service organisation. Any definitions of hospital and non-hospital care must also keep abreast of innovations and developments that can mean that previously hospital-based treatments can now be safely provided outside hospital.

In the UK, more and more healthcare, including minor surgery and diagnostics, currently undertaken in hospitals will be provided in non-hospital settings in the future. Examples include vasectomies, the treatment of varicose veins and some ear, nose and throat procedures. The situation in the UK is therefore likely to vary even within local communities, and this will need to be taken into account. Particularly wide variations also exist between areas in what non-hospital care consumers can expect to receive under the NHS: for example, in many local

health authorities, services such as chiropody are only provided to priority groups of patients such as diabetics. The key issues for patients here are easy access to clear information and advice, and that an EU definition does not limit the provision of more services on a non-hospital care basis.

Access to information

It is vital that individual health insurers or authorities are required to make it clear to patients that they have the right to request treatment abroad. There is a role for each national government in developing clear and consistent information so that all consumers are aware of their rights irrespective of their particular insurer or local health authority.

In the UK, NHS Direct is an important source of information to patients. However, the relevant page starts "Your local NHS Trust or PCT selects patients who they think might be interested in being treated abroad" which, while not directly implying that consumers cannot themselves make a request, may give the impression that the right of initiative lies with the NHS (see Appendix I). This wording appears to reflect the cross-border pilot schemes introduced in 2002, but has not yet caught up with recent ECJ judgments. Nor does it draw attention to patients' rights to seek non-hospital treatment abroad without prior authorisation.

We would like to see an obligation on all Member States to provide specified information on key aspects to patients and medical professionals, including websites that can be accessed directly and also centrally via an EU portal. The availability of a national telephone number for queries and further information would also be valuable. It is essential that this information is readily available, and that it is not provided only if consumers request it.

If consumers are to make informed choices about treatment abroad, they need to know what options are open to them. However, there is little consistent information across EU countries and the quality of what information is available is often poor limited, which makes it difficult for consumers to make the right choice for them about where to be treated. The Commission could do much to facilitate informed choices about cross-border healthcare and the development of appropriate information to enable patients to exercise their rights by sharing best practice and information initiatives from across the Member States, and measures to promote the collection and dissemination of high-quality information for patients.

We set out below the key areas that consumers are likely to be most concerned about. In we discuss redress and the quality and safety of services under Question 4 and Question 7.

Costs

Consumers will need to have clarity about what charges and fees may apply and the extent to which these will be covered by their local health authority or insurer, including professional fees, accommodation, meals, care costs, prescription and non-prescription medicines, medical devices, dressings etc and interpretation if required. Where the funding authority will pay only a fixed amount or a proportion of the costs that also needs to be made clear. Patients will also need absolute clarity about when they do and do not need to seek prior authorisation, and ready access to advice on this point.

Clarity will particularly be needed about patients' travel costs, and those of any carers required, including for visits subsequent to treatment such as follow-up consultations. We note the principle (set out in *Watts*) that patients should be entitled to expect that the same rules will apply for travel and accommodation costs as apply within their own Member State. However, without specific provisions covering cross-border travel costs, in some circumstances some patients will be unable to exercise their rights to cross-border medical treatment, either by reason of their income or because of some special factor, for example where the patient is a child, or is an adult with special care needs.

Consumers will also need to be made aware if their right to seek medical treatment abroad does not entitle them to be reimbursed for the costs of treatments that are not available in their own Member State for reasons of medical ineffectiveness. This will raise particular issues for the UK, where drugs that are nationally approved for use are available in some nations but not others (for example, in Scotland but not in England), or indeed are available in some English health authorities but not within others for reasons of cost rather than effectiveness.

In the UK, most treatment provided under the NHS is free: consumers do not need to pay at the point of use and then reclaim the costs as with some other systems. If UK patients receiving treatment abroad are required to pay significant costs up front and then have to reclaim them from the NHS, it is likely to make it very difficult (if not impossible) for low income consumers to go abroad for urgent treatment, which may well further increase health inequalities. As a minimum therefore there should be a requirement on authorities to refund costs including travel and other costs without delay.

Procedures

We would like to see an obligation on all Member States to publish the procedures under which patients may apply for medical treatment abroad, together with information on the timetable for reaching a decision and on appeals procedures.

