Polish position on the Communication from the Commission of 26 September 2006/SEC (2006)1195/4/

Consultation regarding Community action on health services

The Polish side welcomed with interest the Communication from the Commission regarding Community action on health services and the view presented within it, namely that the Community's action in this field should be founded on increasing legal certainty and support for Member States.

Safe and high quality health services are the undisputed right of every European Union (EU) citizen, as stated in the Charter of Fundamental Rights of the European Union. Accordingly, the most important area to be regulated in this field comprises a series of issues relating to the whole process of delivering health services, from the moment a patient sets out to approach a doctor and choose a service provider through the delivery of the service to the stage of settling for the service, including clinical oversight and potential claims for damages. It should be noted that a range of relevant analyses, findings and recommendations in this field were produced as the outcome of the work of both the High Level Process of Reflection on Patient Mobility and Healthcare Developments in the European Union and the High Level Group on Health Services and Medical Care which is currently active. It appears that these outcomes could serve as a useful starting point for further and more detailed work on the problem areas identified.

It is also important to take into account the judgements of the European Court of Justice (ECJ) on the provision of health services when making decisions concerning the provision of cross-border health services, in particular the principle made clear in the judgements that as services provided for remuneration health services must be regarded as services within the meaning of the Treaty and thus the relevant provisions on the free movement of services apply. The importance of a ruling on this issue for individual Member States is illustrated by the debate that took place on whether health services should be covered by the provisions of the directive on the provision of services on the internal market. The decision eventually taken in this regard and the exclusion of health services from the scope of the directive should represent a further incentive to undertaking essential analyses and consultations on this area. It also means that the Commission's present initiative is particularly valuable.

The Polish side would like to highlight two issues before providing detailed replies to the Commission's questions.

Firstly, when creating a legal framework for new solutions, the relationships and mutual interaction arising between cross-border provision of health services (in the context of patient mobility) and the organisation and financing of individual healthcare systems should be carefully analysed. This is because in addition to the obvious benefits accruing to patients in this regard, related in particular to the free choice of health service and medical practitioner; there can be negative implications for individual healthcare systems. This can in turn result in restricted access to health services at national level and consequently to a situation in which patients did not have equal rights to permanent balanced access to health services. On the basis of the experience gained in Poland, it is important to highlight the significant differences emerging between individual public healthcare systems in EU countries, regarding both the definition of specific medical services/procedures and their costing.

Pursuant to the above and on the basis of the existing EU case law in this field, and taking into account the ECJs guidelines and judgements, and the principle of guaranteeing equal access to public health services to all those entitled to it, the Polish position is that when creating new legal frameworks, particular emphasis should be placed on undertaking a detailed assessment of the implications of regulation. The assessment should take into account the impact of the solutions adopted for cross-border medical care on patients' access to health services at both national and European level.

The second issue Poland would like to highlight concerns the adoption of a single definition of cross-border services. The Commission has put forward different types of cross-border healthcare. It would appear that these have been determined mainly with reference to the GATS approach to defining freedom to provide services, and not with reference to EU Treaty law. Pursuant to Article 49 of the Treaty, cross-border provision of services includes both the case when the service itself is relocated and the case when the service provider and/or the service user change their place of residence (the case described in indents 2 and 4 on pages 4 and 5 of the Communication). A different article of Treaty law covers the case described in indent 3 on page 5 of the Communication, however. The article concerned is Article 43 of the Treaty, concerning the establishment of enterprises, including service enterprises. It would appear more appropriate to retain the distinctions emerging from Article 43 and Article 49 of the Treaty in any potential draft legal acts based on it. This is particularly important, because the application of the GATS distinctions between types of service provision may lead to a situation whereby the same provisions would apply to matters relating to the cross-border provision of services and also the establishment of a service provision enterprise. This is in clear contradiction to the *acquis communautaire.* In the case of Article 43, it is a case of application of the national law of the state receiving the service provider, whilst the

requirements that may be imposed on an entity from another Member State in the case of application of Article 49 are much more limited.

