healthCare cybernētics

CEREBRATING INNOVATION
...THROUGH KNOWLEDGE AND ANALYSIS

Response to:

Consultation on how to ensure legal certainty regarding cross-border health services under Community law

…a healthCare cybernetics EMVIO™ document, designed for easy navigation and reading

(the document consists of 3 separate documents: EMVIO, EMVIO-Contents and EMVIO-TOCs – word document with frames. Ideally, place all 3 in a folder – open by clicking on EMVIO. To only view main file, click on EMVIO-Contents)

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About the Respondent

Dr. Constantinides is a paediatric surgeon by training with additional background in the academic, clinical, technology and entrepreneurial aspects of the healthcare sector. He is the founder of healthCare cybernetics (hCc).

hCc is a healthcare sector think and do tank™ which regards the sector in terms of Domains and Clusters (both of which it identifies and defines).

hCc was incorporated as a Limited Liability Company (LLC) in 2003, in Athens, after a R&D program started in 1997.

We ponder the sector issues and topics and address high impact and developing domains:

- Cancer / Anticancer
- eHealth
- Health Tourism
- Weight / Obesity Management
- Diabetes
- Maternal and Child Health
- Elderly Care

Our Services aim to be internationally relevant and take the form of:

- Analysis and Strategic Thought
- Intelligence (by Country and Healthcare Domain)
- Domain Integration Projects
- Design of Hybrid Health Plans and Services
- Executive and Vocational Training / Education

Consultation regarding Community action on health services

Responding to the 9 Questions

Our approach to regarding and answering the questions

In order to make the questions more comprehensible and resolve ambiguities, we found it necessary to deconstruct them.

The apparent ambiguities were attributed to our unfamiliarity with legalistic and bureaucratic syntax.

It emerged that several of the questions are two- or multiple-pronged and needed to be considered in terms of "component parts".

Furthermore, we found that the questions often implied a desired objective – which needed to be picked out – and made the foundation / object of the reply / response.

Although it was not our intention, we found it necessary to start off by first considering the overall issue of health consumer rights and entitlement – in the context of "contemporary health care systems in a globalised world" before we could focus on the questions and formulate replies / responses.

This intermediate process led to the compilation of a number of headed paragraphs dealing with individual issues related to patient mobility – from which we drew in responding to the questions.

The compilation has been included in the present document and appears under the heading Thoughts on Patient Mobility within the EU, for those who may be interested in reading through it.

Our response to the 9 Questions posed, took into account, amongst other considerations, the following:

- High-quality health services are a priority issue for European citizens (See Eurobarometer 63 at http://ec.europa.eu/public_opinion/archives/eb/eb63/eb63_en.htm)
- Rights to healthcare are recognised in the Charter of Fundamental Rights of the EU (See Article 35 on health care)
- The European Court of Justice has made clear that "Treaty provisions on free movement" apply to Health Services, regardless of how they are organised or financed at national level
- The Consultation expects the responses to the 9 Questions to take into consideration all four types of cross-border healthcare:
    - Cross-border provision of services (delivery of service from the territory of one Member State into the territory of another)
    - Use of services abroad (patient mobility)
    - Permanent presence of a service provider (establishment of a healthcare provider in another Member State)

- Temporary presence of persons (mobility of health professionals)

Although we took into consideration all four types of cross-border healthcare, it was decided to limit our response to aspects relevant to the use of services abroad (patient mobility – health insurance portability).
We only responded to questions 1 – 5 and 8, which fell within our competence.
Our replies / answers appear under the subheading: Response (following the question reiteration) - hopefully, they are in the format expected.

Cross-border Healthcare – Patient Mobility – Health Insurance Portability

Areas of practical concern – and recommended action

We have noted that the Commission considers that Community action should be founded on two pillars:

- Legal certainty…
- Support for Member States in areas where European action can add value…

In considering the overall issue of cross-border healthcare (and in the process of responding to the 9 Questions) we identified three areas of serious practical concern that we feel need to be addressed.

These are listed below (with recommendations for suggested action – possibly European Action – in which healthCare cybernetics would be prepared to participate).

Direction of Patient Flow

With liberalization of patient mobility (and health insurance portability), it is practically certain that there will be a lopsided flow of patients.

Some EU member-countries are perceptually (and probably objectively) superior – in terms of quality and accessibility - to others.

Consequently, under a regime of unrestricted patient mobility, the national healthcare system of the more attractive countries will be inevitably challenged.

Unless timely provisions are made for this eventuality, quality, accessibility and sustainability will suffer in these “endowed” countries.

In other words, we are looking at and called upon to deal with the practicalities of an Imbalance of Patient Mobility.

And it all boils down to financially and administratively managing this imbalance (since accessibility, quality and sustainability are finance- and administration related).

Recommendation

We recommend that a study be commissioned (which could take the form of European Action) to study the direction of patient flow, the volume and economic dimensions.

The findings of the study should be used to pre-emptively instigate suitable measures aimed at averting disruptive challenges to the health systems of EU-member states likely to be net recipients of patients.

Financial Responsibility / Reimbursement

In pondering the issue of financial responsibility (who pays) in the patient mobility scheme, we concluded that for obvious reasons (and in view of the anticipated imbalanced patient flow), it will need to be the dispatching country.

This means that the receiving country will bill the dispatching country and expect payment (imbursement – reimbursement)

Because calculating the exact cost of care provided to each individual patient is a logistical nightmare – and because purchasers / payers want to know the cost of care in advance, each patient is assigned to a Disease Related Group (DRG) and charged / billed accordingly.

This approach and system has been adopted in principle (by mostl EU countries) but in practice, very few have implemented it.

It all has to do with the failure of most to implement “coding”.

The implication is that unless both the receiving and dispatching country have implemented coding (and not only DRG), billing (eBilling) and reimbursement will falter – in other words, it will not work – or at best, will work very inefficiently.

In practical terms, healthcare facilities that do not systematically and consistently use coding cannot realistically be expected to participate in the patient mobility / health insurance portability scheme.

Recommendation

We recommend that an EU-wide survey be conducted to determine which healthcare facilities are DRG and eBilling compliant, and can thus participate in the scheme.

Furthermore, laggards should be encouraged or helped to conform.

Responsibility for ensuring patient safety

The dispatching country bears some responsibility for the safety of the patient going for treatment abroad.

If nothing else, the authorities should be able to advise the patient on suitable and reliable healthcare facilities.