There should also be an obligation on Member States to provide appeals procedure that will allow independent scrutiny of the decisions of the health provider, with no diminution of the right to challenge decisions in national courts (and of course to the ECJ) if necessary.

Choosing a hospital and country

For those consumers who decide to seek medical treatment in another Member State because of urgency, choice on other factors is likely to be a secondary consideration. Nevertheless, we attach considerable importance to a strong element of patient choice, and as a matter of principle we believe that patients should have the right to choose the hospital within the EU where they would like to go to for treatment, although of course their preferences may not necessarily be able to accommodate them. Patients may have family ties or other support in a particular country, or linguistic, cultural or other reasons for a preference.

The principle of patient choice is also important to protect the rights provided by the ECJ. Without it, some providers may be tempted to offer only unattractive cross-border options as a means of discouraging take-up.

In the UK, England is the most advanced in arrangements for patient choice. Since December 2005 patients in England who are referred for specialist care have been offered up to four or five choices from a menu of different hospitals or treatment centres. From the end of 2008, English patients will be able to choose to be treated at any hospital that meets NHS standards and costs, which are set by a standard national tariff; however it is unclear whether this will also extend to hospitals in Europe or other parts of the UK. This has been supported by the development of computerised information systems to enable general medical practitioners to compare the availability of procedures at different hospitals and waiting times, and thus to assist patients in making choices.

As this type of technology develops, it would be valuable if the EU could encourage technical co-operation and appropriate standards to ensure compatibility, with a view to establishing over time an EU-wide system. In the shorter term, consideration could be given to the development of a Regulation or

protocol under which national health authorities would be required to respond to requests for information about availability of treatment without delay.

Language

Linguistic ability or the likelihood of medical staff speaking a particular language is likely to be a significant factor influencing patients' decisions. However, it is vital if patients are to give informed consent to any treatment. In most European countries, informed consent provides the fundamental ethical and legal basis for any medical intervention. Unless patients can understand the likely risks, potential complications and outcomes associated with the treatment and any alternatives regimes, they cannot consent properly to treatment. This implies a high level of language competency on the part of the professional obtaining consent to treatment in the patient's language in order to explain these issues clearly and to answer any ensuing questions.

We suggest that one way forward would be the development of a Europe-wide standard on the provision of cross-border medical treatment which would cover matters such as the availability of language services at the receiving hospital and the basis on which they would be provided if requested. The Commission will also need to undertake further work to establish how the obligations to ensure that patients receive the necessary information to ensure that they can give informed consent to any treatment.

Aftercare

Again, patients will need clarity about where responsibility lies for follow-up consultations and any convalescence required, and who will meet the costs including travel costs.

Medical records

Safe cross-border healthcare depends on high quality, accurate and comprehensive information about the patient's medical history and any treatment they have received previously. Not only is it vital that full records (electronic or hard copy) of any cross-border treatment are kept and promptly forwarded to be included in the patient's medical record in their home country, but also that the treating hospital has access to the patient's medical record, including the results of any diagnostic tests or procedures including scans and x-rays. This is imperative to avoid the need to repeat tests and procedures, which would add to costs and may result in additional pain, discomfort and even health risks for the patient.

In order to achieve this, the Commission could provide clear guidance and standards about what should be included in a patient's medical record. Further consideration should be given to development of the European health card which could hold certain essential basic information that can be read in an emergency as well as any specific information for patients seeking treatment cross-border.

Where patient records are transferred between and used by different organisations, an appropriate level of security and confidentiality must be maintained. The Commission has identified the need to provide an adequate data protection framework necessary to safeguard patients' medical records and to ensure their efficient exchange where necessary. Within this, we would like to see improved rights for patients wishing to have access to their medical records.

Promoting awareness

We would like to see a proactive campaign at EU and national level to promote awareness of the right to seek treatment abroad. At present, patients seeking information on the internet on medical treatment abroad are most likely to come across websites advertising private medical treatment abroad, or the services of intermediaries in arranging private treatment abroad. Without a concerned effort, many patients will be under the impression that they may only seek cross-border medical treatment if they go private.