With all the above in mind, Poland wishes to state that it is fully prepared to become actively involved in the Commission's actions aimed at improving access and also at ensuring equal access to the provision of cross-border health services.

Please find below Poland's detailed responses to the individual issues raised in the Communication from the Commission.

1. The impact of cross-border healthcare on the accessibility, quality and financial sustainability of healthcare systems – benefits and threats. Conditions for the development of cross-border healthcare.

Poland has been a Member State of the European Union for a relatively short time. Its experiences in this area must therefore be considered simply as initial findings and observations.

From May 2004 to date, Polish citizens have not used cross-border healthcare to such an extent as to have a significant impact on the accessibility, quality and financial sustainability of the healthcare system. Initial data also indicate an increasing disparity between cross-border services financed by Poland and cross-border services financed by other Member States. `This is mainly due to the significant differences between the costing of individual medical procedures. As cross-border healthcare is currently relatively insignificant, the aforementioned situation does not impact on the financial sustainability of the Polish healthcare system. It should be borne in mind, however, that if the role of cross-border healthcare increased significantly, it could pose a considerable threat to the financial sustainability of the Polish healthcare system.

This is another reason why, as indicated above, Poland wishes to emphasise the need to undertake a detailed study of the implications of regulations adopted in this area, within the framework of actions on regulating issues pertaining to cross-border healthcare.

To provide further details on the subject, it should be noted that from 1 May 2004 to the end of October 2006, (according to invoices forwarded to the Polish National Health Fund (NFZ) by other Member States), almost 38 thousand persons insured by the Polish National Health Fund received care in other Member States. During the same period and in the framework of the social security coordination system some 18 thousand EU citizens received care in Poland.

German citizens are the most frequent users of healthcare on Polish territory (including on the basis of an E112 form). Polish citizens insured by their National Health Fund are equally

frequent users of our neighbour's medical services, particularly in border areas. An increase in the number of Polish women travelling to other Member States to give birth has been noted recently. Medical centres located in border areas (especially those in Germany) are advertising heavily, encouraging Polish women to use their services at the expense of the Polish authorities. German services are generally far more expensive than similar medical services provided in Poland. It should be anticipated that service providers in border areas (on both sides of the border) would act in a similar way if the requirement to obtain prior authorisation from the competent authority for planned laboratory services to be provided abroad is eliminated.

The highest percentage of all healthcare services provided in the framework of provisions on coordination involves the insured person concerned receiving services considered to be medically essential whilst temporarily present in another Member State. One of the main contributory factors to the frequency of use of services in a given region is the attractiveness of certain localities to tourists, especially if those localities are near a border. As the majority of the most popular tourist spots in Poland are large and well-known cities with many hospitals, healthcare centres and other health and medical facilities, access to healthcare services is adequate. The only potential problems might involve waiting lists to consult a specialist or undergo diagnostic tests.

Poland believes that it is essential to create a unified cohesive system of provisions if EU law is to be implemented correctly. All possible discrepancies of interpretation should be avoided and the case law of the ECJ taken into account. It follows from the information referred to above that the classification of birth, for example, can lead to particular practical problems. On the one hand, this is an essential service, and on the other, it may in certain circumstances be deemed to have been planned. The provisions on coordination are not sufficiently unambiguous in this regard, which leads to difficulties of interpretation concerning the document entitling the bearer to these services (EHIC or E112) and to reimbursement of costs.

At the same time, a study of the movement of patients to the remaining EU/EFTA Member States and obtaining medical care abroad drew our attention to the problem that certain foreign service providers fail to recognise the entitlements accruing from possession of an EHIC, which restricts Polish citizens' access to health services whilst temporarily present in another Member State. It also makes it impossible to reimburse the costs unfairly incurred for treatment abroad. Treatment costs are reimbursed under Article 34 of Council Regulation (EEC) No 574/72, pursuant to which the amount reimbursed depends on the rates applied to invoices issued in the country of temporary presence. What happens is that the service providers do not recognise the entitlements accruing from the social security insurance

document presented and treat patients as if they were not insured, applying commercial rates when calculating the cost of services. The amount reimbursed therefore bears no relation to the costs incurred.

