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Commissioner Markos Kyprianou
European Commission
DG Health and Consumer Protection
Health services consultation
B232 8/102
B-1049 Brussels
Belgium

Brussels, 22 January 2007

Concerning: EU consultation on Community Action on Health Services

Dear Commissioner,

The European Federation of Nurses Associations (EFN) welcomes the opportunity to participate in the consultation process on the Community Action on Health Services. The EFN represents over one million nurses from National Nursing Associations across the European Union and aims to strengthen the status and practice of the profession of nursing and the interest of nurses in the EU and Europe. The EFN members are committed to sharing and disseminating good practice and expertise across the EU, and believe that this can positively impact on improving standards and quality of care for patients. The EFN is, therefore, well placed to contribute to this important EU policy debate and we look forward to continuing to play an active role in this ongoing dialogue.

Executive Summary

The EFN emphasises that the objective of any EU health services activity must be to promote and ensure high quality patient care based on the common values and principles in the EU health systems as agreed by the Council of Ministers.

The EFN believes it is important to:

- have sufficient information at EU level on the movement of patients, professionals, and health services;
- identify the competent authorities in the Member States who are responsible for the supervision of health care services;
- establish an independent point of contact in each Member State (a patient's Ombudsman) that can act as an advocate for the patient;
- develop and agree European standards of care and quality control, and develop mutual nursing sensitive quality indicators;
- identify a common set of indicators to gather information on the quality of the services, the safeguards in place and the mechanisms to address complaints;
- develop patient sensitive indicators, for example, patient safety, complications, and experience, to support and evaluate EU policy making;
- ensure health care professionals are up-to-date through continuous professional development;
- define clear lines of accountability for the continuity of patient care that is initiated in one jurisdiction and requires follow-up care on returning to their country of origin;
- establish a process to collate and disseminate comprehensive information to assist patients in making an informed decision regarding their choice of health care.

Furthermore,

- EU legislation should focus on good quality care, which implies clear, accessible information and patient-sensitive indicators to inform patient choice;
- EU workforce planning should be part of EU Health Services legislation, where EU ethical principles and code of conduct on mobility of health professionals are included;
- The European Commission needs to build on the work of the European Social Dialogue in the nursing sector.
- The distinction between health and social care needs to be clarified as in many Member States a great deal of healthcare, especially elderly care, is delivered within the social care sector, which is outside the scope of this consultation (EFN Position Statement on Services Directive).
- It is important for the EU to have a holistic approach in care, with a focus on health promotion and health management (EFN Position Statement on Elderly Care).
- It is important not to lose sight of the broader public health agenda. There needs to be increased emphasis on health promotion and a shift from disease management to health management.

EFN views on issues not raised in the consultation

Whilst the EFN welcomes this consultation, particularly the initiative to provide greater legal certainty in the light of recent rulings in the European Court of Justice, we are disappointed that its scope is limited to the mobility of patients, professionals, and services, and how the EU might add value to member states' national health systems. The EFN considers that there are a number of other issues which need to be addressed. These issues include:

- The EFN is disappointed that the consultation does not refer to the Common Values and Principles in EU Health Systems, as agreed by the Council of Ministers in June 2006. It is crucial that these principles are enshrined and operationalised in all EU policy and legislation.
- The European Commission must recognise that most citizens want good quality local services and that this must be the primary focus for member states. Member states must retain the autonomy to manage their national health systems and to adapt them to the changing needs of their populations.
- The EFN calls for the EU to give greater consideration on workforce planning across the EU and globally, with a particular emphasis on recruitment (EFN Position Statement on Recruitment), and retention and continuous professional development (EFN Resolution on CPD), to ensure that more vulnerable national health systems are not at a disadvantage by the potential migration of health care professionals within the EU.

EFN RESPONSE TO THE SPECIFIC CONSULTATION QUESTIONS

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?

