Letter dated:
31 January 2007

From:
Vereniging Gehandicaptenzorg Nederland
Oudlaan 4
3515 GA Utrecht
Netherlands

To:
European Commission
Health and Consumer Protection DG
Consultation on health services
B2328/102
B-1049 Brussels
Belgium

Subject: **Consultation regarding Community action on health services (SEC(2006) 1195/4)**
Our ref.: B170107TRA0112

Dear Sir or Madam,

The Association for Care of the Disabled (*Vereniging Gehandicaptenzorg Nederland – VGN*) very much appreciates the fact that the European Commission is also giving social organisations in the Member States an opportunity to respond to the "Consultation regarding Community action on health services " (SEC(2006) 1195/4). It is very important that, in addition to hearing the views of the national authorities regarding cross-border health care, the European Commission should gain a clear impression of the views of grass-roots organisations. These can also help in making an accurate assessment of whether (certain aspects of) health care should be regulated by Community provisions, and what (legislative) instruments might be most suitable for this purpose.

This letter sets out our view of what place the care of the disabled should occupy within the European Union. The *VGN* is the sectoral association in the Netherlands representing organisations which provide professional care and support to persons with mental, physical, sensory and/or communication disabilities. The *VGN* encompasses 173 institutions providing care to around 110 000 clients, and accounting for a budget of € 4.8 billion. The *VGN* seeks to create favourable conditions and actively represent the interests of disabled persons at the level of funding, laws and regulations, employment issues and care provision.

Freedom to provide services in the field of health care

The *VGN* works on the basis that care of the disabled need not be regulated by the European Union. The statutory powers within this field should be transferred to the national authorities. The point of the subsidiarity principle is to ensure that decisions are taken as close to the ordinary citizen as possible. National, regional and local authorities are directly involved with

health issues and problems affecting the disabled. Measures are more effective when they are taken at national, regional and local level rather than at European level.

Care provision for the disabled comprises certain aspects which make it undesirable to strive for complete freedom to provide services in this field. It can be characterised as being of a protracted and integral nature. Treatment of clients cannot simply be split up into components for which cross-border health care is permissible. In addition, effective communication with clients is an essential element in the provision of care. Language and socio-cultural knowledge are important factors. It is also important that efforts be made to allow the disabled to participate in society. The Dutch authorities, at both national and local level, have a leading role to play in creating the conditions for disabled people to participate in areas of life other than merely health care, for example education, employment, travel and living conditions. Participation will not be achieved through large numbers of health care recipients moving across borders, for example if a person's daytime activities are in country X and they live in country Y. Knowledge of local conditions is indispensable when seeking to allow the disabled to participate in society.

Pragmatic approach

Care for the disabled nevertheless provides a number of instances where cross-border care is appropriate, for example in connection with sensory or communication disabilities. One example would be diagnostic tests in which one country specialises but another country does not, i.e. it is conceivable that a client undergo tests in another country, but also that a care provider in another country offer its services. This scenario occurs for the most part in border regions between Member States. The *VGN* considers it important that a pragmatic approach should be taken to deal with possible problems regarding the provision of this care in border regions without any legislation or rules being imposed directly at European level. Thus there is a need for reliable arrangements whereby "receiving" care-providers are remunerated for the cross-border care they have provided. Measures covering the whole of the European Union are therefore not required. Member States can usually find solutions among themselves. The necessary legal frameworks are provided by judgments of the European Court of Justice (the *Kohll*, *Decker* and *Watts* judgments).

Care of the disabled: health services and/or social services of general interest?

Another point which we would like to touch on in connection with the "consultation on health services" is that, at European level, care of the disabled can be arranged into two types of services, namely health services on the one hand and social services of general interest on the other. The latter are described in the Communication on social services of general interest (COM(2006) 177). They include: "statutory and complementary social security schemes ... covering ... risks of life, such as those linked to ... disability" and " activities to integrate persons with long-term health or disability problems". The care provided by our organisations falls within this definition, given that funding for care of the disabled in the Netherlands is provided on the basis of the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten – AWBZ*). The Act provides general sickness insurance against risks which cannot be insured against on an individual basis. The European Commission should realise that Community measures in the field of social services – which in many Member States is the responsibility of the minister for social affairs – may have repercussions for health services, for which the ministers for health are responsible.

The "consultation on health services" does not provide any detailed description of health services, but does give the impression of being concerned with the field of curative care. We would stress most strongly that the European Commission is adopting a position in favour of care of the disabled and thus also long-term care as a whole. In this connection, the *VGN* prefers to regard care of the disabled as a health service, and this for the sake of consistency

with the Dutch system in which long-term care is the responsibility of the Minister for Health, Welfare and Sport. Furthermore, treatment and support for persons with disabilities requires professional expertise so that genuine care for their health can be provided.

As already stated above, The *VGN* believes that Community measures in the field of care for the disabled are not desirable. If the European Commission were to decide to switch over to Community measures, the *VGN* considers it important that the degree to which market forces (i.e. the freedom to provide services) operate should be appropriate to care for the disabled in the Netherlands. The *VGN* is in favour of the operation of the market within the framework of a control model centred upon the client, who chooses a provider on the basis of his individual wishes and needs, and the quality of the care being offered. In this model, the client receives a fixed amount (in the form of money or a voucher) for his health care provision or financial support. Care-providers make it clear what care, and quality of care, they can offer the client within the latter's budget. The client makes a choice on the basis of the quality of care on offer rather than the price.

Institutions vary in terms of the quality of care on offer. A prerequisite in this connection is the continued existence of the personal budget (*persoonsgebonden budget – PGB*) and an individual-trailing budget (*persoonsvolgend budget – PVB*)[1] as used in the Netherlands.

Conclusion

We hope that this letter has given an sight into the place which care of the disabled occupies at European level, and would be happy to provide further clarification of the points we have raised.

Yours faithfully,

(signature)
H.G. Ouwerkerk
President

cc:
– Minister for Health, Welfare and Sport
– Permanent Representative (Health, Welfare and Sport)
– DG SANCO – Health Strategy Unit
– European Association of Service-Providers for Persons with Disabilities (EASPD)

[1] In the case of a personal budget, individuals choose their own care-providers. This budget is covered by the *AWBZ*. Anyone requiring care because of sickness, disability or old age is eligible. Individuals are thus free to choose who is to provide their care. Individual-trailing budgets are related to the new system of covering costs under the *AWBZ*. Health care institutions receive a sum of money geared to the care status (required intensity of care) of their clients. This is still an average amount per bed. Under the new set-up, clients have the opportunity to themselves choose a(nother) health care institution. The budget is assigned to the individual concerned, i.e. the payment "trails" the client.