The principles for obtaining health services whilst in a Member State other that one's own (types of entitlement documents) and the principles of financing these (reimbursement of costs) were regulated in detail in Implementing Regulation No 574/72. Nonetheless, they are often not complied with in practice. Special attention should be paid to these matters, particularly as concerns cross-border provision of services when service providers deal with patients insured by the social security system of a European Union Member State and also with those who are not entitled to services in any Member State of the Union or who have decided to use their own resources to pay for all the care received.

One reason for not recognising the documents entitling patients to health services provided in Member States other than the country of residence or domicile may be that medical centres are unfamiliar with the arrangements regarding payment for healthcare services provided under the provisions of coordination. Another possible reason may be a desire to obtain payment directly from the patient, to avoid a need to settle it with the competent authority later. It may prove that increasing information on the scope of entitlement to healthcare services provided on the basis of coordination procedures will reduce difficulties of this kind in obtaining healthcare in Member States. It also seems appropriate to compel service providers to comply with the aforementioned provisions on pain of penal sanctions provided for in agreements with the competent authorities.

It is also the case that individuals insured in Poland currently make very limited use of telemedicine services, laboratory services or remote prescription services which are provided by foreign service providers. This is mainly due to the language barriers the Poles face and also to patients' reluctance to trust remote diagnoses when there is no direct contact with the doctor. The provision of remote diagnoses and laboratory services is also very infrequent. They are only resorted to in exceptional situations, usually when in order to ensure a correct diagnosis it is necessary to consult doctors from abroad who are highly respected specialists in specific areas of medicine, or when laboratory tests that cannot be undertaken in Poland are required.

Another type of cross-border healthcare involves the permanent presence of a service provider in another Member State. In practice, however, this occurs relatively rarely. Most cases concern private healthcare, when foreign clinics open subsidiaries or branches in the territory of another country. There are very few cases of this nature in the public health service. The most common include enterprises that specialise in dialysis treatment, when

foreign enterprises open dialysis units in the territory of other Member States, including Poland.

With regard to the last type of cross-border healthcare referred to in the Communication, namely the temporary presence of health professionals in the Member State of the patient, it should be noted that in addition to the undoubted benefits for the 'receiving' state, particularly in connection with increased access to healthcare services for patients, there can be negative consequences for the country of origin. This is because access to healthcare services in the country of origin can be restricted as a result of the migration of health professionals and stable, balanced and equal access to healthcare services threatened.

2. Legal certainty – issues requiring specific legal clarification, scope of essential practical information required to enable safe, high-quality and efficient cross-border healthcare to be provided within the EU.

One of concerns raised by the Polish Ministry of Health in 2004 in connection with Poland joining the EU coordination system was the risk of intensification of the so-called 'health tourism' as a way of obtaining non-hospital specialist healthcare services, for which there are long waiting lists in the country of origin. Further concerns identified risks of destabilising the mechanism of reimbursement for services; undermining the financial stability of the healthcare system; the potential lack of control of the quality of services provided, and lowering the standard of care for the consumer/patient. In our view, all legislative and non-legislative instruments should aim at eliminating the aforementioned risks. We believe that further coordination of legal provisions is essential, along with the introduction of efficient information procedures, principles of fair competition and measures to counter corruption, and constant improvement of the quality and accessibility of medical services based on earlier experience and practical solutions.

Poland's experience so far in the area of coordination of social security systems shows the need for further clarification and detailed solutions regarding several legal issues.

The provision of international medical transport for patients receiving cross-border healthcare and the rules for covering its cost should be subject to regulation at Community level. Authorising the provision of planned treatment in another Member State serves no purpose, if medical transport appropriate to the patient's condition cannot be made available and reimbursed.