Dental treatment

Which? campaigns for improved access to NHS dental care as this has been a major problem facing consumers across the UK for sometime, with fewer than half of all UK adults registered with an NHS dentist. Which? research in January, 2005 found[ix]:

- Just over half the people who tried to register with an NHS dentist in the previous two years found it difficult
- 58% of GB dental practices were not taking any new NHS patients and a further 11% were only taking certain NHS patients
- For those needing emergency treatment, only 8% offered an NHS appointment within 24 hours and a further 10% offered an NHS appointment but not within 24 hours
- Access to routine NHS dental care and emergency treatment varied significantly between areas.

Following recent reforms to NHS dental provision, it appears that there may have been a slight improvement in the situation but there are still areas of the country where it can prove almost impossible to get NHS dental care or treatment.

NHS dentistry can cover any treatment that is judged clinically necessary. However, some dentists appear reluctant to provide certain treatments on the NHS (such as crowns or dentures). Some consumers are currently entitled to receive NHS dental care including:

> people aged under 18 (or full-time students aged under 19)
> pregnant women or women who have had a baby in the 12 months prior to treatment
> some recipients of social security.

For those who must pay for NHS dental care, charges in England and Wales are set under a three-band payment system (currently £15.50, £42.50 and £189 in England and £12, £39 and £177 in Wales) according to the amount of treatment required.

Finding a dentist to provide NHS treatment can be difficult, and can lead to people not seeking regular care or treatment. The cost of private fees can be a huge strain on finances, and act as a barrier to people seeking regular care or treatment, and unlike in some European countries the costs of private dental treatment cannot be reclaimed from the NHS. Our concerns about private dentistry were the basis of Which?'s first ever super-complaint in 2001[x] to the Office of Fair Trading, asking the OFT to investigate the private dentistry market in the UK.

Thus obtaining treatment abroad may be an attractive option, and some UK consumers already seek dental treatment abroad, particularly in those countries where treatment is significantly cheaper than in the UK. The scope for dental treatment abroad is therefore of particular interest to Which?.

Spectacles

The number of people entitled to vouchers towards the cost of glasses under the UK is relatively limited. Again, consumers will need information about when they can buy glasses abroad and how they may reclaim the NHS contribution where appropriate.

Audiology

The NHS provides hearing aids on loan, free of charge, but does not contribute to the cost of privately purchased hearing aids. Patients can have to wait several months for an appointment to see an audiologist and may have to wait up to five years for a hearing aid. There may therefore be circumstances in which patients would like the opportunity to go abroad for treatment or to get treatment while already abroad, although fitting and follow-up appointments are also generally

needed. As with dental treatment, the payment system prevents consumers from making informed choices about seeking treatment abroad.

Consumers will need independent information on the effectiveness of hearing aids. It is not clear to us how far international and European standards in this area reflect the needs of users. However, we strongly support the recently announced initiative to assess the need for a European standard for the service of supplying hearing aids that focuses directly on patients' needs, and seeks to clarify what the services offered are, define service commitments, and develop methodological approaches to improve the services. This builds on work started by the French standards body, but will take several years to complete.

This work is being handled by the Services department of CEN rather than the healthcare department, as this currently only deals with products, and not services, which highlights a more integrated approach to the provision of healthcare as services and products cannot be easily divorced from each other. Further investigation is also needed in this area.

Q3: Which issues (e.g. clinical oversight, financial responsibility) should be the responsibility of the authorities in which country? Are these different for the different kinds of cross-border healthcare described in section 2.2 above?

Across Europe healthcare is a highly regulated (although standards may vary between countries), which recognises the significant potential for harm if it fails to meet minimum standards. Also, most patients are unable to assess the availability and quality of medical services, and are likely to expect consistent standards to apply across the EU.

We believe that patients should be able to expect that their own health provider will lead the shared responsibility for an individual's clinical oversight with the health provider in the country of treatment. Without this, there is a risk that the patient's national provider may seek to evade responsibility subsequently by trying to direct the patient back to the provider abroad. In addition, the patient's 'contract' (in the financial sense) is with his or her own national provider. We are particularly concerned at proposals from the NHS Confederation that the principle of caveat emptor should apply where patients seek treatment abroad.

As far as a wider role for the patient's home country is concerned, we would expect national authorities to study closely the collective experience of patients'

going to individual hospitals abroad, to monitor standards and to guide future references.

