academisch ziekenhuis
Maastricht

P. Debyelaan 25
postbus 5800
6202 AZ Maastricht

telefoon 043-387 65 43
telefax 043-387 59 95

Raad van Bestuur

azM

European Commission
Health and Consumer Protection
Directorate-General
Health services consultation
B232 8/12
B-1049 Brussels, Belgium

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Subject: Consultation regarding Community action on health services

Maastricht University Hospital (azM) would like to take advantage of the opportunity provided by the "Consultation regarding Community action on health services" of 26 September 2006, reference SEC (2006) 1195/4, to make known its views on cross-border healthcare. azM's response will not deal with all the questions raised by the Commission but is actually written on the basis of the knowledge and experience it has gained of cooperation and cross-border patient mobility in the Meuse-Rhine Euroregion, thereby implicitly addressing a number of the Commission's questions.
Our approach therefore focuses on the position of and cooperation between hospitals, specifically from azM's perspective. In particular, we describe the problems which are obstructing or delaying cross-border healthcare in our Euroregion.

In the above-mentioned "Communication from the Commission", the European Commission (EC) stresses the practical utility of increasing cooperation in border regions. In future Community cooperation, it will be possible to learn lessons from existing cooperation across internal borders. The consultation emphasises the need for the EC to develop the policymaking process in Brussels on the basis of a practice-oriented approach. Clearly, the development of a European framework for healthcare cannot involve any question of harmonising measures. The judgments of the European Court of Justice in the Kohll and Decker cases[1] and subsequent decisions of the European Court concerning charges for cross-border care make it clear in particular that under the principle of subsidiarity (Europe does not control any matters that a member state can better control itself) member states themselves remain responsible for organising and delivering healthcare to their citizens.

[1] Case C-158/96, Kohll [1998] ECR I-1931 and Case C-120/95, Decker [1998] ECR I-1831

They will not be subject to further legal intervention from Brussels. Cooperation between partners across borders is therefore the solution to the continuing development of the subject of care and Europe. The EC is alert to "best practices" (examples of good practice) which can contribute to the process of Europe progressing to greater coordination and/or convergence between European care systems. azM would like to contribute to this process with its knowledge, experience and completed and planned cross-border activities in the Meuse-Rhine Euroregion. This will give rise to an international policy vision based on daily practice. Cross-border patient flows and cooperation and networking across national borders are of value for underpinning the high level of abstraction in policy-making at European level with practice-oriented examples and providing guidance.

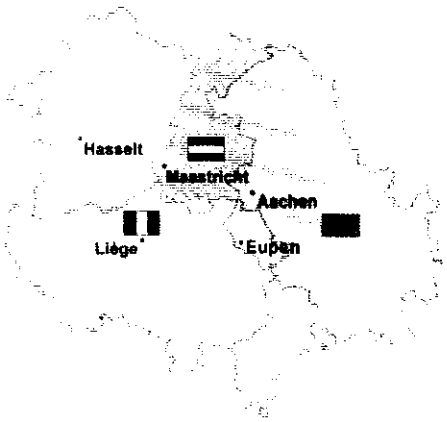
It is in any case not the first time that the EC has consulted the European care sector by asking what the next step should be in developing healthcare from a Community framework. In the High Level Group on Health Services and Medical Care (DG Sanco) and the Social Protection Committee (DG Emplo) the EC is trying to get the parties in the field directly involved in the future design of Community policy. The Lisbon Agenda, the Seventh Framework Programme for research and technological development and the action programmes on public health provide opportunities for further developments in European care with the close involvement of those working in the sector. azM has also included the principles and results of these initiatives and action programmes in its Euroregional strategic agenda.

Meuse-Rhine Euroregion

Because of its position in the Netherlands, close to the Belgian and German borders, and centrally located in the Meuse-Rhine Euroregion, azM is constantly confronted with patients who are registered with a care provider on the other side of these borders. However, cross-border flows of patients in the Meuse-Rhine Euroregion must not be regarded in isolation but in the light of policy, developments and opportunities in the field of healthcare and related research in South Limburg and the neighbouring parts of Germany and Belgium. This region contains the university medical centres of Maastricht, Aachen and Liege, all within a distance of 30 km of each other. Until recently, the university centres in the Meuse-Rhine Euroregion, all located away from the centre of their own countries, had their backs turned towards each other. For a few years they have been turning to face each other and strategic cross-border cooperation is now at the top of the agenda for these institutions. European integration, increasing globalisation and the sweeping changes expected in healthcare have made it a matter of urgency to establish in this region, which is closely bound together economically, far-reaching cooperation in the field of healthcare and, increasingly, its future development.