Furthermore, the authorities as *payers*, need to know who they will be dealing with. For example they will need to know if the Hospital / Facility:

- Has some form of Accreditation (National or International)
- Has an established procedure for credentialing of medical staff / personnel
- Has a Clinical Oversight Department / Case Management Unit, staffed by qualified staff
- Has adopted and applies evidence-based medicine and best practices
- Has adopted and implemented eHealth technologies (including coding and electronic health record)
- Has medical staff with appropriate and adequate insurance cover (for malpractice, medical error and negligence)

Recommendation

We suggest that the authorities in the EU-member states involved in cross-border healthcare collaborate to compile a (dynamic) database of Assessed and Approved Healthcare Facilities / Providers.

This database should be centrally stored and accessible by all interested parties.

This database could be consulted by patients, authorities and referring physicians – for the obvious reasons.

Thoughts on Patient Mobility within the EU

Executive Summary

Patient Mobility – Providing Certainty

Regulations regarding Patient Mobility need to be clearly defined and made known to and understood by all the stakeholders involved.

Issues for which certainty needs to be provided include the following:

- Entitlement to Healthcare Services abroad
- Equity
- Definition of Essential and Discretionary Healthcare Services (unanimity)
- Criteria for "within a medically acceptable time limit…"
- Conditions which are regarded as requiring hospital (in-patient) and non-hospital care
- Cover of non-hospital diagnostic / laboratory investigations
- Cover of Travel Costs
- Prior Authorization
- Public and Private Sector Provider participation in the "Patient Mobility" scheme
- Financial Responsibility – who pays (for what and when)?
- Providing Patient Protection
    - Clinical Oversight
    - Assessed and Approved Healthcare Facilities / Providers
    - Ensuring and providing patient redress in case of medical mishap

The issue of capacity and spare capacity

As a rule, the public sector facilities are operating at full capacity whilst the private sector is typically permanently on the look-out for more "business".

The issue of Direction of Patient Flow balance

It is anticipated that patient flow will tend to be lopsided, with the more *endowed countries* bearing the brunt.

Re-imbursement Systems / Procedures

In the absence of "across the board" adoption of coding (see ICD and DRG) amongst the EU-member countries, we anticipate bureaucratic chaos.

The need to adopt and implement Coding and other eHealth-related technologies

Healthcare Information and Communication Technology is all about Coding (International Classification of Disease – ICD, and Diagnosis Related Groups - DRGs), Communication Protocols (e.g., HL7) and Nomeclature (e.g., SNOMED).

Currently, very few EU countries have adopted and implemented coding in a systematic and consistent way.

Until we have universal implementation and use of these technologies amongst the collaborating healthcare institutions, cross-border healthcare will be associated with gross inefficiencies and frustration.

Three issues of concern – and recommendations

Direction of Patient Flow

With liberalization of patient mobility (and health insurance portability), it is practically certain that there will be a lopsided flow of patients.

Unless timely provisions are made for this eventuality, quality, accessibility and sustainability will suffer in these “endowed” countries.

We recommend that a study be commissioned (which could take the form of European action) to study the direction of patient flow, the volume and economic dimensions.

Financial Responsibility / Reimbursement

Regarding the issue of financial responsibility (who pays) in the patient mobility scheme, we concluded that it will need to be the dispatching country.

This means that the receiving country will bill the dispatching country and expect payment (imbursement – reimbursement).

Today, billing and reimbursement should be based on Disease Related Groups coding – but unfortunately, many healthcare facilities have not yet implemented this system.

In practical terms, healthcare facilities that do not systematically and consistently use coding cannot realistically be expected to participate in the patient mobility scheme.

We recommend that an EU-wide survey be conducted to determine which healthcare facilities are DRG and eBilling compliant, and can thus participate in the scheme.

Responsibility for ensuring patient safety

The dispatching country bears some responsibility for the safety of the patient going for treatment abroad.

Also the authorities should be able to advise the patient on suitable healthcare facilities.

Furthermore, the authorities as payers, need to know who they will be dealing with.

We suggest that the authorities in the EU-member states involved in cross-border healthcare collaborate to compile a database of Assessed and Approved Healthcare Facilities / Providers.

Thoughts on Patient Mobility within the EU

Summary

The regulation of Patient Mobility

The decision has essentially been taken to permit patient mobility within the EU.

The objective should be to establish a scheme that is equitable, operates smoothly and does not cause acrimony.

Why would a patient want to obtain treatment / healthcare services in a country other his own?

The obvious reasons:

- Shorter – or no - waiting list
- Better quality of care (actual / objectively determined or perceived)

Providing Certainty (legal and regulatory)

Entitlement to Healthcare Services abroad

EU-nationals should have the right to seek treatment in any EU - member nation, provided the service qualifies as “medically necessary” and the payer (national healthcare system) is not asked to pay more for it than if it was provided in the patient’s home country.

Equity

A fundamental objective of the scheme for patient mobility should be to ensure equity, with regards to quality and accessibility to healthcare services, for all (locals and patients from abroad).

Imposition / implementation of the scheme should not have the effect of providing preferential (or inferior) treatment to those from abroad or “crowding” out the locals.

One sure way to ensure high quality and equity is to insist that healthcare facilities consistently apply evidence-based medicine and best practices.

Definition of Essential and Discretionary Healthcare Services (unanimity)

As new medical evidence emerges and reveals previously un-associated *cause and effect*, there needs to be an ongoing review and reconsideration of which services should be regarded as essential and qualify for “reimbursement”.

Criteria for “within a medically acceptable time limit…”

The “medically acceptable time limit” *escape clause* should not be invoked in the case of medical conditions:

- Associated with pain
- Which are progressive and are associated with deterioration of health
- Which (left untreated) are associated with probable complications

Conditions which require hospital (in-patient) and non-hospital care

Technology, approach to disease management, rationalization (and even economic considerations) have had a profound effect on which conditions now need to be treated on an “in-patient” basis (and duration of hospital stay) and which can be treated on an out-patient basis

Approving / permitting treatment abroad should not make “hospitalisation” an obligatory precondition.

Cover of non-hospital diagnostic / laboratory investigations

An essential investigation is just as “medically necessary” as treatment – and should be regarded as such when considering patient mobility regulation.

Valid arguments, can be made to support that “denial of service” is unreasonable.

Cover of Travel Costs

Patient Mobility and Treatment Abroad involve travel, and the question arises – will the cost of travel be covered?