It also seems essential to try to develop criteria permitting uniform assessment of what are services essential from a medical point of view (this assessment is currently entrusted to doctors in the country of temporary presence) and of the expression 'without undue delay'

used in Regulation 1408/71. Interpretation of the aforementioned expressions is fraught with uncertainty which very often results in a refusal to reimburse the cost of treatment by the competent Member State. An unclear definition of hospital and non-hospital services could lead to similar misunderstandings.

It would also be appropriate to try to create a list of medical conditions for which treatment may reasonably be postponed and of those for which it cannot be delayed. Publication of a list of this kind containing guidelines for all Member States would streamline the procedure for obtaining authorisation from the institution liable for payment for treatment abroad. It would also provide the citizens of all EU Member States with equal opportunities for access to services. In addition, it would be very helpful to bring together in one place and make available to all concerned knowledge on the various methods of treatment of individual health conditions and their effectiveness.

Facilitating access to cross-border healthcare is very important to ensuring the safety, high quality and effectiveness of such services. This type of movement can be made significantly easier by introducing or increasing the opportunities for concluding contracts for the provision of healthcare services in foreign medical centres. Future contracts of this type should be standardised. The High Level Group on health services and Medical Care (HLG) is currently working on this. The outcome of its work should be used when developing specimen/models for such contracts.

Safe, effective and high quality cross-border medical care calls for more work in many areas of law (also in individual Member States). The result of such activity should be the creation of specific links between the various health systems of European states. In order to ensure the provision of high quality medical services and effective cross-border healthcare the following issues must also be regulated:

- The service provider’s responsibility with regard to complications and medical errors, and also their subsequent treatment in the country of residence, plus the possibility of lodging complaints
- Standardisation of the system for the authorisation of treatment abroad by the institution liable for payment
- The scope and method of transmission of information between individual healthcare systems (arrangements for further care, including continuation of treatment, convalescence and rehabilitation before or after the patient’s return to his or her country of residence)

- The provision of support throughout the journey (language barriers) and special care for older, disabled and seriously ill persons
- Methods of payment and cost reimbursement
- Lists of medication and pharmacy as a whole
- Treatment standards
- Patients' rights
- Mobility of health professionals

The adoption of uniform quality control criteria is an essential precondition for making an informed choice of country and centre where patients want to be treated. The research currently under way (MARQuIS) involving 600 hospitals in 7 countries, including Poland, could serve as the basis of a recommendation or directive on the quality of medical services. The outcome of this research will provide a starting point for assessment of the opportunities and risks for patients receiving cross-border services.

Poland believes that detailed legal solutions must also be found concerning the procedure and scope of reimbursement of costs borne by the patient in a situation when the cost of a certain procedure in the country in which the patient is insured is greater than the cost of that procedure in the country where it was carried out. Certain ECJ rulings allow for such a possibility, but we are of the opinion that it is unethical for a patient to 'make profit' from the fact that a specific procedure was carried out abroad. In such cases the reimbursement of costs should only be as high as the costs actually incurred, otherwise there is a strong likelihood that the 'health tourism' phenomenon will intensify.

Doctors and insurance institutions that bear the cost of the treatment play a key role in informing patients about existing possibilities of treatment in the home country or abroad. They therefore need to have the relevant information at their disposal. Accordingly, it seems essential for European Member States to create a so-called 'information bank' on the possibilities of receiving particular treatments in a given country and on the quality of such treatments. The relevant authorities and health insurance institutions in a given country would provide the bank with standardised data.

Poland proposes that such an information bank on cross-border medical care be created. The bank could be consulted through a special Internet portal, and the person doing so would be able to choose the language in which to access relevant information on:

- The principles for receiving cross-border medical care in individual Member States,
- Centres specialising in undertaking highly specialised medical procedures,

- Specialist procedures undertaken in Member States – information for patients,
- Specialist procedures undertaken in Member States – specialised information for health personnel,
- Cost of medical procedures – information for patients, institutions liable for payment and health personnel.
- Waiting lists for specific treatments.

