

Royal College of Nursing response to the European Commission consultation regarding Community action on health services

With a membership of over 390,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The RCN believes that the ongoing debate concerning public services within the European Union, particularly health and social care, is an extremely important one and one in which the voice of nurses and the nursing profession must be heard. We therefore very much welcome the opportunity to contribute to this consultation. The RCN addresses the consultation questions and has prefaced these responses with some general remarks.

Context

Traditionally the National Health Service (NHS) in the UK both commissioned and provided health care services. However in recent years there has been a move towards a more market-based approach to the delivery of health care services and a clear delineation between commissioners (eg Primary Care Trusts and General Practitioners) and providers (from the voluntary, private, independent etc sectors) of services has been created. This is important in the context of understanding the provision of cross-border services.

General remarks

The RCN is delighted that health was excluded from the services (Bolkenstein) directive but is concerned that the same steps have not been taken with regard to social care. This raises particular issues in the UK where social care comprises a range of services such as mental health, children's services and elderly care. The RCN therefore urges the European Commission (EC) to clarify this distinction.

The RCN argued for the exclusion of health from the services directive, stating:

- That health providers delivering services in another country must be regulated by the standards of that country;
- That health services are not comparable with other service industries and should not be subject to market changes. A "patient" needing treatment is quite different from a "consumer";
- The need for patients to have clear redress in their own country.

These issues must be considered within the context of this consultation and any resulting policy / legislation. This consultation must not be used as a way of re-introducing the principles so clearly rejected earlier.

The RCN believes that it is not appropriate that the European Court of Justice sets EU policy and therefore welcomes the initiative to provide greater legal certainty on cross-border health care, particularly patient mobility. However the RCN believes that any future EU activity should not go beyond the clarification and codification of existing legislation and European Court of Justice rulings.

The RCN firmly believes that member states must retain their right to define, deliver and manage their health care systems, ensuring that they are responsive to the changing context in which they operate. The EU must therefore adhere to the principle of subsidiarity.

Evidence suggests that most patients want high-quality local care. In a recent survey published by the Department of Health in December 2006, over 65% of patients cited proximity and ease of access as the most important factors when choosing a hospital¹. The RCN calls on member states to provide adequate investment in national health care services and professionals. EU activity must not detract from this.

Improving the quality of patient care must sit at the heart of EU activity and it is imperative that principles such as equity and accessibility are applied to ensure that a two-tier healthcare system doesn't evolve (those who are willing / able to travel for treatment and those who are not). The RCN therefore welcomes the adoption by the Council of the European Union in June 2006 of the Common Values and Principles in EU Health Systems and calls on the European Commission and member states to embed these principles in any future EU health services action.

Question 1: What is the current impact (local, regional, national) of cross-border health care on accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

The UK reality is that cross border care is a very small section of the overall number of patients treated within and without the NHS.

UK is an island nation and only shares one land border with another EU member state (Eire and Northern Ireland). In that specific case, there have been studies by the EC on the extent of patient mobility and what issues it has raised for patients, politicians, providers and commissioners². Even where concrete figures exist (mostly for a limited range of acute or hospital based treatments), the actual numbers of 'mobile' patients ranges from 0.3 – 0.6% of total patient numbers treated in Eire and Northern Ireland.

¹ Research cited in 18 January 2007 edition of Health Service Journal. <http://www.hsj.co.uk>

² Magdalene Rosenmöller, Martin McKee, Rita Baeten - Eds (2006). 'Patient Mobility in the European Union: Learning from experience'. EU Health Observatory.

There are, however, examples of complications surrounding patient mobility within the UK, in particular, access to specialist services for Welsh or Scottish patients, when the services are located in England. Recent disagreements between the Welsh Assembly and Alderhay Hospital (Liverpool) over the level of reimbursement for specialist children's services threatened to prevent children from north Wales accessing such services resulting in much longer journey times to other specialist centres in London and the north of England.

In addition, recent involvement of private and independent companies in the delivery of NHS care has demonstrated how practical considerations such as information flows, patient pathways and performance criteria must be clearly laid out in advance of a patient journey. Even with contracts between commissioners and private providers numbering many hundreds of pages and the concerted effort of national government, there have still been widespread concerns about patient selection, variations in quality of care, value for money and staff training and development³.