Although we foresee an increase in the number of people travelling from one country to another to access health care, the EFN emphasises the miniscule level of cross border patient mobility within the EU. However, there are a number of factors that influence the restriction of mobility, such as, limited knowledge of the other Member States' health systems amongst the general population, as well as possible language barriers and the non, or limited, availability of travel insurance for those with pre-existing illnesses. The development of health tourism for lower cost elective procedures is on the increase and in some countries articles are starting to appear in the popular press drawing attention to both the successes and failures of such trips. This form of information does not necessarily provide detailed and accurate information to assist EU citizens to make an informed choice about their health care. Furthermore, it is important to emphasise the need for greater clarity for member states and those delivering health services, as well as for professionals and patients, concerning procedures and rights/responsibilities for travelling abroad for treatment. Finally, the growing reliance on subcontracting and private funding arrangements needs our attention, as it is important for quality, access and financial sustainability.

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?

It will be of significant importance that the professional advisory structures to the EU are fully engaged in these developments and that organisations such as the EFN play a significant role in developing policy positions, as well as offering support through its member organisation to member state governments during the implementation phase.

At European level there is a lack of information about the number of health service employees, the future healthcare needs and the numbers of staff required for the delivery of services. The European Member States need to be assisted and encouraged to collate comparable quality data at local, national and European level. Nursing data is needed for workforce planning and evidence-based nursing care developments. The availability of such information should enhance political decision-making and the financial performance related to quality outcomes. Therefore, in order to make reliable predictions about future trends and needs, there is an urgent need for a Workforce Monitoring Forum to be set up at EU level, that will collate information about health professions and professionals within Europe.

Furthermore, it is important to make sure that the removal of assets from public ownership to private ownership meets EU principles and leads to efficiency and quality of care. The EFN underlines the importance to have solidarity/equitable financed care, while also a competitive care, so that the patient can then choose their own care. There needs to be EU regulation and standardised quality measures, such as nursing quality indicators and nursing diagnosis. The EU can benefit from the experiences at global level.

Mobility presents opportunities and challenges for the healthcare workers and it is crucial for the EFN that a two-tier healthcare system does not emerge, dividing those who can afford to pay and those that cannot. For that reason, it is fundamental to have cross border targets and information systems.

Furthermore, each country publishes a varying degree of information of the quality and delivery of their services. For citizens to make an informed choice (EFN Position Statement on Information to Patient) and to determine the risk/benefit of travelling to another country for care, a common set of indicators needs to be developed. This common core of indicators should include information on the quality of the services, the safeguards in place through the regulation of professionals and any mechanisms that can be used to address complaints. There is a need to have patient sensitive indicators on board, for example, patient safety, complications and experience to support and evaluate EU policy making. EFN believes it is important to identify who is responsible for accepting the patient to the host country and how the treatment and stay will be documented.

A particular challenge will be to determine acceptable waiting time for treatment, related to diagnosis and other relevant factors. The EFN believes it is essential to clarify conditions on the right to seek treatment in another country, including waiting time for elective procedures, to avoid a development that may potentially place unbearable financial burdens on some countries. EFN finds that it is important to clarify the process of seeking healthcare in other member states and who gives the authority to do so.

It is important to ensure clear communication between patients and health professionals. Language skills should never be presumed when deciding a person's ability to make use of the health services they need. Patients exercising their right to treatment in another country should, therefore, be offered interpretative services, as and when needed. The burden for interpretation under the Services Directive needs to be met by providers of services and this will be a significant cost for some countries, and will instantly prejudice the level and quality of information.

The right to treatment in another country must include a mechanism for financial settlements at country level, to avoid a situation where patients pay for their treatment and then get a reimbursement from their national government at a later date. Such a system would only benefit the small portion of citizens that can afford to pay, and be in breach of the general principle of equal access to services.

Finally, the EFN believes it is important to include obligations to measure patient experience of services, as there is a growing awareness that quality is difficult to measure. We should be looking more and more towards measures of patient experience as an indicator of quality.

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?

The quality of care delivered should be the responsibility of the country providing that care, whether this initial intervention, or in the post intervention follow-up. This raises an important issue as complex cases in post intervention care (follow-up) is highly dependent on good discharge notes and ready access to the clinical team who provided the initial intervention. If governments are making the arrangements to refer parts of their population to a reference centre (see recommendations High Level Group), then quality standards and quality control at all levels should be part of the contractual agreement. There may be a need to develop different models for different circumstances, and an EU body needs to oversee healthcare and service providers offering care and treatment to patients from other countries. In essence, the model should be one of open cooperation on a binding basis which emphasises patient safety over cost, and deals in detail with all arrangements for the handover of patient details and care. The patient should only have to deal with one agency, which would have authority over all actors and that should be made clear before any service arrangements are entered into. The governmental point of contact is essential, but synergies need to be developed at European level. There is a need to consider existing practice, for example, the Malta contracts with the UK, where Maltese authorities carry responsibility if anything goes wrong. Increased cooperation between Member States could lead to better quality healthcare. According to EFN, it needs to be clear who is responsible for clinical oversight.