Setting up such a portal would ensure that institutions liable for payment, medical personnel and patients could make an informed and appropriate choice of service providers abroad.

The transfer of health details between different systems requires many issues to be resolved. These include standardising the scope of medical information, the method of transferring it and protection of personal data. It also seems essential to create an integrated system of electronic medical documentation. Adjustments to the EHIC should allow patients and service providers easy access to all information concerning treatment methods, procedures used, initial diagnosis and medication prescribed.

In this connection it is appropriate to consider also the issue of the patients' health and safety in cross-border care, with reference to the example of AIDS patients. Despite the existence of (national, sometimes trans-national) networks of reference laboratories for diagnosis, monitoring of HIV infection and monitoring of ARV therapies, there are significant discrepancies between laboratories and centres. This is the case across countries and also sometimes between individual centres too. Essentially, test result data provided by a laboratory in a given town or country sometimes cannot be related to methodologies applied in another laboratory, and is therefore useless. According to patients' statements (in information provided by AIDS Action Europe, HivEurope, EATG), safety can be compromised as a result. For example, if a patient relocates within the Community and selects a new clinic, a situation could arise in which old test results presented were difficult for new doctors to understand and could therefore be misinterpreted. The tests are sometimes carried out again, which has negative implications for the financial authorities. An effort for greater standardisation of both the ways of presenting data and the methodology applied to tests is advisable. These tasks could be undertaken by the European network of centres of reference mentioned in the Communication from the Commission.

3. Responsibilities of the authorities and institutions for clinical oversight, responsibility for medical errors and financial liability – differences depending on the type of cross-border healthcare. Ensuring redress for patients if they suffer harm.

It appears that the scope of responsibility of Member States' authorities depends on the type of cross-border healthcare. Whenever the healthcare services are provided in the territory of a given Member State, responsibility for clinical oversight and responsibility for ensuring safe and high-quality healthcare should lie with the national authorities of the State in whose territory (patient mobility) or from which (for example, telemedicine) the service is provided.

In principle, the authorities of the country where a particular service is provided should be responsible for monitoring patients' access to health services of the highest possible quality in terms of the standards of each specific country. The authorities should also be responsible for the proper provision of these services and for monitoring respecting patients' rights by the centres providing medical care. As to ensuring payment for the actual services provided, responsibility for this should lie with the authorities of the country where the person concerned is insured.

The authorities' responsibility is not as clear in cases when a doctor or clinical team from one Member State provides services in the territory of another Member State (mobility of health professionals). The 'receiving' Member State is responsible for the conditions in which the services are provided, including hygiene (for example, the issue of hospital-based infections) and for supplies of equipment and efficient medical apparatus, medication and medical products for example. Accordingly, it bears part of the responsibility for the safety and quality of the services. Particular attention should be paid to this issue and detailed legal solutions developed, especially concerning responsibility for medical errors and redress in cases of harm.

Regarding responsibility for the safety of healthcare services, it is clear that professional associations of healthcare workers should be involved (professional responsibility) and the appropriate institutions (responsibility of the institution liable for payment and body contracting the services). It therefore seems appropriate to consider the possibility of each Member State creating a single institution with responsibility for the provision of cross-border healthcare. Consideration should also be given to diversity of legal provisions pertaining to this area currently in force in individual Member States

Poland is of the opinion that responsibility for ensuring the safety and quality of cross-border healthcare should be regulated within the social security system and take into account legal provisions of the Member States concerned and the Community legislation.

There should be a transparent mechanism for awarding appropriate compensation and taking follow-up action to avoid repetition of errors in the provision of healthcare. A patient receiving cross-border healthcare should be able to obtain information about the provisions

and institutions that deal with such issues, both in the country of domicile and in the country of residence.

