SECTORAL ORGANISATION FOR MENTAL HEALTH AND ADDICTION TREATMENT (ggz)

ADDRESS Piet Mondriaanlaan 50/52, 3812 GV Amersfoort POSTAL ADDRESS Postbus 830, 3800 AV Amersfoort TELEPHONE 033 460 8900 FAX 033 460 8999 info@ggznederland.nl www.ggznederland.nl
KVK 40483580 ING-BANK 68.72.11.808 POSTBANK 3531353

Nederland

European Commission
Attn. DG SANCO
B232 8/102
B-1049 BRUSSELS
BELGIUM

Encl.

Date
30 January 2007
Contact person
C. Huitink
Direct number 033 - 4608988
Our ref.
FB/cshk/wlkk/100993/2007
Your ref.
Re.
Response to the European Commission's consultation on health services

Response of the sectoral organisation for mental healthcare *GGZ Nederland* to the Commission's consultation on health services

1. Introduction

We agree that "High-quality health services are a priority issue for European citizens", and mental health services are an integral part of this.
We agree with the Commission that effective means of ensuring citizens' rights of access to healthcare across Europe must be found.
To the Commission's view that Community action focusing on legal certainty and support for the Member States can add something to national policy, we would like to point out the importance of facilitating initiatives of care providers to provide cross-border care.
One aspect of this is recognising that the healthcare systems of the various Member States are very different, as is the way that healthcare is positioned.
European citizens are entitled to know the quality of the care provided so that they can make meaningful comparisons.

2. The need for Community action on health Services

2.1. The need for legal certainty

The Commission's conclusion that, despite the various European Court of Justice judgments (Decker, Kohl, Watts), clarification is still required, is illustrated by the its own questions.

Another question is how the "receiving" care providers (i.e. more specific than the "healthcare systems" mentioned by the Commission) can be properly financially reimbursed for the cross-border health services they have provided.

2.2 Different kinds of cross-border healthcare

According to the Commission, patient mobility is only one of the four possible types of cross-border healthcare. It also rightly comments that the cross-border provision of services (delivery of service from the territory of one Member State into the territory of another), such as telemedicine services, remote diagnosis and prescription, laboratory services, etc. can also play a role. This area has been very limited so far, but would, in our view, deserve to be stepped up if it provided significant added value. There is also the more traditional consumption of services abroad (where the patient goes to a provider of health services in another Member State for treatment). The Commission calls this patient mobility. The European Health Insurance Card is for necessary medical treatment for citizens temporarily visiting another Member State. In our view, this raises problems calling for practical solutions. Finally, the Commission also counts as cross-border healthcare the permanent presence of a provider in another Member State, e.g. local clinics run by large service providers, and the presence of persons (i.e. the mobility of health professionals, for example moving temporarily to the Member State of the patient to provide services). These are and will remain for the time being marginal phenomena which can provide a solution to local capacity problems, the impact of which on the provider's Member State of origin should be investigated in more detail (e.g. Polish doctors going to other European countries to practise there).

2.3 Relevance of Community action to overall health system objectives

We agree with the Commission that cross-border healthcare has often encountered problems due to incompatible rules between the countries concerned and the lack of a transparent legal framework and European structure for cooperation. Better coordination of the European rules of the European Union with those of the Council of Europe is required. The Council of Europe has established rules which allow bilateral and multilateral (often regional) collaboration between care providers in Europe. Implementation of these agreements in Community law could significantly reinforce their legal force and meaning, as well as supporting these forms of collaboration.

In our view, clear information is urgently needed, as the lack thereof often leads to wrong-headed views, leading to wrong conclusions and wrong decisions.

2.4 Nature and impact of cross-border healthcare

We agree with the Commission's position that the economic, social and health impact of cross-border healthcare on citizens and on health and social security systems must be analysed with care, looking not only at the impact on the "receiving" countries (including the appropriate reimbursement for cross-border healthcare) but also the impact on treatment after the patient's return to their country of origin. We also agree with the Commission that the lack of information on treatment possibilities in other Member States and the absence of a clear framework stops some people going abroad for treatment even if that would be a good idea.

Question 1: What is the current impact (local, regional, national) of cross-border healthcare on accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

In mental healthcare, there is currently too little cross-border patient movement for it to have an impact on the accessibility and financial sustainability of the healthcare system. It is to be expected that cross-border patient movement for mental healthcare will remain limited.