The Meuse-Rhine Euroregion is one of the oldest cross-border joint ventures in Europe. In 1991, this Euroregion obtained a legal charter in the form of a foundation under Dutch

law (*Stichting*). The Meuse-Rhine Euroregion covers an area consisting of the southern part of the province of Limburg (Netherlands), the province of Limburg (Belgium), the province of Liege (Belgium), the region of Aachen (Germany) and the German-Speaking Community (Belgium).



Meuse-Rhine Euroregion

This region has long been characterised by the cross-border movement of people to work, live, shop, go out, study, do business, etc. In recent years, there have also been clear shifts towards cross-border spatial planning, industrial estates, transport and healthcare. This is therefore creating a strong and ever closer economic coherence and relationship.

Cross-border patient flows

In the area of healthcare, there has been a rapidly increasing cross-border patient flow since the beginning of this century which initially involved Dutch patients who attended Belgian hospitals because of the waiting lists in their own country. However, contact between hospitals has gradually acquired a broader and more structural aspect. This cooperation at institutional level is dictated by the fact that hospitals can no longer stand alone in the 21st century. Traditionally hierarchical and inward-looking care organisations are giving way to customer-oriented network structures. This trend towards networking offers patients the prospect of a wide range of care, personalised treatment and tailored care being available across the region. Care organisations no longer need to provide everything themselves but can focus on and specialise and excel in parts of the care provision according to their strengths, enabled to do so by complementarity, diversity and interconnections within the network. Where a university or other hospital is situated close to a national border, as in the case of Maastricht, these regional interconnections develop into a Euroregional network. Maastricht University Hospital has already put this into practice by establishing cross-border alliances.

Cooperation agreements have been concluded (in 2003) with Vesalius General Hospital in Tongeren (Belgium) and (in 2004) with Aachen University Hospital just across the border in North-Rhine Westphalia. The aim is to create complementarity of facilities with a view to making as wide a range of healthcare as possible available at Euroregional level. This means that healthcare services are available a short distance from where patients live and that patients no longer have to travel to hospitals elsewhere in their own country. The aim of these alliances is not only to achieve patient mobility across borders but also to facilitate the exchange of medical specialists as well as videoconferencing, the exchange of knowledge and information and the establishment and availability of ICT connections between the partners involved.
What is also interesting in this regard is the fact that in the Meuse-Rhine Euroregion, three healthcare systems are coming together, communicating with each other and consequently converging in practical forms of cross-border movement, such as the joint ventures which have been established, the mobility of patients and health workers and the exchange of information and knowledge.

Obstacles to cross-border movement

Cross-border healthcare in the Meuse-Rhine Euroregion is a highly ambitious project but is also characterised by major barriers. Patients and hospitals are confronted day in and day out with obstacles posed by national borders.
The main problems/obstacles are listed below:

1. Funding
As a result of the Dutch system of financing hospitals, earnings from foreign patients treated in Dutch hospitals cannot actually be posted as income as it is covered by the budget system and the related restrictions such as a maximum allowance for (domestic) growth. This is an obstacle to patient mobility from neighbouring countries to azM and new initiatives to treat foreign patients in Maastricht or to refer patients to each other in joint ventures between partners are nipped in the bud.

2. Scheduling top-quality clinical care
Cross-border cooperation between university medical centres such as azM and Aachen University Hospital mainly involves cooperation in the area of top-quality clinical care and therefore explicitly affects the policy for scheduling top-quality clinical care (based on the Dutch Special Medical Procedures Act [*Wet Bijzondere Medische Verrichtingen*]) in the Netherlands. National legal obstacles in this area should be minimised as far as possible in order to achieve effective and successful cross-border cooperation. In the example of the cooperation between Maastricht and Aachen, their shared intentions and ambitions in terms of top-quality clinical care should be considered within a wider context.