It seems essential to create a transparent and straightforward system of awarding compensation. The amount of compensation should be appropriate to the extent of the harm caused. To this end, the action is required to:

- Standardise the sums relating to civil liability, to avoid situations in which claimant's demands cannot be satisfied
- Simplify the claims procedure (language and legal barriers exist)
- Establish the competence of courts
- Standardise the system of exclusions in the compensation procedure

Payment of compensation may be regulated in various ways:

- Compensation is paid by the service provider's insurer
- Compensation is paid by the patient's insurer
- A combined arrangement may also be used.

4. Action to ensure permanent and balanced access to healthcare service (especially hospital services) in 'receiving' countries.

The solutions adopted in Poland, aimed at ensuring universally accessible balanced healthcare were enshrined in the Constitution of the Republic of Poland and in the provisions of the Act of 27 August 2004 on healthcare services financed from public funds (Dz.U. No 210, entry 2135, and subsequent amendments).

Under the provisions of the Constitution, (Article 68) everyone is entitled to healthcare in Poland. The public authorities ensure equal access to healthcare services, which is financed from public funds for all citizens, regardless of their financial situation. The scope and conditions of service provision are laid down in the Act.

Pursuant to the provisions of the aforementioned Act, hospital healthcare services and specialist non-hospital healthcare services are provided according to the order of applications on days and at times specified by the service provider, which had concluded a contract with the National Health Fund. The service provider establishes the order in which the services are provided on the basis of applications from service users. Should the medical condition of a service user change indicating a need to provide the service earlier than it was arranged, the service user must inform the service provider accordingly. If the medical

criteria indicate that the service should be provided earlier, the service provider changes the date when the service is to be provided and informs the service user of the new date without delay.

The waiting list is administered so as to ensure compliance with the principle of fair, equal non-discriminatory and transparent access to healthcare services. It should be emphasised, however, that in emergencies the service user receives healthcare services immediately.

The above rules on access to healthcare services apply to all persons entitled to receive medical care in the territory of the Republic of Poland. This means those insured by the Polish National Health Fund, service users other than those insured and persons entitled to services on the basis of coordination provisions (insured in other Member States).

In response to the question posed by the Commission and with reference to Poland's introductory comments, Poland would like to highlight once again that reimbursing the 'receiving' state for the cost of treatment is a crucial issue. Particular attention must be paid to it and detailed legal solutions devised so as to ensure financial sustainability of national healthcare systems, which in turn impacts on balanced access to high quality healthcare services for citizens of the 'receiving' country.

Ongoing monitoring of services provided to entitled persons from other Member States will allow for quantitative analysis of service provisions that are required to maintain continuity and access to healthcare. Areas with a high rate of patient mobility (due to large-scale tourism, for example), should be 'supported' with additional financial resources for the purchase of healthcare services until the costs are reimbursed to the 'receiving' state.

High patient mobility may result from, amongst other factors, lower costs of provision of healthcare services in another, e.g. a neighbouring Member State. Therefore the Community should take action to analyse costs and set realistic prices appropriate to settlement requirements. It should also ensure compliance with the deadlines set for reimbursement and immediate provision of relevant information and explanation needed for settlements between authorities in Member States. Financial compensation would guarantee that no other action other than providing appropriate information on cross-border healthcare available to EU Member States' citizens was required.

5. Further issues to be addressed in the context of healthcare services regarding movement of patients and health professionals or establishment of healthcare providers not already addressed by Community legislation. Facilitation of cross-border healthcare.

Action aimed at eliminating barriers in the medical services market should address the following issues: the simplification of administrative procedures imposed on service providers, the introduction of electronic procedures, and the elimination of many requirements imposed on service providers. Issues relating to the recognition of professional qualifications along with the delegation of workers to provide services and the safety of the services should also be taken into account.

International medical transport is one of the services not covered under Community law, and it can have a significant impact on the treatment process. There are cases where the cost of treating a patient abroad considerably exceeds the cost of transporting the person insured and the cost of continuing treatment in the country where the person is insured. Accordingly, Community law should also enable international transport services to be financed in duly justified cases. Patients' freedom of movement is severely restricted by the lack of rules for financing transport services for the sick within the framework of provisions on coordination.