While we would expect the 'sending' Member State to exercise all reasonable care in relation to the standards of the 'receiving' country, we are concerned that it will defeat the objects of free movement if senders attempt to impose their own detailed requirements on the receiving hospitals. We have already seen one example of this: "the principle of exporting domestic standards is also apparent in the case of English patients treated in Belgium and France, as part of a short-lived attempt to reduce waiting lists. Thus, the English NHS undertook a separate, thorough assessment of the quality of providers, with contracts prescribing the care to be delivered in great detail, with the result that Belgian providers viewed the assessment procedures as unnecessarily bureaucratic and, in frustration, some withdrew from the process"[xi].

The Commission could perhaps encourage Member States, providers and stakeholders to produce a concise model document setting out the rights and responsibilities of the sending and receiving bodies and patients, to facilitate co-operation. There is also scope for the Commission to facilitate the development of common standards or benchmarking.

Q4: 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?

Redress can be vital in helping to mitigate the consequences of medical errors, including any financial loss or additional costs faced. Patients should be given the right to choose to seek redress in either their own Member State which authorised the treatment at the hospital concerned, or directly in the Member State where it was carried out.

Despite arguments of a compensation culture, the majority of UK consumers who experience problems with their healthcare are reluctant to complain or seek redress, often as a result of their poor health or the emotional consequences of the incident. Requiring patients who have been harmed following cross-border treatment to pursue any legal claim in the treating country will be punitive and act as a major barrier to seeking redress. Patients should not be obliged to sue in another jurisdiction under a different legal system, with all the difficulties and costs that would imply. Where a patient successfully obtains redress against his/her own national health system in respect of treatment in another Member State, then his/her own Member State should be entitled to reclaim the costs from the country concerned.

We recognise that there may be a case for different levels of liability/responsibility where patients have chosen a hospital themselves, as opposed to one arranged through their health authority or doctor: a further issue here is whether there is compliance with any relevant EU quality standard for health services (as discussed under Question 7). At the same time, there is a risk that different levels of liability/responsibility may lead to confusion. In any event, it is clearly desirable as a goal that all EU citizens using health services should have access to redress procedures that are effective, inexpensive, speedy and impartial, with the right of appeal to the courts if necessary.

To avoid protracted disputes and the need to establish blame, Which? would like to see consideration of a European no-fault compensation fund and/or proposals to deal with the liability of suppliers of defective medical services. Establishing a true no-fault scheme across Europe will be extremely difficult, involving consideration of different rules of evidence, liability and proof, but it merits detailed consideration. However, such a fund should not preclude a consumer seeking redress through legal means if they feel that the risks and potential costs are justified.

Q5: What action is needed to ensure that treating patients from other Member States is compatible with the provision of balanced medical and hospital services accessible to all (for example by means of financial compensation for their treatment in 'receiving' countries?

The question is posed in rather defensive terms. Provided that the sending country meets the actual treatment costs concerned, there can be significant benefits to the receiving country in increasing its ability to maintain general or specialist services, or services in a particular geographical area, which it might not otherwise be able to do.

We recognise that population shifts, such as the large number of UK citizens now resident in Spain, may impose particular localised demands. These should be seen in a different context to those arising from the cases of Watts, Kohll and others and that they need to be addressed separately.

Q6: 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?

Which? has long been concerned at a weakness in the EU framework dealing with the free movement of professionals. We support the principle that a medical

professional qualified in one Member State may practise in any other, but regret that the converse does not apply: a medical professional barred from practising in one Member State remains free to work elsewhere in the EU, potentially putting patients at risk.

Which? believes there is a strong case for a central malpractice register to assist health authorities in their checks. As a minimum, the Commission must require all EU healthcare regulators to share information with their counterparts in other EU countries about professionals subject to disciplinary action or who have been removed from the professional register. We also believe the Commission should consider the feasibility of imposing a legal duty on all healthcare providers to undertake full pre-employment checks on any employee, and to respond fully and accurately to any requests for information from any potential employers, detailing any disciplinary findings.

The Commission also raises the issue of those providing medical services either cross-border (such as remote diagnosis and prescription, and laboratory services) or on a temporary basis (for example a mobile clinic providing hearing tests, glasses or contact lenses). We recognise the advantages that such services may offer, and support in this case the principle of home country authorisation within an agreed EU framework subject to an element of host country supervision in areas directly related to the treatment of patients. It is important that those providing services on a temporary basis have the language skills necessary both to ensure that patients can give informed consent and to treat patients safely.