Prior Authorization

Rules and regulations, concerning the need for prior authorization (for certain treatments, investigations or medication) should not be any more stringent or onerous in the case of treatment abroad.

Public and Private Sector Provider participation in the “Patient Mobility” scheme

In a move aimed at addressing and remedying the gross inefficiency and waste associated with public sector healthcare facilities, national healthcare systems have introduced benchmarking and competition. Specifically, they now allow both public and private sector providers to compete for *public sector* patients.

Of course, provision and costing of services needs to based on Diagnosis Related Groups (DRG's), in order to provide a level playing field.

A case is made (with arguments) to support the inclusion of private sector healthcare facilities and providers in the Patient Mobility scheme.

Financial Responsibility – who pays (for what and when)?

There are two obvious approaches to dealing with the issue of “who pays”

- The Dispatching Country pays (each pays for its own)

or

- The Receiving Country pays

In a perfect world, dispatching and receiving would cancel out – and the question would not arise.

In reality, we anticipate a lopsided flow of patients. In view of this, it is reasonable to expect the dispatching country to pay – but reimbursement procedures are currently “archaic and chaotic” – see Re-imbursement Systems / Procedures, below.

Providing Patient Protection

Clinical Oversight

Ideally, the Receiving Healthcare Facility should assign a qualified Case Management Coordinator who will be primarily responsible for clinical oversight.

Assessed and Approved Healthcare Facilities / Providers

We suggest that the authorities in the EU-member states involved in cross-border healthcare collaborate to compile a database of Assessed and Approved Healthcare Facilities / Providers.

This database should be centrally stored and accessible by all interested parties.

The procedure for evaluation / assessment falls outside the scope of this response, but basic criteria should include:

- Some form of Accreditation (National or International)
- Clinical Oversight Department / Case Management Unit, staffed by qualified staff
- Established Procedure for Credentialing of Medical Staff / Personnel
- Adoption and application of evidence-based medicine and best practices
- Adoption and practical implementation of eHealth technologies (including coding and electronic health record)
- Adequate insurance cover of Medical Staff for malpractice, medical error and negligence

This database could be consulted by patients, authorities and referring physicians – for the obvious reasons.

Ensuring and providing patient redress in case of medical mishap

The management of the healthcare facility must provide assurance that provisions exist for appropriate and adequate redress, in case of a medical mishap.

One fundamental requisite is that the medical staff are adequately covered (professional liability insurance) for malpractice, medical error and negligence.

The issue of capacity and spare capacity

As a rule, the public sector facilities are operating at full capacity – and are in fact, usually overstretched (see “waiting lists”).

Any additional demands made on a national system will result in disruption.

On the other hand, the private sector is typically permanently on the look-out for more “business” and has actual (existing) or potential spare capacity.

The issue of Direction of Patient Flow balance

It is anticipated that patient flow will tend to be lopsided, with the more *endowed countries* bearing the brunt.

There is an urgent need to consider the implications for both, to ensure neither suffers – or that neither benefits, unduly.

In view of this – we recommend the urgent commissioning of studies into the Anticipated Direction of Patient Flow and the quantitative (and qualitative) impact – on both Receiving and Dispatching country.

Re-imbursement Systems / Procedures

In the absence of “across the board” adoption of coding (see ICD and DRG) amongst the EU-member countries, we anticipate bureaucratic chaos.

Without the adoption and implementation of DRG coding, we cannot realistically talk about a National Tariff for Healthcare Services – on which to base claims and reimbursement for services rendered. The same holds true for eBilling.

Currently, very few EU countries have adopted and implemented coding in a systematic and consistent way.

The need to adopt and implement Coding and other eHealth-related technologies

Successful cross-border healthcare provision and procurement relies heavily on Information and Communication Technology.

Healthcare Information and Communication Technology is all about Coding (International Classification of Disease – ICD, and Diagnosis Related Groups - DRGs), Communication Protocols (e.g., HL7) and Nomeclature (e.g., SNOMED).

Although most EU countries have adopted these *in principle*, practical implementation and use is still only sporadic.

The other eHealth element whose implementation has fallen behind is the electronic health record.

Until we have universal implementation and use of these technologies amongst the collaborating healthcare institutions, cross-border healthcare will be associated with gross inefficiencies and frustration.

Thoughts on Patient Mobility within the EU

(Unabridged)

The regulation of Patient Mobility

The decision has essentially been taken to permit nationals of one EU country to seek treatment / healthcare services in an EU country other than his / her own.

What needs to be resolved are the regulations governing this right.

The objective should be to establish a scheme that is equitable, operates smoothly and does not cause acrimony.

Resentment is bound to creep in. Some will feel that their healthcare system is being exploited by providing services to foreigners at the expense of the locals.

The scheme should include mechanisms aimed at preventing exploitation / abuse / fraud – but not "bureaucratic obstacles" which aim to discourage the exercising of the right to treatment / healthcare services abroad.

Why would a patient want to obtain treatment / healthcare services in a country other his own?

This question refers to individuals who plan and deliberately aim to obtain treatment / healthcare services "abroad" – and not to individuals who happen to be abroad (temporary work, holiday / vacation, in transit) and are faced with a medical emergency.

The obvious reasons:

- Shorter – or no - waiting list
- Better quality of care (actual / objectively determined or perceived)

Providing Certainty (legal and regulatory)

Entitlement to Healthcare Services abroad

In a single EU market, the indisputable rights of a patient / healthcare consumer should include the right to seek treatment in any EU - member country – provided the cost burden of this treatment (for the payer) is no higher than if the same treatment was provided in the patient's "home country".

For example, a patient living in Chios cannot (in principle) be denied the right to seek treatment in Athens. But, unless "referred", the national health system / health fund may refuse to cover the cost of travel.

Who and under what circumstances should one be entitled to treatment abroad?

Obviously, the principle criterion should be that the service qualifies as "medically necessary" (see "essential / medically necessary" and "discretionary" services).

Equity

A fundamental objective of the scheme for patient mobility should be to ensure equity, with regards to quality and accessibility to healthcare services, for all (locals and patients from abroad).

Imposition / implementation of the scheme should not have the effect of providing preferential (or inferior) treatment to those from abroad or "crowding" out the locals.

One sure way to ensure high quality and equity is to insist that healthcare facilities consistently apply evidence-based medicine and best practices.

Definition of Essential and Discretionary Healthcare Services (unanimity)

The distinction between essential and discretionary healthcare services is becoming more and more unclear, as procedures once considered "cosmetic" are now proving to be "therapeutic".