Finally, there is a requirement to have sufficient resources for any follow-up care/treatment required in the patient's home country after receiving healthcare abroad.

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?

Each Member State should have an independent single governmental point of contact, who should act as an Ombudsman, as an advocate for the patient. In addition, the patient should have information on the type of insurance cover that is in place in the event of the provider of care making a serious error. This insurance should cover no-fault schemes, employer liability, and professional indemnity arrangements. Clarity of information and rights/responsibilities is paramount. The responsibility should be placed on the country and/or institution providing the service. It may be a challenge to develop clear protocols, as risk assessment, quality of care etc. may differ from one country to the other and supporting systems are not up to standard.

Many legal procedures regarding damage compensation in the case of medical errors may also involve health care professional, including nurses. It is important that health professionals enjoy appropriate legal protection in cross-border situations. In case a health professional is liable for errors or accidents that are related to circumstances falling under the employers' responsibility, such as high time pressure, bad quality of instruments, insufficient training, etc. , the employee should be entitled to compensation for the damage s/he have suffered because of legal procedures. Whether or not the employee is directly employed by the health care institution, hired through agencies, or self-employed should not affect these rights.

Question 5: what action is needed to ensure that treating patients from other Member States is compatible with the provision of a balanced medical and hospital services accessible to all (for example, by means of financial compensation for their treatment in 'receiving' countries)?

Where there are significant variations in the flows of patients into a Member State throughout the year (for example, skiing holidays into mountain resorts in the winter months, or beach holidays in the summer), national governments need to ensure that local services are not overwhelmed and health planners and service providers in these areas have arrangements in place to ensure that there is an adequate number of beds, assessment resources, and that quality staffing are available to provide services both to the indigenous population and those visiting the area. These known changes in the volumes of patients should, particularly were there is a capitation based model of payment in place, be reflected in the funding available to the services.

From a more general point of view, a significant level of patients from other countries may lead to an undesirable change of priorities, because these patients represent a source for better income. There is a potential risk of reduced accessibility for citizens in the host country, in addition to a shift to chronic illness and other "demanding" patient groups, to services that are more financially beneficial to the service providers.

The EFN finds it important to identify who will be responsible for the guidance of patient flow and in the case that waiting lists are long in the home country, who decides where the patient goes? Furthermore, it needs to be clear how the same treatment for citizens in the host country is safeguarded.

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 not already addressed by Community legislation?

There is a significant issue in relation to the different approaches taken by regulatory bodies across the Member States. For example, in some countries a different level of proof is required to remove a poorly performing practitioner from the register. In addition, a crime that takes place in the practitioners' private life can in some countries result in the practitioner being removed from the register, whereas in other countries this would not be the case. Therefore, the patient may be placed at a higher level of risk than they would expect if they received care in their own country.

Another related matter to regulation is the issue concerning where a service is being provided to a patient in one country, but the practitioner works and lives in another. In the event of a patient complaint, it needs to be very clear that the practitioner must meet the standards required in the country where the patient lives and is receiving the care, or those standards where the practitioner lives. The situation is even more complicated when the citizen comes from one country, receives the care in a second, and the practitioner is living and professionally regulated in a third. Such a situation could easily arise where tele-nursing or advice, and/or diagnostic services are being provided. European countries may find some of the work that has been undertaken in the United States, Australia and Canada helpful in developing National/EU policy, since professionals in these countries have to deal with cross-state/province/territory matters for some time.

In line with the recommendations of the High Level Group and the Council decisions on ethical recruitment guidelines, the EFN has developed ethical principles and a code of conduct concerning mobility to ensure that there is not a shift from using high cost to low cost countries (EFN Good Practice Guidance on International Nurses Recruitment). Countries outside the EU, such as the USA, Canada and Australia, are recruiting nurses, often the more experienced professionals, and this may leave the European region with an under-resourced and under-developed health service in the future.

