

Communication from the Commission.

Consultation regarding community action on health services.

Q1: What is the current impact (local, regional, national) of cross-border healthcare on the accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

The requirement on the part of the UK for prior authorization, via the E112 form for care in another member state is not consistent with the shared values and principles for health services on which citizens can rely throughout the EU. The current prior authorization requirement in which the patient needs the support of a UK consultant to gain the approval of the health authority has created an unjustifiable barrier to free movement. In addition to this barriers are created for patients by attempts to discourage them from seeking help outside the UK with warnings about not knowing what the standards are elsewhere. The current "choice" for patients in the UK amounts to a choice between 4 establishments which generally provide similar services for common conditions. There is frequently no provision for many less common painful conditions. This lack of provision causes a great deal of unnecessary suffering. In the UK a relatively small number of conditions are selected as priorities whilst others are neglected. This is not consistent with the charter of fundamental rights of the European union.

In some EU countries such as France and Belgium a great deal has been invested in training of healthcare professionals and expertise has accumulated in less well known conditions. Given the relatively small numbers of patients affected, there should be much easier access for patients to the expertise in those countries which have invested in developing such clinical expertise in response to patient need. Patients who are affected in these areas of medicine will go anywhere if they are physically able to get there. (Pain in Europe survey, 2004). Where expertise exists patients generally prefer to be treated near home, however where it doesn't exist or is unsatisfactory patients are willing to travel significant distances and across borders. (I have gathered patient data on this matter). The cost of facilitating access for patients to such expertise elsewhere is frequently less expensive than the cost in the UK in many cases. The care is of a higher standard with greater patient satisfaction. Patients who go outside of the UK to countries such as France and Belgium report that standards of care are significantly higher than in the UK.

The organization I represent as a patient advocate for several less common conditions, based on personal experience of care for the same condition in several countries and the experience of many other patients through their feedback is that outcomes are greatly improved in places where clinical expertise has been developed over many years. I have a significant amount of contact with such patients.

Q2 What specific legal clarification and what practical information is required by whom to enable safe, high quality and efficient cross border healthcare?

3.1.1 The term "undue delay" needs clarification particularly in cases of severe pain – is one year considered acceptable for a process of consideration in the case of a patient who is in severe pain?

There is currently little information that could enable patients to make informed choices about treatment in the UK. This is more transparent in many other European countries where there is a more individual patient-centred approach based on a wider consideration of evidence. In the area of medicine I'm involved with, patients are provided with information on success rates for an individual surgeon and any risks and complications that are greater than 1%. This data should be provided as matter of course. This information is not provided in the UK.

The authority of the receiving country should be responsible for ensuring the quality and safety of health services provided to people from other member states. Similarly the complaints and compensation system of the receiving country should apply.

In the case of less common conditions, the patient should have access to follow up care in the country where the treatment was provided.

Q3 Which issues should be the responsibility of the authorities of which country ..?

The EHIC card should replace the current E112 to enable patients to access cross border healthcare more readily. It should be possible for patients to seek a diagnosis in another member state especially in less common and less glamorous conditions where there has been little emphasis or attention in the patients country of origin. The country of origin of the patient should pay for the cost of care in the receiving country. Where harm is caused it should be the compensation and follow up system of the receiving country that applies.

Effective reporting and learning systems should be integrated within health systems – this is currently inadequate in the UK.

Q8: In what ways should European action help support the health systems of the Member States ?

European networking should be actively encouraged – in less common disease areas such networking should be mandatory. The UK tends to look to the USA rather than other European countries in healthcare. There needs to be a much greater emphasis on cooperation with other European countries many of whose healthcare systems have significant advantages over those of the USA and the UK. Each country needs to take account of research carried out in the other member state – there are enormous disparities in pelvic pain management, fertility, women's health etc. Assessment of outcomes is more transparent in some countries than in others. France has a very detailed assessment of public hospitals and all disease areas. This data is published annually in a national news magazine.

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 ?

The issue of pre-authorization should be addressed through community legislation – pre-authorization is a barrier that is against the fundamental principles of the EU. Healthcare professionals who support patients accessing care outside of the UK can be marginalized amongst their colleagues. There should also be a requirement to

cooperate with those in other EU countries who are working in the field of less common diseases and managing pain. Patients cannot be treated via telemedicine – it is necessary for the patient to be seen by the treating team prior to treatment. The difficulty with non-legislative means is that they are not considered important and therefore generally ignored.

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