As new medical evidence emerges and reveals previously un-associated *cause and effect*, there needs to be an ongoing review and reconsideration of which services should qualify for "reimbursement".

An example is bariatric surgery for obesity.

Criteria for "within a medically acceptable time limit…"

It has been suggested that patients should only be entitled to reimbursable treatment abroad, if treatment cannot be provided "within a medically acceptable time limit". But the time limit is essentially *arbitrarily and subjectively set.*

In cases of pain or / and progressive deteriorating health – or where delay in treatment is associated with probable complications, any delay or deferment of treatment is unacceptable.

Consequently, the "medically acceptable time limit" *escape clause* should not be invoked in the case of medical conditions:

- Associated with pain
- Which are progressive and are associated with deterioration of health
- Which (left untreated) are associated with probable complications

Conditions which require hospital (in-patient) and non-hospital care

It was also suggested that entitlement to treatment abroad should be limited to conditions that required hospitalisation.

Technology, approach to disease management, rationalization (and even economic considerations) have had a profound effect on which conditions now need to be treated on an "in-patient" basis (and duration of hospital stay) and which can be treated on an out-patient basis. Even surgical procedures (with or without general anaesthesia) which conventionally required admission at least a day prior to surgery – and needed to be kept in hospital for several days following the procedure, have now become "day cases".

So approving / permitting treatment abroad should not make "hospitalisation" an obligatory precondition.

Cover of non-hospital diagnostic / laboratory investigations

Regulators concerned with cost containment and system abuse, have proposed that in the context of patient mobility, only *treatmen*t be sanctioned.

This means that essential diagnostic investigations that an individual would be entitled to at home cannot be sourced abroad.

This issue needs to be reviewed / reconsidered, because a strong case, with valid arguments, can be made to support that "denial of service" is unreasonable.

An essential investigation is just as "medically necessary" as treatment – and should be regarded as such when considering patient mobility regulation.

Cover of Travel Costs

Patient Mobility / treatment Abroad involves travel, and the question arises – will the cost of travel be covered (and at what tariff – first- business- economy class – air, rail sea)?

Will the regulators aim to discourage Patient Mobility by not covering travel costs?

Prior Authorization

Under the national health systems of some EU-member countries, access to certain treatments, investigations or medication, requires "prior authorization" (a frustrating, time consuming and even humiliating experience).

This control / gate-keeping service is provided by a Medical Controller or committee.

No one disputes the need for mechanisms aimed at controlling abuse and fraud.

This imposed inconvenience though, should not be used as a tool for cost containment (discouraging the legitimate demand for healthcare services).

The same thinking and policy should apply to patients seeking treatment abroad – the rules should not be any more stringent or onerous.

Public and Private Sector Provider participation in the "Patient Mobility" scheme

Because the issues of cost and payment are central to patient mobility, the natural inclination of the regulators is to limit the provision of healthcare to public sector facilities and providers (on the assumption that the public sector facility is unlikely to overcharge or abuse the system).

But this conventional mentality runs contrary to contemporary thinking.

Public sector facilities are classically associated with inefficiency. This is directly attributed to the fact that cost is not a consideration and competition does not enter.

In a move aimed at addressing and remedying this inefficiency, national healthcare systems have introduced benchmarking and competition. Specifically, they now allow both public and private sector providers to compete for *public sector* patients.

Of course, provision and costing of services needs to based on Diagnosis Related Groups (DRG's), in order to provide a level playing field.

See more on Coding, Communication Protocols, and Nomenclature in the section on Financial Responsibility and Reimbursement.

Financial Responsibility - Who pays (for what, how and when)?

The issue of who pays for what, how and when is the Big Conundrum – and is dealt with in our responses to the Nine Questions.

There are two obvious approaches to dealing with the issue of "who pays"

- The Dispatching Country pays (each pays for its own)

or

- The Receiving Country pays

The Dispatching Country pays

This would seem the rational and fair approach, if it were not for the inherent complexities and inefficiencies of reimbursement and control (to avert abuse and fraud).

The EU does not have a harmonized healthcare system (and it seems we are not pressing for one).

Furthermore, eHealth principles and practices have not been adopted and implemented *across the board* (EU-wide).

In most EU countries, *coding* has only been adopted in principle but not in practice.

Without the practical adoption and consistent implementation of International Classification of Disease coding (ICD – used for disease / diagnosis definition and classification) and Diagnosis Related Groups (DRG's – used for practical costing and charging of services) – trans-national billing and reimbursement procedures will be characterised by “chaos”.

Without the adoption and implementation of DRG coding, we cannot realistically talk about a National Tariff for Healthcare Services – on which to base claims and reimbursement for services rendered.

Over and above this, each country must determine which services would qualify for reimbursement and what other costs would be covered (e.g., cost of travel).

The Receiving Country pays

This seems the *least fair* approach (in view of the expected lopsided patient flow) – but the simpler, from the point of administration, since it does not involve reimbursement.

For precedents and paradigms of this approach, look to the international postal system (each country assumes / absorbs the cost of delivering incoming mail - i.e. mail from abroad).

But we doubt that this approach will be accepted by the countries likely to be *net recipients of patients from abroad*, without acrimony.

Under the prevailing circumstances (non-adoption of ICD and DRG coding) we cannot objectively cost and claim for the services rendered to individual patients.

A conciliatory approach would be for Dispatching countries to set up a fund, and use this to pay Receiving countries, for services rendered, based on *a mutually arrived at* estimate.

Providing Patient Protection

Clinical Oversight

Ideally, the Receiving Healthcare Facility should assign a qualified Case Management Coordinator who will be primarily responsible for clinical oversight.

Assessed and Approved Healthcare Facilities / Providers

We suggest that the authorities in the EU-member states involved in cross-border healthcare collaborate to compile a database of Assessed and Approved Healthcare Facilities / Providers.

This database should be centrally stored and accessible by all interested parties.

The procedure for evaluation / assessment falls outside the scope of this response, but basic criteria should include:

- Some form of Accreditation (National or International)
- Clinical Oversight Department / Case Management Unit, staffed by qualified staff
- Established Procedure for Credentialing of Medical Staff / Personnel

- Adoption and application of evidence-based medicine and best practices
- Adoption and practical implementation of eHealth technologies (including coding and electronic health record)
- Adequate insurance cover of Medical Staff for malpractice, medical error and negligence

This database could be consulted by patients, authorities and referring physicians – for the obvious reasons.