3. Mobility of Belgian patients
Belgian patients seldom obtain permission to go to a Dutch hospital. The competent authorities in Belgium operate a very restrictive policy which is dictated and determined by the Belgian federal government and national legislation and regulations. A situation has therefore arisen in which Dutch patients go to Belgian hospitals while on the other hand Dutch care providers seldom have the opportunity to treat Belgian patients.

4. Liability
Cross-border cooperation agreements and the mutual referral of patients raise a number of issues with regard to contractual liability. Question 4 in the above-mentioned "Communication from the Commission" rightly raises this problem as well as the issue of the safety of patients in the case of cross-border care.

5. Training of medical specialists
As a university hospital, azM has a large number of medical specialists in training. Assistants form an important part of the complement of medical specialists whom it must also be possible to deploy in the current and proposed forms of international cooperation. For this reason they will also be starting to perform some of their daily duties in the foreign centre. There will likewise have to be an opportunity for foreign trainee medical specialists to complete (some of) their training in Maastricht. This will have to happen in accordance with the rules governing the training courses and the recognition of foreign trainers and training institutions will have to be arranged.

6. MRSA
Because of its prudent policy on antibiotics, the Netherlands could be said to form an oasis within a European environment in which resistance to antibiotics is much higher, especially in hospitals. Although the realisation is growing, not only in our neighbouring countries Germany and Belgium, but also at European level, that authorities everywhere will have to work towards creating a "Dutch situation", this has not yet been achieved and this bacteriological aspect is another factor inhibiting the expansion of cross-border cooperation on (top-quality) clinical care. It is true that project-based initiatives have already taken place or are still in progress, also together with other German-Dutch Euroregions. But this issue certainly deserves the attention it is due from the point of view of quality, patient safety, patient mobility and the migration of professionals and, in particular, also from the point of view of funding.

Commitment from the European Commission

According to the principle of subsidiarity, it is first and foremost, but not exclusively, the task of the neighbouring member states concerned to facilitate cross-border care and resolve the issues highlighted. We see things the same way and accept the situation. But in addition, and in connection with this, we would issue a plea for some commitment

from the European authorities. Following on from this, we have set out below a number of main points/recommendations for consideration by the European Commission. Then, specifically for the Meuse-Rhine Euroregion, we will argue for the creation of an experimental situation in which the coordination of different healthcare systems will be put into practice.

The main points/recommendations are as follows:

a. Complementarity
The European Commission should encourage member states to arrange better coordination of their care facilities in border areas and make it easier to use them across the border. We are pleased to refer to, inter alia, Article III-278 of the Draft Constitution which provides for this kind of facilitating role for Europe and calls upon member states to create complementary facilities in their border regions.

b. Observatory
With a view to forming a rational cross-border care policy, both for the member states and for the European authorities, the European Commission should map out the current scale of cross-border mobility and cross-border cooperation between care institutions and the trends and problems that occur. Such a monitoring or observation function will provide strong encouragement and support for policy development in this area, both for the member states and for the EU as a whole. The EU should take the initiative in creating such a European observatory for cross-border care.

c. Migration of professionals
In particular, we would argue for a monitoring function for the migration of doctors and other care professionals. Already, unexpected and unforeseen movements can be seen, especially in the new member states and further developments in this regard can be expected. Without detailed information with regard to cause, extent and trends in this area, it will also be impossible to pursue the right policy on this issue that will do justice both to the freedom of movement of people within the European Union and to the powers of the member states to take measures autonomously with regard to training, the planning of the recruitment of professionals, establishment and professional practice.

d. Quality
We believe that the European Union also has a role to play in developing the quality of care. Although hardly anyone today doubts that it has been good for the development of the European market that the Union has established and also applied general quality standards, this principle has not yet been generally accepted in the healthcare sector as a service. Of course, European quality standards for the products (medicines, medical equipment) used in healthcare are generally respected, but this is not yet the case in the care sector as a service provided by the care professional to the patient. We believe that it would be a good idea for the Union, in association with the member states, to encourage and assist professional groups in Europe to draw up these kinds of professional

quality standards in the care sector. There is a growing need for these standards in the light of the current increase in mobility of patients and professional practitioners and services.

e. Liability

As noted above, Question 4 in the above-mentioned "Communication from the Commission" rightly raises the issue of the safety of patients in the case of cross-border care and that of (civil-law) liability and compensation.

