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EUROPEAN COMMISSION CONSULTATION REGARDING COMMUNITY ACTION ON HEALTH SERVICES – SUBMISSION FROM UNISON

About UNISON

With 1.4 million members working in public services, UNISON is the largest union in the UK. We are the major union for health services and our health care service group represents more than 400,000 employees in the UK National Health Service and staff employed by private contractors, the voluntary sector and general practitioners. UNISON is a member of the European federation of Public Service Unions (EPSU).

Q1: 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 terms of the actual amount of cross-border healthcare, the impact may have been exaggerated and is at best very hard to measure accurately. There may even be a need to question whether the level of cross-border healthcare is sufficient to justify Community Action as embodied in the Commission's paper. Although there are acknowledged limitations in the data available, a recent European Observatory on Health Systems and Policies paper makes clear that "the absolute volumes of patient and professional mobility within the European Union remain relatively limited." Movement is taking place and may increase in the future but the paper notes that the most recent survey among members states carried out by the European Commission in 2000-01 showed that only Belgium and France registered considerable cross-border provision. In terms of reimbursement for claims incurred as a result of cross-border healthcare these values are reported as being as little as 0.1-0.2% of overall expenditure on healthcare in the European Union.[1] Even allowing for an increase since this data was produced, proportionately the amounts are still likely to be very small.

The Commission should undertake a full evaluation of the actual extent of cross-border healthcare and a social and economic impact assessment before embarking on Community Action that may have implications for national health systems that will be disproportionate to the reality of cross-border patient care. A few high-profile cases may be conveying the impression that this is a more important aspect of European healthcare than is actually the case.

[1] European Observatory on Health Systems and Policies, Policy Brief: Cross-Border Health Care in Europe, 2005

Q2: 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?

UNISON supports the adoption of a broad legal framework for Public Services to safeguard the principles of general interest by the European Union. Measures relating to the different sectors of the public service should only be proposed once these broad public service principles have been agreed. UNISON regrets, therefore, that the Commission has chosen to take a solely sectoral approach in this consultation.

There is a question not covered by the paper about whether greater legal clarification is actually necessary. It may be reasonable to claim that where legal decisions have been taken this has been at the expense of a comprehensive approach to analysing the impact of their decisions on the health policies of individual countries. But to date all of the European Court of Justice rulings have stated clearly that whilst health is a service and therefore bound by the same regulations as other services, there is at the same time a justification for restricting patient mobility to ensure the viability of national health systems.

To this end, any Community Action should recognise the principle of subsidiarity and the autonomy of the Member States regarding the organisation and funding of their health care systems.

The principle of transparency is crucial to patient mobility. Patients should have full access to information about their treatment before making decisions. This might include information about funding procedures, additional insurance (such as for repatriation), liability, the nature and cost of treatments on offer and the governance and regulatory framework should something go wrong. However, the provision of such information should not impose unnecessary additional administrative and financial burdens on existing healthcare systems. Nor should some patients be able to access services faster than other patients with greater need simply because they have been able to pay for third-party intermediaries to investigate and provide this information for them.

There is no mention in this question of staff. If specific legal clarification is produced then healthcare professionals need to know where they stand in relation to European legal systems and specifically how these overlap with their own national systems.

Q3: 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 principle of subsidiarity should prevail:

- National health systems must retain the ability to plan services and allocate finite resources in a cash-limited system
- National healthcare systems should have the ultimate responsibility for determining benefit packages and prioritisation criteria
- Commissioners of healthcare must continue to retain decision-making power within a referral gatekeeper system.

Clear limits need to be established as to the extent to which the European Union can establish standards or criteria that will have cost implications for Member States. Waiting lists are one such an example where the ‘sending country’ should retain responsibility.

The Watts case was won on the basis of waiting times, despite the fact the UK government has clear guidelines on waiting times and in this case treatment would have been delivered within these guidelines.

Q4: 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?