Ensuring and providing patient redress in case of medical mishap

The management of the healthcare facility must provide assurance that provisions exist for appropriate and adequate redress, in case of a medical mishap.

One fundamental requisite is that the medical staff are adequately covered (professional liability insurance) for malpractice, medical error and negligence.

The delivery of national healthcare – vizz-a-viz the issue of Patient Mobility

The role of the Public and Private sectors

Practically every country / nation has both a public and private healthcare sector.

The conventional understanding is that healthcare is provided / delivered by and sourced from either the Public- or Private sectors.

In the case of the public sector, services are paid for by the “payer” (a government or state entity - who has first collected the money – in the form of taxes or “purpose specific” contributions from the taxpayer or worker - and uses it to pay for the cost of providing the services). In this case, some health consumers find themselves consuming less healthcare than they paid for and others consuming more than they paid for (i.e., their consumption has been subsidised by other citizens).

In the case of the private sector, health consumers consume the healthcare they pay for (which may be fully, partially or non- tax deductible).

In practice things are not clear-cut and both the private and public sectors impinge or encroach on each others territory.

We find that the public and private services are interwoven and interdependent.

Specifically, for reasons of “policy” or “inadequacy” – the public sector may partly outsource the provision of healthcare services (from the private sector).

Conversely, providers who ostensibly belong to the private sector, not infrequently, offer their clients services through the facilities of the public sector.

When an EU Member state or the EU Commission considers the issue of patient mobility – the primary concern is “who pays” (regardless of whether the services are sourced from the public or private sectors).

The participation of the private sector in the provision of care - once the issue of patient mobility (and provision of legal certainty) has been resolved – is of secondary concern. Regardless of whether the Patient is obliged to obtain treatment from a public institution or has a choice (public or private) costs have to be paid by the Payer.

The Payer (public sector / national healthcare system) has a finite annual budget with which to pay for the services consumed.

Because the issues of cost and payment are central to patient mobility, the natural inclination is to limit the provision of healthcare to public sector facilities and providers.

But this conventional mentality runs contrary to the contemporary thinking.

Public sector facilities are classically associated with inefficiency. This is directly attributed to the fact that cost is not a consideration and competition does not enter.

In a move aimed at addressing and remedying this inefficiency, national healthcare systems have introduced benchmarking and competition. Specifically, they now allow both public and private sector providers to compete for *public sector* patients.

Of course, provision and costing of services needs to based on Diagnosis Related Groups (DRG's), in order to provide a level playing field.

The issue of *capacity* and *spare capacity*

As a rule, the public sector facilities are operating at full capacity – and are in fact, usually overstretched (see “waiting lists”).

Any additional demands made on a national system will result in disruption.

It is not a matter or rational redistribution – i.e., those with spare capacity “helping out” those who have an “overflow”. There is very little – if any – spare capacity in the public sector – which unlike the private sector, is practically inelastic.

On the other hand, the private sector is typically permanently on the look-out for more “business” and has actual (existing) or potential spare capacity.

The issue of Direction of Patient Flow balance

In “Patient Mobility” we have a Dispatching and a Receiving country.

There is an urgent need to consider the implications for both, to ensure neither suffers – or that neither benefits, unduly.

In a perfect world, the numbers of patients seeking treatment outside their national borders (in another EU country) and cost involved, would cancel out – and there would be no disruptive impact.

In practice we do not have *sameness of quality & accessibility* and harmonized healthcare systems. It is anticipated that patient flow will tend to be lopsided, with the more *endowed countries* bearing the brunt.

In view of this – we recommend the urgent commissioning of studies into the Anticipated Direction of Patient Flow and the quantitative (and qualitative) impact – on both Receiving and Dispatching country - and the formulation of plans and strategies to pre-emptively address the issue (and its components – regulation / legal certainty, cost burden for the "payer" and infrastructure adequacy).

As should be immediately obvious, direction of patient flow has serious financial implications (who pays for what and how).

healthCare cybernetics does not have a ready solution to the conundrum of "how to deal with an imbalanced patient flow" but is prepared to participate in any working group set up for the purpose.

Re-imbursement Systems / Procedures

Billing, Claims and Reimbursement are contentious and complex issues even under the best circumstances. In the absence of "across the board" adoption of coding (see ICD and DRG above and elsewhere) amongst the EU-member countries, we anticipate bureaucratic chaos.

To limit the frustration associated with an imperfect regime (and until coding is adopted), efforts should be made to keep things clear and simple – to limit bureaucratic wrangles, abuse and fraud.

The implications of non-adoption / non-implementation of Coding

Reimbursement

Without the practical adoption and consistent implementation of International Classification of Disease coding (ICD – used for disease / diagnosis definition and classification) and Diagnosis Related Groups (DRG's – used for practical costing and charging of services) – trans-national billing and reimbursement is very likely to involve haggling and lead to acrimony.

National Tariff for Healthcare Services

Without the adoption and implementation of DRG coding, we cannot realistically talk about a National Tariff for Healthcare Services – on which to base claims and reimbursement for services rendered.

eBilling

Likewise, eBilling, a precondition for efficient claim submission and reimbursement, cannot be implemented without the prior adoption and implementation of coding (ICD and DRG).

The need to adopt and implement Coding and other eHealth-related technologies

Successful cross-border healthcare provision and procurement relies heavily on Information and Communication Technology.

Healthcare Information and Communication Technology is all about Coding (International Classification of Disease – ICD, and Diagnosis Related Groups - DRGs), Communication Protocols (e.g., HL7) and Nomeclature (e.g., SNOMED).

Although most EU countries have adopted these *in principle*, practical implementation and use is still only sporadic.

The other eHealth element whose implementation has fallen behind is the electronic health record.

Until we have universal implementation and use of these technologies amongst the collaborating healthcare institutions, cross-border healthcare will be associated with gross inefficiencies and frustration.

Healthcare System Harmonization

The EU does not have a harmonized healthcare system (and it seems we are not pressing for one).

We also understand and respect the principle of Subsidiarity.

Nevertheless, Patient Mobility cannot be expected occur smoothly without the uniform and consistent adoption and implementation of at least some basic eHealth-related principles and practices – specifically, *Coding*.

In most EU countries, *coding* has only been adopted in principle but not in practice.

See more on this in the section on Financial Responsibility (The implications of non-adoption / non-implementation of Coding).

Consultation regarding Community action on health services

Response to the Nine 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?