In essence the RCN does not see a case for an EU-led encouraged evolution of patient mobility unless a whole range of issues about existing cross-border care are resolved.

Even if the market for such mobility were to increase, the RCN's prime concern would be to see that such a market **adds** to the range of services available and **improves** the quality of the patient experience in terms of outcomes and would constitute value for money. Cross border mobility mustn't be seen as an opportunity to rationalise services and reduce provision.

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?

There are three issues within this question that need exploring

- Information for commissioning
- Information to support patient choice
- Handling sensitive information

Information for commissioning

If patient mobility were to evolve beyond its current low level of activity, effective commissioning will be an important factor in its success.

The commissioning process will need provider data on

- access criteria, treatment protocols, and standards;
- datasets and processes for monitoring activity, clinical practice and outcomes;
- clinical and financial risk assessments for individual services; and

³ See for example the evidence to the House of Commons Health Select Committee on 'Independent Sector Treatment Centres' (Fourth Report of Session 2005–06, Volume I) July 2006

- consortia and / or risk-sharing mechanisms there are in place already where appropriate.⁴

Where a commissioner is seeking information from another member state provider, there will be challenges to overcome in terms of terminology, disease classification, payment systems, IT compatibility and cultural norms.

There are already significant challenges in gathering this type of information for commissioning services within the National Health Service. Considerable attention will have to be given for finding ways of consistently generating and sharing provider information with commissioners across national borders. Commercial sensitivity may make this process more complex or less transparent.

Whilst there are some examples of specialist information services being contracted to supply this kind of information⁵, it is early days and more will need to be done to reassure both commissioners and the public that information supplied is fit for purpose.

Information to support public & patient choice

In order for the public to make decisions about where and when they receive their care, there are a number of issues to be resolved.

‘Which?’ an independent UK consumer group and a member of the BEUC (The European Consumers’ Organisation) has produced 10 core principles that they believe should underpin all patient information⁶

- | | |
|-------------------|-----------------------|
| • Accessibility | • Accuracy |
| • Appropriateness | • Consistency |
| • Currency | • Evidence-based |
| • Non-biased | • Timeliness |
| • Transparency | • ‘Understandability’ |

Clearly there are a number of challenges within this list which are amplified when dealing with cross border care.

The public will need to feel confident that the information they receive will be balanced and provide enough detail for them to decide between one provider over

⁴ Department of Health (2003). ‘Guidance on commissioning specialist services’.

⁵ Dr Foster Intelligence is a new public-private partnership that aims to improve the quality and efficiency of health and social care through better use of information. They have been contracted by the Department of Health to provide a range of information services including ‘better’ information on patient outcomes. See www.drfoosterintelligence.co.uk

⁶ Which? (2003) ‘Patient information: What’s the prognosis? A Policy Report’ www.which.co.uk/files/application/pdf/0302patientinfo_pol-445-55723.pdf

another. In addition, any information provided may need to be supplied in a range of formats to ensure the widest range of people can access the information effectively. For example, large print, Braille or talking book formats for visually impaired; different language translations; paper based, virtual and other verbal formats.

In addition to 'formal' information sources, we are aware that personal recommendation and self directed research plays a large role in shaping public and patient views over health services. The existence of websites such as DIPEX⁷, Patient Experience⁸, and Patient Opinion⁹ show a developing interest in 'patient stories' as an indicator of provider performance rather than the more formal measures provided by regulators or inspectors of services.

The EC may want to consider its role in encouraging the development of shared standards for patient information services such as these which encourage the sharing of patient stories or experiences. In particular the public will want to be reassured that if they use this information, it is reliable, up to date, and as free from commercial bias as possible (this can be addressed for example by requiring such organisations to openly declare funding sources or corporate sponsors).

Handling sensitive information

There are already firmly established laws in the UK on the management of sensitive information¹⁰ and much of this legislation is overseen by the 'Information Commissioner's Office' (ICO). From the EU perspective and issues surrounding patient mobility, the ICO would be the supervisory authority in the United Kingdom for the purposes of the Data Protection Directive 95/46/EC. In this role they have a duty to exchange information with the other supervisory authorities in the EEA states and also the European Commission.