3. Areas of possible Community action

3.1. Legal certainty

In the Commission's view, both citizens and care systems need clarity in order to facilitate the general application of the Treaty provisions on free movement to health services, in the light of the legal developments described above.

3.1.1. More information and clarity in order to facilitate cross-border healthcare.

We agree that the procedures and conditions to be observed to take advantage of cross-border healthcare must be clarified. Moreover, existing procedures must be made simpler, so that the costs incurred by care providers can be reimbursed quickly and properly.

We also agree with the Commission that being entitled to healthcare in other countries is not sufficient

unless patients or professionals have adequate information to make informed choices about treatments and providers in other Member States.
As far as the transfer of patient details between different care systems is concerned, we would like to express our reservations, given that the privacy of patients and medical confidentiality are at stake.

Question 2: What specific legal clarification and what practical information is required by whom (e.g. authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?
In our view, clarification is necessary as far as the tasks and responsibilities of providers in the Member States are concerned and the conditions under which the competent authorities (e.g. insurers/health insurance funds) give permission to their policyholders/patients to go abroad for treatment. More specifically, it is important to clarify the tasks and responsibilities of treatment providers, the residence and admission requirements which national and regional governments set for providers and the quality requirements that apply in the legislation of the individual Member States.

3.1.2. Identifying the competent authorities and their responsibilities.
As far as the application of the internal market rules is concerned, it is important, according to the Commission, to clarify which Member States' authority is responsible for supervising health services for each of the different kinds of health service provision described in section 2.2. above. Specific issues which need to be dealt with include continuity of care when a patient is transferred to another Member State for treatment and then returned to their own country, or when treatment is provided by professionals who move temporarily to another country.

Question 3: Which issues (e.g. clinical oversight, financial responsibility) should be the responsibility of the authorities of which country? Are these different for the different kinds of cross-border healthcare described in section 2.2 above?
Oversight must, in principle, be the responsibility of the care provider in the country where the treatment is actually provided. Only in this way can the quality of care in the country where it is provided be properly supervised by the national authorities.
The financial responsibility should reside mainly with the system to which the insured party belongs.
Concerning the different kinds of cross-border healthcare, these may indeed differ. For the cross-border provision of services from the territory of one Member State in the territory of another Member State (e.g. telemedicine) the oversight should be exercised in the Member State from which the treatment is actually provided, not the Member State where the patient is located, as the oversight should be associated as closely as possible with the professional providing the treatment and/or who is primarily responsible for the implementation of the treatment.

3.1.3. Liability for harm caused by treatment and compensation arising from cross-border healthcare.
Although it is clearly intended to help patients, treatment can sometimes be faulty or negligent. It is therefore important to establish clarity with regard to how to guarantee patient safety in the event of cross-border healthcare provision, how to compensate patients for harm and, in the event of error, whose liability rules apply and how to follow up any errors. Health insurance companies and their local offices also play a role here. Effective reporting and feedback systems are necessary, incorporated in the system. If harm is caused, a clear mechanism must be triggered to ensure that appropriate compensation is provided and measures are taken to avoid a repetition.

Question 4: Who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm, how should redress for patients be ensured?
In this context, more clarity is needed about the applicability and legal consequences of cross-border liability for health professionals from other Member States. There should also be better legal guarantees and safety conditions to ensure the safety of patients.
The system of the Member State of origin (in which the patient is registered and, in most cases, where he or she actually lives) must create an appropriate scheme to provide redress for direct harm caused to patients.

4.1.4. A balanced healthcare system which is accessible to all.
Although the percentage of patients consuming cross-border treatment is small, it can be higher in certain circumstances, e.g. in border areas or popular tourist destinations.
There must be more clarity about what the Member State of treatment (i.e. the "receiving" country) can do

to prevent the treatment of patients from other Member States becoming an obstacle to a balanced healthcare system which is accessible to all or threatening the financial sustainability of the healthcare system of the Member State (e.g. in terms of organisation and provision).