Response

The rules governing Patient Mobility must be such that promulgated patient rights / freedom do / does not adversely effect accessibility and quality or disrupt the (financial) stability of the healthcare systems of either the receiving or dispatching country.

Currently, the impact (local, regional, national) of patient mobility on accessibility, quality and financial sustainability of healthcare systems is imperceptible.

The number of patients seeking treatment in an EU Country, other than their own (at the expense of a National Healthcare System) is very small (they are discouraged by the perceived difficulties / inconvenience involved and uncertainty regarding entitlement).

But in the event of liberalization / promulgation of patient mobility, this is very likely to change, with a considerable impact on “endowed” countries / healthcare systems.

There is bound to be an imbalanced (lopsided) direction of patient flow – with endowed countries bearing the burden.

In view of this – we recommend the urgent commissioning of studies into the Anticipated Direction of Patient Flow and the quantitative (and qualitative) impact – on both Receiving and Dispatching country - and the formulation of plans and strategies to pre-emptively address the issue.

Furthermore, competent authorities must resolve the issue of “who Pays” for what and based on what tariff.

The need to establish a uniform system for costing and pricing – based on Diagnosis Related Groups (DRG's) – to be used for claims and reimbursement is repeatedly emphasised in the present document.

Response – long version

a. How does the cross-border provision of healthcare (currently) impact on national systems, with regards to?:

Accessibility

For Locals

Currently, the cross-border provision of healthcare has no perceptible effect, with respect to the ease of accessibility, on the locals (i.e., they are not being "crowded out").

For Patients from Abroad

The bureaucratic formalities and uncertainties / ambiguities (innate / inherent or intentional) discourage non-nationals from setting out to seek treatment in another EU country.

They do so:

- "In desperation" (delay, denial of service)
- "Opportunistically" (to take advantage of higher quality of services than those provided in their own country)
- To pointedly "test / challenge" the system

Quality

At current levels of "demand from abroad", the quality of provided services does not seem to be suffering.

Financial Sustainability

Generally, public healthcare provision facilities are "financially stretched" – but the current demand from abroad does not seem to have perceptibly made their financial situation any worse.

b. How might this evolve?

If there was intra-EU sameness of quality & accessibility and harmonization of systems, there would be practically no "premeditated / deliberate patient movement".

Countries would then find themselves providing only emergency healthcare services to non-nationals (temporarily domiciled or visiting / vacationing).

But, in reality, some countries are perceptually and objectively superior – in terms of quality and accessibility - to others.

Consequently, under a regime of unrestricted patient mobility, the national healthcare system of the more attractive countries will be inevitably challenged.

And unless timely provisions are made for this eventuality, quality, accessibility and sustainability will suffer in these "endowed" countries.

In other words, we are looking at and called upon to deal with the practicalities of an Imbalance of Patient Mobility.

And it all boils down to financially managing this imbalance (since accessibility, quality and sustainability are finance-related).

The question is do we allow unrestricted patient mobility – and if so, who pays?

Who pays – at what tariff - and for what (include travel costs?)

Study the anticipated (direction of) flow of patients in a – and plan to deal with it.

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?

Response

We feel that the following specific clarification and practical information is required by all stakeholders in cross-border healthcare:

- Entitlement to Healthcare Services abroad
- Definition of Essential and Discretionary Healthcare Services (unanimity)
- Criteria for "within a medically acceptable time limit…"
- Conditions which require hospital (in-patient) and non-hospital care
- Cover of non-hospital diagnostic / laboratory investigations
- Cover of Travel Costs
- Prior Authorization
- Public and Private Sector Provider participation in the "Patient Mobility" scheme
- Financial Responsibility - Who pays (for what, how and when)?
- Providing Patient Protection
    - Clinical Oversight
    - Assessed and Approved Healthcare Facilities / Providers
    - Ensuring and providing patient redress in case of medical mishap

Entitlement to Healthcare Services abroad

In a single EU market, the indisputable rights of a patient / healthcare consumer should include the right to seek treatment in any EU - member country – provided the cost burden of this treatment (for the payer) is no higher than if the same treatment was provided in the patient's "home country".

For example, a patient living in Chios cannot (in principle) be denied the right to seek treatment in Athens. But, unless "referred", the national health system / health fund may refuse to cover the cost of travel.

Who and under what circumstances should one be entitled to treatment abroad?

Obviously, the principle criterion should be that the service qualifies as “medically necessary” (see “essential / medically necessary” and “discretionary” services).

Definition of Essential and Discretionary Healthcare Services (unanimity)

The distinction between essential and discretionary healthcare services is becoming more and more unclear, as procedures once considered “cosmetic” are now proving to be “therapeutic”.

As new medical evidence emerges and reveals previously un-associated *cause and effect*, there needs to be an ongoing review and reconsideration of which services should qualify for “reimbursement”.

An example is bariatric surgery for obesity.

Criteria for “within a medically acceptable time limit…”

It has been suggested that patients should only be entitled to reimbursable treatment abroad, if treatment cannot be provided “within a medically acceptable time limit”. But the time limit is essentially *arbitrarily and subjectively set.*

In cases of pain or / and progressive deteriorating health – or where delay in treatment is associated with probable complications, any delay or deferment of treatment is unacceptable.

Consequently, the “medically acceptable time limit” *escape clause* should not be invoked in the case of medical conditions:

- Associated with pain
- Which are progressive and are associated with deterioration of health
- Which (left untreated) are associated with probable complications

Conditions which require hospital (in-patient) and non-hospital care

It was also suggested that entitlement to treatment abroad should be limited to conditions that required hospitalisation.

Technology, approach to disease management, rationalization (and even economic considerations) have had a profound effect on which conditions now need to be treated on an “in-patient” basis (and duration of hospital stay) and which can be treated on an out-patient basis. Even surgical procedures (with or without general anaesthesia) which conventionally required admission at least a day prior to surgery – and needed to be kept in hospital for several days following the procedure, have now become “day cases”.

So approving / permitting treatment abroad should not make “hospitalisation” an obligatory precondition.

Cover of non-hospital diagnostic / laboratory investigations

Regulators concerned with cost containment and system abuse, have proposed that in the context of patient mobility, only *treatmen*t be sanctioned.

This means that essential diagnostic investigations that an individual would be entitled to at home cannot be sourced abroad.

This issue needs to be reviewed / reconsidered, because a strong case, with valid arguments, can be made to support that "denial of service" is unreasonable.

An essential investigation is just as "medically necessary" as treatment – and should be regarded as such when considering patient mobility regulation.

