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Position of the Finnish Medical Associations on cross-border healthcare in the European Union; starting points

1) Because of the increasing mobility of patients and healthcare professionals within the EU there is a need to regulate or give guidelines about providing cross-border health care on EU level.

2) The health care system of Finland must be able to produce the services needed by Finnish nationals. However, cross-border co-operation should also be a possibility.

3) A patient must have the right to receive treatment also outside Finnish borders under certain conditions.

4) The patients must have equal treatment and enjoy the same rights regardless of the service provider.

5) Cross-border health care must not undermine patient safety.

6) Particular attention must be paid to the security and effective transmission of patient data.

7) The patients' freedom of choice and their right to information must be enhanced.

8) The mobility of physicians and supply of medical services across borders must be facilitated further.

Answers of the Finnish Medical Association to the questions posed by the commission in the public consultation

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 Finland the effects of patient mobility have so far been minor. It is likely that the majority of Finns wants to receive health care services close to their homes also in the future.

The fact that the mobility of health professionals has become easier is reflected in the increased number of foreign doctors in Finland. In some cases their inadequate language skills have had a negative impact on the quality of services. This migration is likely to continue and improve the availability of doctors in Finland while it might weaken the level of health care services in their countries of origin.

Question 2: what specific legal clarification and what practical information is required by whom (eg; authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?

A definition of hospital and ambulatory care is a prerequisite for the functioning of cross-border health services. The definition of hospital care by the Standing Committee of European Doctors (CPME) is the following: "medical care under the supervision and responsibility of medical doctor(s) and provided in specific facilities where medical surveillance is available 24H/day and which normally requires accommodation in the facility." This definition must be revised when necessary and it must not be allowed to form an obstacle to the development of health care systems.

Medically accepted timelines (such as the G-I-N clinical practice guidelines) should be approved as recommendations in Europe. This might help to solve the problem of defining undue delay. If a national system has defined a time limit before the end of which ambulatory treatment of an illness must be provided and there is a doctor's referral for it, the patient must be able to seek treatment also in another member state without a specific decision.

In order for the regulation to be functional it might be necessary to define also the concepts of public and private health care. Lack of this borderline may leave too much room to interpretation in the application of compensation systems.

It is important that patients and doctors have information on health services that are available. The health portal maintained by the commission is a good way to compile information produced by member states on the care available and its quality, the rights based on legislation as well as liability and compensation issues.

Due to the specific nature of medical services European guidelines on their marketing are needed. This guidance must cover also the marketing of so-called belief-based remedies. The marketing must always be carried out according to the legislation of the member state where it is targeted. Also the responsibility of marketing control lies with the member state to the area of which it is targeted.

In the attempts to clarify and give instructions on the practice of cross border health care also pharmacotherapy as well as pharmacies and distribution systems affecting its implementation should be taken into account.

Question 3: which issues (eg: 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 responsibility of the quality of health services offered by a national system belongs to each member state. Also the supervision of health services must in all cases be carried out by the authorities of and according to the legislation of the country where the care is given, as controlling a service provider from another member state is not a realistic option.

If a statutory health system commissions services from another member state, it must assure the quality of these services. In these cases a framework must be defined for the patient's right and possibility to make a complaint about poor quality services. Remote services and those provided through the internet must be overseen in the member state where the provider is registered.

The economic responsibility of the care must be borne by the health care system of the member state where the patient is permanently resident, that is the sending country. Also the power of decision on the level of compensation including for example travel expenses must lie with the sending country. Funds for care given abroad must be included in treatment budgets.

In hospital care in addition to the referral a separate order by the payer is required. The compensation of medicines should be arranged so that the patient is responsible for the cost abroad and receives the compensation in the home country after returning. The follow-up of treatment and eventual continuation of care should as a general rule be arranged in the patient's home country.

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?

Normal consumer protection rules are not sufficient to guarantee patient safety. From the legal protection viewpoint it is important that for example all health care providers in Finland are covered by the Finnish patient insurance scheme.

If a patient is referred to receive treatment in another member state, he or she must be covered by insurance in the same way that would be case in the sending country. In cases where a patient seeks treatment him-/herself, the system of the receiving country must be applied. A common no-fault patient insurance scheme should be the goal for the whole European Union.

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)?

Health services to nationals of other member states must be offered on equal medical preconditions as to the citizens of the country in question.

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?

The relocation of the provisions concerning mobility of physicians from the professional qualifications directive to a new health services directive would ease their alteration in the future. The present general directive that concerns all professions should include a reference to the health services directive, which would regulate specifically issues related to physicians.

For guaranteeing patient safety it is of utmost importance that all information needed about health care professionals is available in the country where the treatment is given. In health care, it is essential to have the possibility to require proper licences, registration and other necessary requirements from posted workers regardless of the duration of the working period.

Member states must inform each other about revoked or limited licences in order to prevent their misuse. A pan-European professional card must be the goal.

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?

Data protection issues must be given special attention. Patient information in cross-border health care is controlled by the patient, the physician and the health care system. Of these the patient must be in the key position and transmitting information abroad must be based on his or her active will.

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 establishment of health service providers must not be unnecessarily restricted. It must be free as long as issues related to control, patient safety and insurance are properly looked after.

The community can best support the member states by collecting, analysing and distributing information about health care and by giving quality recommendations.

Centres of reference are worthwhile and their role especially useful in creating new knowledge, but the major part of health care capacity issues cannot be resolved through them.

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?

Legal clarity offered by regulation or guidelines is needed for both the effective control of cross-border health care and compensation of costs related to it. The goal must be a legally binding instrument, as broad as possible, and taking into account the interests of patients, health care professionals and systems. Because of its flexibility a directive suits this purpose better than a regulation. In addition minimum standards of health care would be useful to define as recommendations.