An issue, which has not yet been resolved, is the provision of healthcare services to persons from EU/EFTA Member States who are not insured. Services to save patients' life and health must be provided regardless of whether the patient is insured or not. In general, however, service providers do not receive payment for the aid given to a person who is not insured in any country, and such aid tends to be very expensive. Careful consideration should be given to this problem, and an effort made to resolve it at Community level, for example by introducing an objectively calculated flat rate to reimburse the 'receiving' state for the costs incurred in providing treatment.

Another issue, which needs to be addressed in the context of healthcare services and become the focus of all Community policies, is a need to determine high standards of healthcare. An effort should be made to reduce inequality of access to healthcare and of the quality of care in Member States by establishing comparable standards. To that end, greater transparency of national health systems is required. Cross-border cooperation should be strengthened, particularly in the area of treatments for rare diseases.

There is a strong link between ethical issues and cross-border healthcare. Every person has the right to expect his or her physical, psychological and moral integrity to be respected and any action, which affects any area of this integrity, requires the consent of the person concerned. Therefore, it would be appropriate to tackle issues related to objective and sometimes subjective conditions that should be met in order to ensure that specific medical interventions are legal and comply with ethical standards. This also applies to scientific experiments and establishing when such experiments are permissible (subject, of course, to prior consent of the patient).

Directive 2005/036/EC on the recognition of professional qualifications provides for free movement of health professionals (doctors, nurses, etc.). This directive lays down the minimum educational standards required for qualifications (diplomas, specialisations, etc.) to be recognised. The existing provisions in this regard seem to be sufficient. However, there are no provisions that would regulate the exchange of information about the professional responsibility of health professionals, especially with regard to their competence to continue practising their profession.

Furthermore, all doctors across the EU should be assessed against unified criteria permitting them to practice in a given country.

It should also be noted that as far as their country of origin is concerned, the emigration of health professionals means that training provided to meet the country's own needs is wasted. Over time, emigration also makes it impossible to ensure balanced access to high quality healthcare services.

6. **In what way should European action help support the health systems of the Member States and the different entities involved in them?**

Poland believes that the very fact of undertaking actions, at Community level, which concern medical services, patient mobility, cross-border healthcare and the development of healthcare within the EU, and which were initiated by the High Level Process of Reflection, will encourage Member States to transform their national healthcare systems and make them more efficient and effective. Common European aims must be respected throughout this process, and these include universal access to high quality healthcare based on the principles of financial sustainability, equality and social solidarity, which constitutes an element of added value for the health systems of individual Member States.

Cross-border cooperation programmes within the framework of the INTERREG Community Initiative are one of Poland's sources of support for cross-border healthcare. Between 2004 and 2006 Poland participated in seven operational programmes within the framework of the aforementioned Initiative. Amongst other actions, the programmes supported the development of medical services, the modernisation of medical infrastructure, for example purchase of new equipment, and cooperation in the area of medical rescue services. In particular, these actions influenced three programmes on the Polish-German border and the Poland-Belarus-Ukraine Neighbourhood Programme. The following projects were financed: purchase of equipment for treatment and diagnosis of patients with diseases of the circulatory system for SPZOZ [Independent Public Healthcare Centre] in Zgorzelc; setting up a telemedicine network that supports treatment of patients suffering from tumours in the Euroregion Pomerania; strengthening the cross-border cooperation through the means of

training in new methods in diagnostic haematology in the Western Pomerania Province; and improvement of safety of health services and lifestyle of the citizens of the Ostrolecki District and Mostowski Region. The key criterion for the award of INTERREG funding for a specific project was to demonstrate its cross-border impact, in other words, demonstrate that persons on both sides of the border would feel the benefits of the project.