Cover of Travel Costs

Patient Mobility / treatment Abroad involves travel, and the question arises – will the cost of travel be covered (and at what tariff – first- business- economy class – air, rail sea)?

Will the regulators aim to discourage Patient Mobility by not covering travel costs?

Prior Authorization

Under the national health systems of some EU-member countries, access to certain treatments, investigations or medication, requires "prior authorization" (a frustrating, time consuming and even humiliating experience).

This control / gate-keeping service is provided by a Medical Controller or committee.

No one disputes the need for mechanisms aimed at controlling abuse and fraud.

This imposed inconvenience though, should not be used as a tool for cost containment (discouraging the legitimate demand for healthcare services).

The same thinking and policy should apply to patients seeking treatment abroad – the rules should not be any more stringent or onerous.

Public and Private Sector Provider participation in the "Patient Mobility" scheme

Because the issues of cost and payment are central to patient mobility, the natural inclination of the regulators is to limit the provision of healthcare to public sector facilities and providers (on the assumption that the public sector facility is unlikely to overcharge or abuse the system).

But this conventional mentality runs contrary to contemporary thinking.

Public sector facilities are classically associated with inefficiency. This is directly attributed to the fact that cost is not a consideration and competition does not enter.

In a move aimed at addressing and remedying this inefficiency, national healthcare systems have introduced benchmarking and competition. Specifically,

they now allow both public and private sector providers to compete for *public sector* patients.

Of course, provision and costing of services needs to based on Diagnosis Related Groups (DRG's), in order to provide a level playing field.

See more on Coding, Communication Protocols, and Nomenclature in the section on Financial Responsibility and Reimbursement.

Financial Responsibility - Who pays (for what, how and when)?

The issue of who pays for what, how and when is the Big Conundrum – and is dealt with in our responses to the Nine Questions.

There are two obvious approaches to dealing with the issue of "who pays"

- The Dispatching Country pays (each pays for its own)

or

- The Receiving Country pays

The Dispatching Country pays

This would seem the rational and fair approach, if it were not for the inherent complexities and inefficiencies of reimbursement and control (to avert abuse and fraud).

The EU does not have a harmonized healthcare system (and it seems we are not pressing for one).

Furthermore, eHealth principles and practices have not been adopted and implemented *across the board* (EU-wide).

In most EU countries, *coding* has only been adopted in principle but not in practice.

Without the practical adoption and consistent implementation of International Classification of Disease coding (ICD – used for disease / diagnosis definition and classification) and Diagnosis Related Groups (DRG's – used for practical costing and charging of services) – trans-national billing and reimbursement procedures will be characterised by "chaos".

Without the adoption and implementation of DRG coding, we cannot realistically talk about a National Tariff for Healthcare Services – on which to base claims and reimbursement for services rendered.

Over and above this, each country must determine which services would qualify for reimbursement and what other costs would be covered (e.g., cost of travel).

The Receiving Country pays

This seems the *least fair* approach (in view of the expected lopsided patient flow) – but the simpler, from the point of administration, since it does not involve reimbursement.

For precedents and paradigms of this approach, look to the international postal system (each country assumes / absorbs the cost of delivering incoming mail - i.e. mail from abroad).

But we doubt that this approach will be accepted by the countries likely to be *net recipients of patients from abroad*, without acrimony.

Under the prevailing circumstances (non-adoption of ICD and DRG coding) we cannot objectively cost and claim for the services rendered to individual patients.

A conciliatory approach would be for Dispatching countries to set up a fund, and use this to pay Receiving countries, for services rendered, based on *a mutually arrived at* estimate.

Providing Patient Protection

Clinical Oversight

Ideally, the Receiving Healthcare Facility should assign a qualified Case Management Coordinator who will be primarily responsible for clinical oversight.

Assessed and Approved Healthcare Facilities / Providers

We suggest that the authorities in the EU-member states involved in cross-border healthcare collaborate to compile a database of Assessed and Approved Healthcare Facilities / Providers.

This database should be centrally stored and accessible by all interested parties.

The procedure for evaluation / assessment falls outside the scope of this response, but basic criteria should include:

- Some form of Accreditation (National or International)
- Clinical Oversight Department / Case Management Unit, staffed by qualified staff
- Established Procedure for Credentialing of Medical Staff / Personnel
- Adoption and application of evidence-based medicine and best practices
- Adoption and practical implementation of eHealth technologies (including coding and electronic health record)
- Adequate insurance cover of Medical Staff for malpractice, medical error and negligence

This database could be consulted by patients, authorities and referring physicians – for the obvious reasons.

Ensuring and providing patient redress in case of medical mishap

The management of the healthcare facility must provide assurance that provisions exist for appropriate and adequate redress, in case of a medical mishap.

One fundamental requisite is that the medical staff are adequately covered (professional liability insurance) for malpractice, medical error and negligence.

Recap

The objective is to enable (facilitate / make possible) cross-border healthcare which is Safe, High-quality and Efficient.

Towards this end, unambiguous legal and regulatory stipulations, in the form of clear and easy to understand Practical Information needs to be made freely available to the stakeholder groups (authorities, purchasers / payers, providers and patients).

Legal clarification and practical information can be provided in booklet form – a separate version for each group.

Authorities – (ministries of health and local or regional health authorities, of both dispatching and receiving countries) need to know the boundaries of their legal responsibility and liability.

They need to know which patients are entitled to treatment abroad and on what conditions.

Authorities have an obligation to ensure that provisions are in place for the safety of the patient, not only in the receiving country but also in transit.

The must also ensure that the patient is in a fit enough condition to travel.

They have an obligation to ensure that the healthcare facility to which the patient is going is accredited and that the medical staff has been credentialed.

An important issue is the satisfactory management of medical mishaps, in terms of remedial treatment and financial compensation. Consequently the authorities need to ensure that the care providers have been adequately insured for medical error / negligence.

Clinical oversight is an issue often neglected. Ideally, the authorities should ensure that the patient is assigned a Case Management Coordinator – who in addition to clinical oversight will also be responsible for liaison (between care providers, authorities and family).

Finally, the authorities must ensure that bilateral agreements have been ratify to ensure that the patient is not involved in any wrangles over entitlement to treatment and reimbursement.

Question 3:

Which issues (eg: clinical oversight, financial responsibility) should be the responsibility of the authorities of which country?