Question 5: 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? (e.g. by way of financial compensation for treatment in the "receiving" country)?
To ensure that the treatment of patients from other Member States is compatible with the provision of balanced medical and hospital services accessible to all, financial compensation for the treatment in the "receiving" country can be agreed, corresponding to the real costs incurred for the treatment in the "receiving" country. The guiding principle should be to give patients as much freedom of choice as possible and to compensate treatment providers on the basis of the real cost price of the treatment.

5.1.5. Other questions
We agree with the Commission about the need for clarity concerning ethical issues and for Member States to be allowed to differ with regard to the type of care they wish to provide (e.g. for addicts).

Question 6: Are there further issues to be addressed in the specific context of health services regarding movement of health professionals or establishment of healthcare providers?
The problem with this question is that it relates to more than just patient movement, which is regrettable. Our guiding principle is that Member States, in the specific context of health services, should have as much freedom as possible in the establishment of their own laws and regulations pertaining to, for example, ethical issues relating to treatment. However, Community action would be appropriate where health or safety is threatened (e.g. in the area of infectious diseases) to ensure a high level of protection, in accordance with Article 152 of the EC Treaty. Other issues include making it compulsory for health workers or healthcare providers wishing to become established in another Member State to demonstrate that they have not been convicted elsewhere of a disciplinary or criminal offence.

Question 7: Are there other issues where legal certainty should also be improved in the context of each specific health or social protection system? How can cross-border healthcare be simplified, according to those who will be directly involved in receiving patients from other Member States, such as care providers and social security institutions?
In this context, we would like to point out in particular the need to maintain and, where possible, improve freedom of choice for patients in the EU. Legal certainty could be improved though increasing use of best practices developed in the various Member States. Legal obstacles that sometimes stop patients from travelling to other Member States for treatment should be removed where possible. Cross-border healthcare could be simplified above all by making the approval procedure for care in intramural institutions as simple as possible and enabling the direct financial settlement of the costs of treatment.

Question 8: In what ways should European action help support the health systems of the Member States? Are there areas not identified above?
Via the open method of coordination. We do not expect an approach which is too controlling as far as the health systems of the Member States are concerned. The open method of coordination is used to create a common framework to help the Member States to reform and develop the various aspects of their systems. These opportunities can be useful to make practical progress in the cooperation between Member States, but offer legal certainty in encouraging patients' freedom of choice only in the long term. Freedom of choice should be the starting point in the promotion of cross-border healthcare. In addition to the areas identified, there are others which are indirectly of interest for cross-border healthcare provision, including the application of the rules on European tendering for health institutions, where European tendering cannot be possible in Member States where competition between (private) health insurance and private treatment providers has been chosen. Furthermore, a study into the consistent application of European competition law would be important to create clarity about the comparability of statistics, whereby providers in systems where the market has been introduced (in a regulated fashion) are at a disadvantage compared with providers in (semi-)public systems but who may be competing (improperly) with providers in systems where the market has been introduced. The same could apply for the application of the rules on prohibited state aid.

Question 9: What tools would be appropriate to tackle the different issues related to health services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

The issue of whether legal certainty can be guaranteed best by a binding legal instrument should be examined. This instrument could be a regulation or a directive (based on Article 95, for example), although the results of this consultation should be taken into account in the choice of instrument. But the question is whether this would lead to progress in this area. A modernised system to coordinate the social security systems, to replace Regulations 1408/71 and 574/7224, is another possibility.

If the Commission were to clarify the case law (e.g. in an interpretative communication), this would throw more light on the subject.

It would also be possible to combine different instruments to form a general package of Community measures. However, for the sake of legal certainty, at least some elements should be laid down in a legislative instrument. Other issues can be dealt with using 'softer' mechanisms, such as recommendations, communications or guidelines. Support for practical cooperation between healthcare systems (e.g. more networking between reference centres) should probably be extended to ensure that practical structures are available so that cooperation is possible in practice.
In the light of the ongoing reforms of healthcare systems, a mechanism to update the instruments and rules should also be needed.
The existing instruments (i.e. regulations and the existing directives) have proved to be adequate. However, in order to solve the particular difficulties outlined here, we should look at whether a new health services directive could be useful. We would also call for an investigation into the possibilities for better aligning the regulations with those of the Council of Europe. Bilateral cooperation agreements (and treaties) can provide a boost for further pilot projects, and the EU should support these initiatives (financially, too, e.g. with the seventh framework programme).

Yours faithfully,

J.F. de Beer,
Director