Support of this nature will continue throughout the period 2007-2013, through cross-border cooperation programmes currently being prepared by international working groups within the framework of European Territorial Cooperation and the European Neighbourhood and Partnership Instrument. Projects, that involve cross-border healthcare, will receive funding under these programmes if significant cross-border impact can be demonstrated.

In addition, projects implemented under the 2004-2006 Integrated Regional Development Operational Programme notably in border areas, and in the field of broadly understood healthcare had specific, though difficult to identify and report, impact on accessibility of certain types of specialist medical services.

Actions undertaken as part of other projects such as ‘Regional healthcare infrastructure’ and ‘Local healthcare infrastructure’ included redeveloping and modernising healthcare facilities and purchasing new medical equipment for diagnosis, treatment and rehabilitation. In addition, facilities were adapted to suit patients’ needs, particularly the needs of disabled patients. Amongst the beneficiaries were institutions that also provided services to citizens in neighbouring countries (hospitals, sanatoria, spa, rehabilitation and occupational therapy treatment centres). The same applied in the case of the ‘Microenterprise’ Programme where assistance was granted to many beneficiaries - the entities that provide medical services, also in border areas. The entities included dental surgeries, opticians and businesses that supply artificial limbs and dentures. Healthcare systems can also to receive assistance from Regional Operational Programmes allocated for distribution between 2007 and 2013.

Therefore the investment in healthcare supported by Community funding in border provinces may well contribute to significant increase of interest in cross-border medical services amongst the residents of border areas in neighbouring countries. This could have a considerable impact on the development of cross-border care.

European action can lead to an improvement of healthcare services in Member States, notably by providing citizens of different Member States with equal opportunities for accessing effective treatment. To achieve that, facilities at centres along with requirements concerning staff qualifications should be standardised. This will become possible when individual Member States allocate similar financial resources to the citizens’ healthcare.

In this regard, European action should focus on ensuring comparable target funding for care in individual countries. At present, the significant financial differences between Member States and considerable differences in the quality of services provided, measures undertaken by European institutions that aim at improving cross-border medical care will bring the desired effect. It therefore seems essential to provide financial assistance in order to reduce inequalities.

7. Choice of the appropriate tool to regulate the European market in health services. Legislative and non-legislative action on cross-border care.

A Community framework for the provision of safe, high quality and effective healthcare services should be created by tightening cooperation between Member States, and also by increasing certainty concerning the application of Community law in the area of healthcare services and health systems.

Poland believes that a binding legal instrument of a type appropriate to the issue and scope concerned is the best way of increasing legal certainty. Poland suggests considering the possibility of regulating part of the issues concerning patient mobility and the provision of cross-border healthcare services through regulations on the coordination of social insurance services. It also proposes that a possible directive should cover related issues such as the quality of medical services, clinical oversight and the responsibility of the authorities, institutions and service providers, together with safety, patients' rights, the mobility of health professionals, contracting for the provision of healthcare services, and access to information (including data bank, standards of information, protection of personal data).

It would seem that a legal instrument standardising principles of procedure is required to regulate a number of varied matters related to cross-border healthcare raised by the Commission in its Communication. These principles should be defined as clearly as possible, so as to minimise the risk of discrepancies in their interpretation. It will be important to draw on existing experience gained in applying provisions on coordination of social security systems and ECJ case law. The action, which is currently under way at Community level, should be harmonised.

It is also worth considering financial assistance for Member States, aimed at modernising the base and medical equipment, training health professionals and also facilitating broader access to the specialised knowledge acquired by more developed countries and the exchange of experience between health centres (research institutions, clinical facilities).

Mutual exchange of information between partners about legal and practical changes to the systems in individual countries, especially when the changes impact on to cross-border

healthcare services by EU citizens' access, would be advisable. National authorities could then interpret and process information of this nature appropriately and make it available to their own citizens.

This would be in line with the Commission's position and with the premise that Community action should be based on two fundamental pillars: legal certainty and support for Member States.

Warsaw, 30 January 2007