Response

Clinical Oversight

Clinical oversight, during treatment, is provided by the receiving country (through the services of an assigned case management coordinator) – who in turn regularly liaises with the patients family physician and family members.

The authorities of the dispatching country also have a “clinical oversight” responsibility to ensure the quality and appropriateness of treatment provided.

Financial Responsibility

In a perfect world, the numbers of patients seeking treatment outside their national borders (in another EU country) and cost involved, would cancel out – and there would be no disruptive impact. In this case, the receiving country would bear the cost of care provision, to avoid the unnecessary reimbursement transactions.

In practice we anticipate a lopsided patient flow – with endowed countries bearing the burden. Consequently, the financial responsibility should be borne by the dispatching country.

Even so, as indicated already, the fact that coding (ICD and DRG's) has not been universally adopted and implemented, will result in repeated bureaucratic disputes and acrimony.

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?

Response

Responsibility for ensuring patient safety

Responsibility for ensuring patient safety should be shared between the authorities of the dispatching and receiving country.

The dispatching country must ensure that the receiving healthcare facility has and implements all necessary safety measures.

The receiving healthcare facility must demonstrate / prove to have in place the factors that ensure safety.

The dispatching authorities should stipulate that evidence-based medicine and best practices are applied. Additionally, they should demand that clinical oversight be provided by an assigned qualified case management coordinator.

Having said all this, the ultimate responsibility for patient safety rests with the receiving healthcare facility, its healthcare staff and management.

Assessed and Approved Healthcare Facilities / Providers

We suggest that the authorities in the EU-member states involved in cross-border healthcare collaborate to compile a database of Assessed and Approved Healthcare Facilities / Providers.

This database should be centrally stored and accessible by all interested parties.

The procedure for evaluation / assessment falls outside the scope of this response, but basic criteria should include:

- Some form of Accreditation (National or International)
- Established Procedure for Credentialing of Medical Staff / Personnel
- Clinical Oversight Department / Case Management Unit, staffed by qualified staff
- Adoption and application of evidence-based medicine and best practices
- Adoption and practical implementation of eHealth technologies (including coding and electronic health record)
- Adequate insurance cover of Medical Staff for malpractice, medical error and negligence

This database could be consulted by patients, authorities and referring physicians – for the obvious reasons.

Ensuring and providing patient redress in case of medical mishap

The management of the healthcare facility must provide assurance that provisions exist for appropriate and adequate redress, in case of a medical mishap.

One fundamental requisite is that the medical staff are adequately covered (professional liability insurance) for malpractice, medical error and negligence.

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)?

Response

Equity

A fundamental objective of the scheme for patient mobility should be to ensure equity, with regards to quality and accessibility to healthcare services, for all (locals and patients from abroad).

Imposition / implementation of the scheme should not have the effect of providing preferential (or inferior) treatment to those from abroad or "crowding" out the locals.

One sure way to ensure high quality and equity is to insist that healthcare facilities consistently apply evidence-based medicine and best practices.

Of course, equity and willingness to treat patients from abroad cannot work if the issue of "who pays" and the system for reimbursement has not been resolved and agreed by both sides.

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?

Response to this question is not provided

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?

Response to this question is not provided

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?

Response

In considering the overall issue of cross-border healthcare (and in the process of responding to the 9 Questions) we identified three areas of serious practical concern that we feel need to be addressed.

These are listed below (with recommendations for suggested action – possibly European Action).

Direction of Patient Flow

With liberalization of patient mobility (and health insurance portability), it is practically certain that there will be a lopsided flow of patients.

Some EU member-countries are perceptually (and probably objectively) superior – in terms of quality and accessibility - to others.

Consequently, under a regime of unrestricted patient mobility, the national healthcare system of the more attractive countries will be inevitably challenged.

Unless timely provisions are made for this eventuality, quality, accessibility and sustainability will suffer in these “endowed” countries.

In other words, we are looking at and called upon to deal with the practicalities of an Imbalance of Patient Mobility.

And it all boils down to financially and administratively managing this imbalance (since accessibility, quality and sustainability are finance- and administration related).

Recommendation

We recommend that a study be commissioned (which could take the form of European action) to study the direction of patient flow, the volume and economic dimensions.

The findings of the study should be used to pre-emptively instigate suitable measures aimed at averting disruptive challenges to the health systems of EU-member states likely to be net recipients of patients.

Financial Responsibility / Reimbursement

In pondering the issue of financial responsibility (who pays) in the patient mobility scheme, we concluded that for obvious reasons (and in view of the anticipated imbalanced patient flow), it will need to be the dispatching country.

This means that the receiving country will bill the dispatching country and expect payment (imbursement – reimbursement)

Because calculating the exact cost of care provided to each individual patient is a logistical nightmare – and because purchasers / payers want to know the cost in care in advance, each patient is assigned to a Disease Related Group (DRG) and charged / billed accordingly.

This approach and system has been adopted in principle (by practically all EU countries) but in practice, very few have implemented it.

It all has to do with the failure of most to implement coding.

The implication is that unless both the receiving and dispatching country have implemented coding (and not only DRG), billing (eBilling) and reimbursement will falter – in other words, it will not work – or at best, will work very inefficiently.

In practical terms, healthcare facilities that do not systematically and consistently use coding cannot realistically be expected to participate in the patient mobility scheme.

Recommendation

We recommend that an EU-wide survey be conducted to determine which healthcare facilities are DRG and eBilling compliant, and can thus participate in the scheme.

Furthermore, laggards should be encouraged or helped to conform.

Responsibility for ensuring patient safety

The dispatching country bears some responsibility for the safety of the patient going for treatment abroad.

If nothing else, the authorities should be able to advise the patient on suitable healthcare facilities.

Furthermore, the authorities as payers, need to know who they will be dealing with. For example they will need to know If the Hospital / Facility:

- Has some form of Accreditation (National or International)
- Has an established procedure for credentialing of medical staff / personnel
- Has a Clinical Oversight Department / Case Management Unit, staffed by qualified staff
- Has adopted and applies evidence-based medicine and best practices
- Has adopted and implemented eHealth technologies (including coding and electronic health record)
- Has medical staff with appropriate and adequate insurance cover (for malpractice, medical error and negligence)

Recommendation

We suggest that the authorities in the EU-member states involved in cross-border healthcare collaborate to compile a database of Assessed and Approved Healthcare Facilities / Providers.

This database should be centrally stored and accessible by all interested parties.

This database could be consulted by patients, authorities and referring physicians – for the obvious reasons.

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?

Response to this question is not provided