The standards of care, governance and liability of the 'receiving country' should apply when patients choose to go abroad for treatment. When a patient specifically requests that they receive treatment in another member state at the expense of their home health system they should not normally be able to seek redress from the home member state in the event that something goes wrong.

In the UK, there are established agencies for dealing with patient safety. In England and Wales the National Patient Safety Agency is responsible for this and it would be logical for it to retain the responsibility where cross-border healthcare is concerned as the best means of ensuring equity of provision and service for patients. Denmark has similar structures and these could be developed within other European countries as a means of ensuring safety for all those treated within a country's borders.

Furthermore, it is important that not just patients but also healthcare workers have legal protection where cross-border healthcare is concerned.

Q5: 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)?

The key element in any appraisal of healthcare across the European Union and the principle that should inform any Community action is to ensure that effective policies on quality of care exist within each country and that these should promote care that is delivered in the most equitable fashion. There are inequalities in access to healthcare both within Member States and between different countries of the European Union. Community action should look to reduce health inequalities rather than entrench them further.

The concept of patient mobility as envisioned in the Commission's consultation has serious implications for patient equity and could further entrench health inequalities. There is a need to analyse the impact of the Watts case given that the Court ruled that reimbursement for costs of the operation itself were to be met but not those for the travel to receive the treatment. Patient mobility will also entail additional costs relating to the process of actually exploring the possibilities for treatment in another country. The result will be that those who can afford to cross borders to receive healthcare will do so, but for the less fortunate the economic reality is that this will simply not be possible.

The potential for greater health inequality applies not only within individual member states healthcare systems but also between different national systems. Patient mobility should not lead to healthcare institutions prioritising patients from another member state over home patients because it would be more profitable to do so.

Equity between citizens should be the cornerstone of any Community Action on patient mobility. Patients should not be able to access services faster than other patients with

greater need simply because they can afford to travel for the care and pay any additional costs above the cost of treatment at home.

Q6: 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?

Any Community Action should not adversely affect the provider of health systems. Changes in legislation could have significant workforce implications in areas such as training and capacity planning.

Some sending countries have experienced particular problems with the migration of key parts of their workforce, for example the Estonian health service has experienced problems with workers migrating to Finland. In the UK generally more health professionals move to work in the NHS from outside Europe, but the principle of assessing the impact on sending countries remains.

European action could also usefully work to ensure that minimum employment standards apply for health professionals working in other countries, as a means of raising the level of employment rights across the European Union.

The European Commission should consult the social partners in the hospital sector before it takes action that would affect the hospital workforce and the organisation of the hospital sector.

Regulatory regimes would need to be looked at more carefully if levels of professional healthcare mobility did increase substantially.

Q7: 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?

Q8: 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?

One area not identified in the paper is the establishment of a social dialogue between trade unions and management around healthcare policies. The European Public Services Union has led the way in establishing partnership working on health which has brought in representatives from both the trade union and management sides as recognised partners in social dialogue. This emphasises the importance of consultation for any development on health and provides a vehicle for ensuring that patients and professionals have a proper stake in the delivery of their healthcare. At the moment this dialogue has only applied to the hospital sector, so there would be considerable benefit in this approach being extended into other parts of the healthcare sector.

Q9: 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?

An area which European action could look into would be regulatory frameworks to monitor the involvement of the private sector in the commissioning and provision of healthcare. One angle of cross-border healthcare which is likely to become more prevalent in future years is the involvement of large healthcare companies delivering services in other countries, which presents a major threat to health systems where care is free at the point of need and based on a patient's clinical need rather than their ability to pay . In the UK the most high-profile examples of firms taking up large contracts are companies from the USA and South Africa, but there is, for example, Capio from Sweden, and the European subsidiaries of US health giants may become increasingly significant. European action could produce a framework to ensure that private sector involvement is at the very least properly monitored and its impact reviewed, particularly in countries where private sector involvement is fragmenting traditional nation health services. Another area that could be examined is legislation to tackle unethical recruitment practices of healthcare workers.

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