Therefore, it is urgent to:

- have strong EU ethical principles and code of conduct on mobility of health professionals and patients;
- establish clear protocols for all health care organisations and recruitment agencies, including the private and independent sector;
- develop explicit criteria for the selection of professionals, such as nurses;
- have extensive information from the recruiting country, including details about working visas, work permits, registration contracts, accommodation, cost of living, salary, job descriptions and employee legislation;
- support migrated professionals, such as nurses, to adapt, both socially and within the workplace.
- create incentives to improve the retention of professionals.
- Exchange of information on registration of nurses

Question 7: are there other issues where legal certainty should also be improved in the context of each specific health or social protection system? In particular, what improvements do stakeholders directly involved in receiving patients from other Member States – such as healthcare providers and social security institutions – suggest in order to facilitate cross-border healthcare?

One area that needs to be clarified is the issue of means/testing and co-payments. Where this is the practice in one country and a patient comes from another, it is currently unclear as to how the country providing the care can readily access the information from the other country in order to determine whether a co-payment is due from the patient. Furthermore, EU legislation needs to secure equal access to healthcare and patient safety, taking into account the cultural barriers. EU initiatives need to ensure that patient safety; patient rights and patient information are key components and have priority over providers' profit.

Question 8: in what ways should European action help support the health systems of the Member States and the different actors within them? Are there areas not identified above?

The issue of networks of care has been raised. Where a service is not provided, due to insufficient critical mass of patients, quality of care, or cost of service, it will be important that practitioners who have to provide follow-up to patients in their home country have sufficient skills and knowledge of the procedure to deliver safely post-intervention care.

It is important to have cross border targets and information systems. The issue of cross border education, continuous professional development and access to video-conference based consulting or advice should be considered. IT compatibility would be very important in order to facilitate exchange of patient details – this could only be done through forcing providers to invest. There is a whole raft of issues in terms of who pays, accredits and protects professional standards of education.

Similarly, the potential for both multi-centre and longitudinal research studies should also be considered as part and parcel of continuous quality improvement and evidence based service provision. The EU plays an important role in facilitating the exchange of good practice and expertise through EU research and funding.

Furthermore, national health systems should maintain a degree of investment in healthcare and some services should be provided locally, especially in the field of elderly care. Outsourcing these services to other Member States is unacceptable for the EFN (e.g. Portugal outsourcing some maternity services to Spain). It is important to evaluate, from the perspectives of the citizens and patients, what is a good solution. There is some experience between Sweden and Finland to support our argument.

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 EFN believes that health services must remain a national responsibility, and that the Commission should focus on codifying existing Court rulings into community legislation, rather than changing existing EU legislation or breach the subsidiarity principle.

Therefore, the European Federation of Nurses Associations on behalf of nurses across all the Member States ask for your personal commitment in order to meet these challenges and to guarantee the compatibility between European social policy and the free market principles.

IN CONCLUSION

The EFN believes that even if there is the potential for a higher level of patient mobility in Europe, mobility will be rather limited. There are a number of reasons for this. One is the fact that most patients prefer being treated at home, as close as possible to where they live. Another is the fact that most patients in hospitals are elderly people, most often admitted for acute care.

Mobility is, therefore, an issue primarily linked to elective treatment. Although people generally want care near their homes, they may choose to go abroad for treatment, if this option costs less, provides better quality, or is more accessible. However, growing patient mobility may not only be a positive development. It may increase the problems in the national health sector, which already receives too little investment.

In other words, increased patient mobility may, to a certain extent, be seen as involuntary rather than desired. Patient mobility or cross-border delivery of care may never be an excuse for a Member State to neglect its own national health care facilities.

Finally, any development of European health services must focus on principles such as solidarity and accessibility, rather than “open health care markets.” The EU emphasis should be on raising overall standards in health, starting with an understanding of the various challenges and working out ways to encourage cooperation in the first instance through sharing best practice and resourcing the development of standards of communication and cooperation. The EU needs to ensure that commercial interests do not inhibit patient/public/professional involvement in service design, delivery and transparency. Most reformers agree that the key to sustainable development of health services is the fully engaged scenario where the public are co-owners of their health.

Yours Sincerely,

Annette Kennedy
EFN President