They also have a duty to help other supervisory authorities investigate complaints about the processing of personal data outside the UK where the data controller is UK based and has specific duties in relation to certain decisions he may make about the international transfer of personal data.

The European Data Protection Supervisor oversees the protection of individuals' personal information in the institutions of the European Union but its role is not

⁷ www.dipex.org/ - **DIPEX** provides a wide variety of personal experiences of health and illness. Members of the public can watch, listen to or read patient interviews, find reliable information on treatment choices and where to find support.

⁸ www.patient.co.uk/ - Patient UK provides 'comprehensive, free, up-to-date health information' which has been provided by GPs to patients during consultations

⁹ www.patientopinion.org.uk/ - Patient Opinion was set up by a GP, Paul Hodgkin, and states that 'is all about enabling patients to share their experiences of health care, and by doing so help other patients'.

¹⁰ For example, the Data Protection Act, the Privacy and Electronic Communications Regulations (PECR), the Freedom of Information Act and the Environmental Information Regulations.

widely known by members of the public or some commissioners / providers in the UK.

Regardless of the legal framework for these issues, the patient must be absolutely clear about the process of cross border care and give their explicit and informed consent to each and every aspect of the process, particularly in sharing confidential information such as medical records.

The RCN believes it would be useful to clarify the roles of the various information agencies at an EU level and determine how their function might be made more accessible for public consumption before attempting to add further to legislation or guidance at the EU level on handling confidential information in cross border services.

In summary, the RCN believes that

- The role of information in this context should be about supporting the informed choices of members of the public to access different types of services whether in or out of their home member state
- The role of the EC may be in assuring the quality of information or ensuring that the appropriate checks and balances are in place within member states legislation. This does not address a vast number of other issues however such as translation, cultural differences in practice, access and dissemination of information.
- There is already a vast amount of best practice in this field that should be evaluated and shared in a coordinated fashion and in way which raises the quality of information available to commissioners, providers and the public.

Question 3: What issues (e.g. clinical oversight, financial responsibility) should be the responsibility of the authorities of which country?

There are different responses to the above question depending on whether the patient is self funded or funded from an insurance scheme or state funded service.

Where patients are self funding and elect cross border services this is an individual transaction and they should be made fully aware of the risks inherent in electing to receive a health service in another country. The arrangement they would have with the provider and the patients rights in any event would have to be considered in light of the regulations and statues of the provider's member state. Whilst this is an individual transaction, the EC might still want to consider its role in ensuring such people have adequate access to information about complaints mechanisms and redress.

For members of the public who choose through a state funded system to go to another member state, there are other issues to consider:

- Commissioner responsibilities;
- Provider responsibilities; and
- Individual responsibilities.

Commissioner responsibilities

As the commissioner is in effect shaping the choices available to the public, they have a responsibility to ensure that the service on offer meets the relevant standards within their regulatory framework and that they do so in a non-discriminatory manner.

Whilst some providers may reject patients from other member states for good clinical reasons, commissioners must make every effort to ensure that choices are not limited for those with particular lifestyles, disabilities, beliefs, or special needs.

Where the standards offered by providers are different, commissioners must be able to justify those differences on the basis of best practice, clinical judgement and a thorough risk assessment.

Commissioners must also ensure that patients are completely clear on the practical implications of their choices, and clarify before treatment begins what the arrangements for transportation, communication, and post procedure follow up are.

“Patients should be given a detailed explanation of what the package of care will cover, and what it will not. They should be told about any documents they may need to sign (for example, consent to treatment forms) and see examples. They should be informed that relevant personal data will be shared with the overseas provider – the patient’s explicit consent should be obtained to the sharing of this information. They should be told what assistance will be available at the overseas hospital. Finally, they should be told what aftercare and social support will be available when they return to the UK. It is essential that the patient’s decision to travel abroad for treatment is an informed one.”¹¹
(DH, 2004)

Over the duration of the contract with the provider, the commissioner must also demonstrate how they are effectively managing the performance of the contract and taking whatever appropriate steps to address quality or other service concerns.

The EC may want to consider its role in encouraging member states to facilitate the free exchange of information for commissioners on regulatory frameworks, clinical outcomes, financial sustainability, complaints and ‘rogue’ providers.