As part of the Interreg IIIC project "Change on Borders" ("Telemedicine and e-health in cross-border hospital cooperation and healthcare"), an inventory is currently being made of the relevant legal aspects in order to tackle the issue of liability and an investigation will be carried out to devise a method or methods of achieving greater legal unity and legal certainty. Although the project focuses on telemedicine, its significance is not confined to this form of care provision as it is mainly general (i.e. applicable to the whole medical sector), contractual and extracontractual liability law on the basis of which liability for loss and damage or injury must be assessed. Comparative legal research, initially aimed at the Netherlands and Germany in connection with the project, has already clearly shown that discrepancies exist between the different legal systems on various points (e.g. Who is contracted by the patient in the case of (joint) medical treatment? From whom can compensation be claimed in the event of medical errors? How is the burden of proof allocated? What periods of limitation apply?) Further research is required in this case, as in the case of the interpretation of patients' rights. The same applies to the question whether the rules in force in the area of international private law (which court has jurisdiction in the case of cross-border claims? Which legal system applies?), and in particular the specific provisions under consumer law contained therein, are adequate where the legal position and protection of patients are involved.

As part of cross-border cooperation in care provision, the development of model contracts and/or checklists for items to be covered by contracts, paying due regard to the relevant insurance aspects, could make a contribution to achieving greater legal unity and certainty. At a "higher" level of regulation, consideration could be given to drawing up model rules tailored to the health sector, following the example of the "Principles of European Contract Law" and "Principles of European Tort Law" developed within the European context (for a German approach to this matter see the "Einbecker recommendations" produced by a medical group specially for the field of telemedicine in 1999). Further research also seems desirable in this case.

f. Objectives of the High Level Group

In this response, we would also like to refer to the objectives as set out by the High Level Group on Health Services and Medical Care, and in the resolution of the European Parliament on cross-border patient mobility (Report on patient mobility and healthcare developments in the European Union (2004/2148(INI)). As Maastricht University Hospital, which is located in a border area and has cross-border alliances with hospitals in various neighbouring countries, we would like to be of service with all the means at our disposal to the people of the region, Euroregion and Europe. We therefore subscribe to

disposal to the people of the region, Euroregion and Europe. We therefore subscribe to the principles and the methods indicated in these documents produced by the Commission and Parliament as meaningful steps on the way to achieving and improving cross-border patient mobility and cross-border medical care provision in Europe. In view of our location, experience and ambition we feel called upon, obliged and able to make an ongoing special contribution in this respect. This would be in close cooperation with the other actors in this field, including government agencies, the patients, the healthcare insurers and the professional groups.

Experiment in the Meuse-Rhine Euroregion

International coordination and national liberalisation of legislation and regulations are essential prerequisites for removing obstacles and offering Euroregional ambitions the prospect of success.
In this regard, we would argue for a pilot project to be set up in the Meuse-Rhine Euroregion, and in particular in a joint venture between azM and Aachen University Hospital, to uncover solutions to the problems outlined above. In an experimental situation it is possible to identify and resolve any problems that arise. A result-oriented approach would be adopted which would compare the consequences of the regulations governing different healthcare systems as they relate to a specific situation. Joint proposals for removing bottlenecks, thereby allowing the systems to converge, can be drawn up. European policy on the care sector will therefore be shaped both in fact and by right.

Conclusion

Most national ministries in the respective countries have thus far paid relatively little attention to bottlenecks that may occur or possibilities for making obstructive regulations and procedures more flexible or removing them altogether. We are encouraged to note that a change is now taking place and that governments, at both European and national level, are catching sight of the fact that in border regions such as the Meuse-Rhine Euroregion many people and organisations have shared interests and seek each other out and choose each other for cross-border cooperation.

We trust that the Consultation from the European Commission represents a major step forward in terms of European healthcare policy and will give consumers and providers in European border regions the opportunity to take part in cross-border movement and activities.

Over the years, Maastricht University Hospital has accumulated a vast store of knowledge and experie e with regard to cross-border care. Further information can be provided by the undersigne or by Prof. J. Scheres, Euroregional Coordinator, and P. Daemen MPM, Policy Adviser t e Executive Board.

G.J.H.C. . eeters, M.D.
Ch x tive Board

CC:
Ministery of Health, Welfare and Sport
FAO M.J. van Rijn
Director-General of Healthcare
P.O. Box 20350
NL-2500 EJ The Hague