Q7: 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?

Quality of healthcare

Most consumers will be unable to make fully informed choices about the quality of medical services generally in other Member States or at specific hospitals. We note with interest the development of the independent Euro Health Consumer Index (EHCI) which uses 27 indicators to assess the consumer friendliness of national healthcare systems in the Member States. We suggest that there is a good case for wider independent EU benchmarking of quality, perhaps through an EU agency.

While there may be scope for voluntary initiatives to ensure the quality of services, including codes of practice, we would be concerned if there were to be a proliferation of national codes and/or of sectoral codes. This would be likely to be very confusing for consumers.

More widely, there may also be scope for the development of Europe-wide benchmarking of services and standards on the provision of cross-border medical treatment which would set out what patients would be entitled to expect at receiving hospitals and the basis on which services would be provided.

As noted earlier, UK consumers have little or no rights of entitlement to NHS healthcare. We support the proposal by BEUC for a comprehensive Patients Charter, which would of course have benefits well beyond patient mobility: "assuming that this cannot be achieved by purely legal measures, the Commission and Member States should use the Open Method of Co-ordination. A Patients Charter would help to raise standards, and serve as a guide to consumers of health services"[xii]. A Charter would also be practical way of carrying forward the recommendation of the High Level Reflection Process on Patient Mobility and Healthcare Developments "to explore further the possibility of reaching a common understanding on patients' rights, entitlements and duties, both individual and social, at European level, starting by bringing together existing information on these issues and how they are addressed within the Member and acceding States".

The Commission refers to the likely development of European networks of centres of reference. We would certainly encourage this development which may produce centres of excellence, but we would like safeguards to ensure that Member States cannot seek to limit patient mobility by restricting prior authorisation to hospitals within such a network.

Cross-border private medical packages

Cross-border private medical packages are widely on offer, often involving a consultation in the patient's own country or electronically, air travel, local transport, accommodation for the patient and family, interpretation services, and treatment. We suggest that the Commission consider the possibility of undertaking some research into patients' experience of these cross-border services, to look at levels of satisfaction and the adequacy of complaints and redress procedures.

Cosmetic surgery and beauty parlours

Which? shares the concerns of ANEC, the European consumer standards body ANEC[xiii] regarding cosmetic surgery and beauty parlours. ANEC has noted that:

"Health and safety issues related to the services provided by beauty parlours and cosmetic surgery institutes are of high consumer concern. Many beauty parlours offer services such as electric muscle stimulators, permanent make-up or laser treatments, all of which may carry serious health risks to the consumer if not provided in hygienic conditions by trained personnel with the relevant health history of the consumer checked in advance. The same holds even more true for private sector cosmetic surgery services, performing e.g. face lifts, rhinoplasty and liposuction. Not only are these invasive operations not always performed by plastic surgery specialists, but they are also available as part of so-called scalpel safaris, meaning that the service is offered in conjunction with a holiday. With the enlarged Europe, many consumers are offered less costly cosmetic surgery services abroad, without having adequate knowledge of the host country's standards or legislation in the field. Furthermore, such services are often offered via the internet, with face-to-face consultations with the surgeon only taking place at a later stage".

Q8: 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?

In addition to the other areas that we have referred to, we suggest that the Commission examine the possibility of systems for assessing the effectiveness of pharmaceuticals on an EU-wide basis. Some European countries have already established bodies to evaluate the effectiveness of different medicines and treatments. In England, this body is the National Institute for Health and Clinical Excellence (NICE), whose decisions significantly determine what medicines should be offered on the NHS on the basis of their cost-effectiveness.

Establishing a Europe-wide organisation to fulfil this function would minimise duplication of effort across European countries, share expertise and yield cost savings. Such a body would be in addition to European Medicines Agency (EMEA), which is responsible for assessing the safety and efficacy of medicines. A Euro-NICE would be able to assess the relative effectiveness of medicines, and their cost-effectiveness for health services/insurers. While this is something that the Pharmaceutical Forum is currently considering, the progress of their work is very slow.

In addition to its current role, we also believe that EMEA may have a role in coordinating the reporting of adverse drug reactions across Europe, in a more systematic and patient-centred way. Which? believes that all Euro consumers should be able to register suspected adverse drug reactions with the European Medicines Agency.