Provider responsibilities

Providers from one member state providing services to another will have to comply with the standards set out by the commissioner – the vehicle for this compliance will be the contract for services. As previously discussed, these contracts are likely to be complex.

Any provider contemplating services to citizens outside of the member state should consider their additional responsibilities such as translation services, effective

¹¹ Department of Health (2004) ‘Treating More Patients and Extending Choice: Overseas Treatment for NHS Patients. Guidance for Primary Care and Acute Trusts’.

communication with commissioners (particularly with regards the patient's medical records and condition upon discharge), and effective discharge arrangements.

Individual responsibilities

Whilst the public have a right to expect a high standard of care from both commissioner and provider, it should also be made clear about the risks inherent in cross border services of this nature. The patient should be clear about the arrangements for transportation and follow-up and who is responsible for arranging this. Where possible the patient could also be briefed about cultural differences and prepared for differences in service delivery.

There is already evidence of best practice in terms of patient information leaflets and advocacy services for cross border care which may be of interest to the EC¹².

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?

There is a reasonable view which suggests that if a member of the public chooses to go outside of their own country's system of regulation and legislation for health care that they should do so fully aware of the risks involved, and with a clear view about how they would access complaints and litigation procedures in the provider's own country.

This view presupposes that the public already know how to access such advocacy services in their own country. Unfortunately there is plenty of evidence to suggest that on the whole the public are unclear about their rights, how to complain and what they can expect from providers in the UK, never mind overseas¹³.

Whilst it is right to clarify the issues of redress, there are also several stages to clarify before legal action which would be useful for a much larger number of patients.

RCN believes that before discussing litigation, it is essential to clarify complaints procedures and how patients choosing cross border services can be helped to raise concerns with the service provider without prejudicing their care or dignity.

In terms of litigation, we don't believe that there needs to be any further legislation. Instead we believe that the EC may have a role in promoting alternatives to conflict through arbitration, conciliation and mediation. Fast track, no fault processes may provide on two fronts:

¹² See for example the NHS Direct website and the DH guidance on overseas health care for providers, commissioners and patients www.nhsdirect.nhs.uk/articles/article.aspx?articleId=907 and www.dh.gov.uk/PolicyAndGuidance/International/OverseasTreatmentGuidanceForNHS/fs/en

¹³ See the Health Service Ombudsman's report 'Making things better? A report on reform of the NHS complaint procedure in England'. 2nd Report - Session 2004-2005. Presented to Parliament Pursuant to Section 14(4) of the Health Service Commissioners Act 1993

- Reduce the commercial and/or financial pressure to cover mistakes
- Reduce the stress and expense on providers and the public in pursuing claims, particularly where it would involve providers in another member state.

Consideration could be given to an EU wide accountability framework which offers some protection for patients choosing cross border care (self funded or state funded). This framework could be supported by industry in a similar manner to how vehicle insurance companies collaborate on claims outside of the country of origin¹⁴.

Risk assessment based on a thorough assessment of the patient's needs and condition will help avoid errors. However in adopting such risk assessments into commissioning processes we must also make sure that equality is fully integrated as an overriding concern.

As mentioned earlier, this would be particularly important to ensure that patients who may be deemed high risk do not have their choices limited in an effort to avoid complications, costs and possible litigation (e.g. those with HIV, chronic conditions or other disabilities).

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)?

As stated earlier, member states must retain their right to define, deliver and manage their health care systems. This means that it is for member states (at national / regional / local level) to take a political role in deciding what health services to provide to their citizens and to balance collective versus individual interests.

We are clear that receiving member states should be fully reimbursed for any care they give to a citizen of another member state. However, where there are seasonal variations (such as winter ski resorts, summer holiday destinations) the EC should give consideration to supporting effective dialogue between member states around ensuring that there is also appropriate workforce and capacity to deal with seasonal fluctuations.

In terms of planned patient mobility, rather than attempting to create additional legislation around the issue of entitlement and reimbursement, it would be useful to gain the Commission's view on exactly what the ECJ rulings mean for the public, politicians, commissioners and providers.

There are two issues within this

- Ensuring effective reimbursement for seasonal or emergency care delivered to a citizen of another member state
- Ensuring effective and felt fair reimbursement of care delivered under a planned arrangement.