We would welcome initiatives to improve the language skills of medical professionals, through the development of dedicated teaching programmes and standardised language testing for medical professionals.

Q9: 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?

Which? would like to see a Regulation which will set out clearly the rights of patients to cross-border treatment, in order to ensure consistency across the Member States and for ease of enforcement.

As far as the framework is concerned for the practical operation of cross-border treatment by the Member States and reimbursement are concerned, we recognise that a directive may be more appropriate given the different health systems and the need to encourage flexibility and innovation. However, it is essential that the principles and safeguards for consumers are clearly defined on an EU-wide basis.

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Appendix: information from NHS Direct web site[xiv]

"Can I go abroad for NHS treatment?

"Your local NHS Trust or PCT selects patients who they think might be interested in being treated abroad. This is based on a number of factors, such as the number of people waiting for a particular treatment.

"You will be contacted directly by your local hospital or PCT and invited to a local assessment centre called an Overseas Assessment Clinic (OAC). Here you will have a medical examination and a chat with an overseas consultant to see if you are fit for the treatment and fit to travel.

"If, after your assessment, you decide that you don't want to go abroad for treatment, that's fine. You'll stay on the waiting list at your local hospital or trust for treatment with your local consultant.

"If you are suitable for treatment abroad and you agree to go, dates and transport will be arranged, usually within 3-5 weeks. You will travel to a hospital or clinic abroad called a Designated European Provider. Travel will either be by train or plane and usually includes some coach travel. You are likely to travel with a group of 5-25 other patients and will be accompanied by a Euro-PAL, who is your bi/multi-lingual point of contact while abroad.

"A relative or friend is welcomed to escort you but will need to pay for their own travel and accommodation.

"After you have recovered from your treatment the Euro-PAL will arrange your travel home. If there are any complications after your treatment you will stay in the hospital or clinic until you are able to return home. Your notes (discharge summary) will be given to your GP or consultant in the UK and any follow-up appointments will be held in the UK.

"Overseas treatment is an NHS service and you will not be expected to pay any of the treatment, travel or accommodation costs.

"If you need treatment that is not available on the NHS or cannot be given in the time necessary given your state of health you may be able to go abroad. The Department of Health may authorise another European Union (EU) country to provide specific treatment under their state healthcare scheme. They do this by isssuing [sic] form E112. This certifies that the the [sic] UK will reimburse the country providing the treatment.

"If you want to be treated outside the EEA (European Economic Area) your condition must be of a serious nature and the treatment you are requesting must be well established (not experimental), not available in the UK or the EU and likely to be of significant benefit to your health. If the treatment you are requesting fulfils these criteria, your PCT may consider your request, but they are not under any obligation.

"For more information, speak to your GP or consultant."

References

i Which? was formerly known as the Consumers' Association

ii Patient Mobility in Europe: Legido-Quigley, McKee and Nolte, presentation to Austrian Congress of Health Management 2006

iii Patient Mobility in the European Union: Learning from Experience: edited by Magdalene Rosenmoller, Martin McKee, Rita Baeten, 2006

iv Avril Doyle, MEP

v National Assembly of Wales

vi The Scotsman, 24 October 2006, unnamed response to article "Scots hospitals hit by influx from England"

vii Patient Mobility in Europe. page 106

viii A Which? research 2004: omnibus survey of a representative sample of 986 adults in Britain interviewed face-to-face between 20th and 26th February 2004

ix Which? research (2005):

- an omnibus survey with a nationally representative sample of 1,894 GB adults aged 16+. Interviews conducted in- home between 12th-16th January 2005
- Situation Research to test access to NHS dental care (479 calls to dental practices across England, Wales and Scotland between 24th-28th January 2005) and access to Emergency Dental Treatment on NHS (321 calls to dental practices across England only between 15th-18th February 2005).

x Under the 'supercomplaint' procedure established by UK legislation, designated bodies such as Which? may submit a formal complaint to the OFT which must give a reasoned response within a specified period.

xi Patient Mobility in Europe

xii BEUC, response to Commission Communication "Enabling Good Health For All" 2004

xiii ANEC briefing ANEC-SERV-2006-G-011. May 2006

xiv NHS Direct. Can I go abroad for NHS treatment? http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=907 (accessed 2 February 2007)