¹⁴ See Motor Insurers Bureau www.mib.org.uk

The UK has some experience of such arrangements in terms of ensuring that ex-patriot citizens of the UK in Spain, France etc receive proper medical attention where required. However the matter of what is and who pays for social care remains a vexed one.

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 RCN believes that the MRPQ Directive has provided a good start in ensuring that professionals can move more freely between member states without encountering unnecessary bureaucracy. Despite the fact that mutual recognition arrangements have been in place for some time, concerns remain that there are insufficient checks to identify health care professionals who have been struck off for professional misconduct or criminal offences in other EU countries, thereby endangering patient safety. This issue has been identified by the Alliance of UK Health Regulators on Europe (AURE) in their response to this EC consultation¹⁵ and is one that needs to be addressed at EU level.

There are a growing number of unregulated health care workers working in social and home care settings and these workers fall outside the scope of the MRPQ Directive. The Department of Health recently published a series of conclusions setting out how best to regulate these non-medical health care workers¹⁶ and this is an issue that the EU will also need to address.

The RCN is concerned that there is still no strategy, either at European or international level, concerning workforce planning and the mobility of health care professionals. Until this is adequately addressed some countries will continue to lose their qualified and experienced health care professionals to other countries within the EU and beyond, thereby running the risk of destabilising their national health systems. The RCN therefore urges the European Commission to address this issue as a matter of urgency. The European Commission is encouraged to refer to existing good practice on international recruitment, including guidance produced by the RCN and the European Federation of Nurses Association¹⁷.

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

¹⁵ AURE is a network of 10 UK health and social care regulators. www.aure.org.uk

¹⁶ 'The regulation of the non-medical healthcare professions: a review by the Department of Health' July 2006 www.dh.gov.uk

¹⁷ 'Internationally recruited nurses: good practice guidance for health care employers and RCN negotiators' 2005 (www.rcn.org.uk) and 'Good Practice Guidance for International Nurse Recruitment' (<http://www.pcnweb.org>).

Member States – such as healthcare providers and social security institutions – suggest in order to facilitate cross-border healthcare?

The RCN urges caution in using legislative tools at EU level where other non-legislative measures have yet to be explored and which may provide solutions. Where possible non-legislative measures should be used.

Question 8: In what ways should European action help support the health systems of the Member States the different actors within them?

The EC would have a valuable role in encouraging the development of best practice networks to ensure that as member states develop their own health systems over time, that they are able to access a range of information on the experiences of other countries who might be further ahead in their reform program.

Where there are stark differences in the quality and level of provision between one member state and another, consideration should be given to the EC role in encouraging a levelling up of standards and more concerted investment in infrastructure, workforce development and public involvement.

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?

As stated above, the RCN believes that EU action should respect the principles of proportionality and subsidiarity. Community legislation should only be used to clarify and codify existing legislation and European Court of Justice rulings concerning patient mobility. Non-legislative tools including the Open Method of Coordination and other mechanisms which capitalise on the wide range of formal and informal groupings such as the Social Dialogue in the European Hospital Sector and EU Platforms / Forums, should be used to benchmark member states' health care services, to identify practical solutions to shared challenges and to facilitate the sharing of best practice.

Conclusion

The RCN welcomes the European Commission's initiative to consult with stakeholders on the important issue of health services and urges the continuation of this dialogue, particularly as EU policy / legislation is drafted.

In summary, the RCN believes that:

- The EC must respect the principle of subsidiarity, with member states retaining their right to define, deliver and manage their health care systems and to respond to the changing context in which they operate.

- Greater legal certainty concerning cross-border health care, particularly patient mobility is welcomed, however it should not go beyond the clarification and codification of existing EU legislation and case law;
- High quality, up to date information is key to ensuring that commissioners, providers and the public are able to make informed choices. The RCN believes the EC should evaluate and share existing best practice before issuing further guidance / legislation.
- Whilst there is a need to clarify issues of redress, further legislation is not the answer. Instead the RCN believes that the EC could have a role in promoting alternatives to conflict through arbitration, conciliation and mediation.
- The EC needs to draw on existing guidance and good practice concerning workforce planning and the mobility of health care professionals.
- The EC has a valuable role in encouraging the development of best practice to support the continuous improvement of national health systems across the EU.

Royal College of Nursing
January 2007

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