The European Older People's Platform
La Plate-forme européenne des Personnes âgées

29 January 2007

AGE Response to Communication from the Commission Consultation regarding Community action on health services
SEC (2006) 1195/4

http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/comm_health_services_comm2006_en.pdf

AGE - the European Older People's Platform is a European network of organisations of people aged 50+ and directly represents over 25 million older people in Europe. AGE aims to voice and promote the interests of the 150 million inhabitants aged 50+ in the European Union and to raise awareness of the issues that concern them most.

AGE would like to submit this contribution to the consultation launched by the European Commission regarding Community action, on health services; this response has been drafted in consultation with our member organisations and experts.

Introduction

AGE sees of utmost importance the need for a comprehensive EU legal framework for all social services, including health services, to ensure that European citizens can enjoy a high level of care and medical services accessible to all within the EU. The European approach to health must be based on a fundamental value to protect and improve health as a human right. Every citizen has rights to healthcare (*right of access to preventive health care and the right to benefit from medical treatment*), which are recognised in the Charter of fundamental Rights in the EU (article 35).

The current dialogue that the Commission is developing with the consultation regarding Community action on health services is welcomed but we feel it is missing an important target i.e. the citizens. Within the array of questions that are presented in the consultation on the Communication only few are directed at users/citizens[1] although, the Commission acknowledges that the current volume of patient mobility is low and that more accurate data is needed, and states that "many patients are interested in cross-border healthcare" (p.7 of COM).

[1] Interesting questions could have been, e.g.: Have you ever considered treatment in another Member State? If not why? What are the major barriers and advantages for you in receiving treatment abroad? (Price, quality, language, availability of treatment, efficiency of services, cost reimbursement etc?) What do you think about the quality of care you received? If needed, would you consider doing it again? What were your major motivations in seeking treatment in another Member State?

More research is needed to evaluate the economic and legal impact of cross-border healthcare but more importantly, the social impact of cross-border healthcare for citizens, in particular older people and those with long-term conditions. The Commission's initiative on health services should be first of all, based on commitment to guarantee the quality of services for all and respect the fundamental rights of users/citizens. AGE would like the Commission to engage in an extended and coherent dialogue with citizens, including older people "that make up a significant element of the patient population, especially in the regions or in areas that are particularly attractive for long-term residents"[2]. It seems from the Communication that the current dialogue in this matter is mainly targeting healthcare service providers, social security bodies and Members States.

Our response concentrates on those questions which are most relevant to citizens.

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?

Cross border impact and information

Although the issue of patient mobility in Europe is, as the Commission recognises, still a marginal phenomenon, and most patients, especially older people, prefer to receive treatment as close to home as possible, to be able to communicate in their own language and within a healthcare system that they are familiar with, there is a growing trend on the entire territory of the European economic area (EEA) and Switzerland of cross border health care with an increasing number of pensioners moving and residing in another Member State for part of the year or even permanently. A new type of "Health tourism" is also developing as patients travel to seek treatment in another Member State to avoid long waiting lists in their own country (for example, patients from the UK and the Netherlands seeking treatment in Belgium or France).

It is of common knowledge that patient mobility is higher between States and regions (the so called Euregios) that have common borders with common structural problems, common language(s) and culture, high population density and high level of cross-border workers[3]. In these cases it is easier to establish cross-border agreements and to put into action a common health framework that enables easy access, ensuring patients with common standard levels of quality and efficiency of health services. Based on those agreements there seems to be no negative impact on the financial sustainability of each healthcare system and savings made by combining resources, seem to compensate for any higher care costs incurred.

The free movement of citizens and the resulting patient mobility, offer advantages and opportunities to all government, care providers, health insurers and patients but they also create new challenges for health authorities and there may be risks involved for patients.

In theory, patients are now free to choose to receive treatment either closer to home, or on the other side of the border or to be treated abroad when on holiday. Patient mobility can enable health insurers or governments to contract foreign care and reduce waiting lists, a problem commonly faced by older people in some Member States. The rationale behind the EU action is that by stimulating the European market, this could lead to improved quality, more freedom of choice for the patients, and more efficiency for the health authorities.

In practice however, our member organisations report that when older people are abroad as tourists or as long term residents and wish or need to take advantage of their European Health Insurance card (ex- E111 form - Regulation EEC Nº 1408/71) the procedures do not always

[2] Baeten R., Mckee M., Rosenmoller M. (2006): Patient Mobility in the European Union – Learning from Experience. The Cromwell Press, UK.

[3] Mertens, K (2006): Libre circulation des patients et coopération transfrontalière en matiére de santé – Exemple de la region "Sarre-Moselle". Presentation in Lisbon, Portugal, 16/03/2006 at conference" European Health Reforms Against the background of an Ageing society – same challenges – same solutions? " organised by European Association of Paritarian Intitutes of Social Protection.
Conill, Xavier (2006): Hôpital commun transfontalier de la Cerdagne et du Capcir. Presentation in Lisbon, Portugal, 16/03/2006 at conference"European Health Reforms Against the background of an Ageing society – same challenges – same solutions? " organised by European Association of Paritarian Intitutes of Social Protection.

work as efficiently as they should and many older people experience problems. In Spain, for example, older people are asked to pay out of their own pocket and then reclaim the money from their government or travel insurance policy[4]. It is difficult for older people to know which is the public health service provider that accepts the European Health Insurance card in the receiving country and often older people are taken to private health providers without being aware of that. Older people also face language barriers, lack of information and of human support. Older people tend to have fewer complaints when they are sent abroad by their healthcare systems for hospital care but the process of receiving an authorisation from their healthcare system is often long and can aggravate their physical and psychological conditions. The recent Watts case demonstrates that there is an urgent need to clarify what are "unacceptable waiting times" and to ensure that patients have access to full information.

The Commission and Members States should clearly define precise arrangements that are necessary to support patient mobility. A better organisation of local healthcare services, management and funding process is needed. AGE would like clearer information on these issues to be widely accessible and national contacts points to be established to provide immediate support to solve patient's mobility problems when they occur.

Increased patient mobility in Europe can also lead to a displacement of domestic patients by foreign patients especially in the case when patients cross the borders on their own initiative. "This can happen if foreign purchasers are willing to pay above official tariffs[5]". This can translate into increased prices and waiting lists in the receiving country. The principle of equity may also be jeopardised. In this case national/resident patients unable to seek treatment abroad due to a lack of financial resources may face a reduced access to care in their own country[6]. Moreover, a "brain drain" of health professionals between Member State countries is already occurring as a result of higher salaries, surplus and shortages.

Lastly, the mobility of health related goods and services without the patient or service provider being "mobile themselves" also known as eHealth, is a growing market in the area of cross-border health (acquisition of therapeutic aids, drugs, etc). But the eHealth tools and solutions go beyond the simply Internet-based applications. "These include tools for health authorities and professionals as well as personalised health systems for patients and citizens"[7]. There is an obvious added value in ensuring that EU's wide eHealth systems are interoperable in order to facilitate and foster the collaboration of health professionals and organisations as well as between health professionals and their patients. To achieve this, national/regional representatives and stakeholders must cooperate in order to resolve the various associated legal, organisational, policy and ethical issues. eHealth guidelines have already been published to facilitate the implementation in the various Member States and at the Union level[8]. This initiative will enable easy and fast access to a citizen's electronic health record or a targeted extract from it (like a patient summary or emergency data), from any place, and at any necessary time, in Europe. However, the implementation of an EU eHealth action plan raises many issues such as data security and quality standards that must be overcome.

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")?

[4] Baeten R., Mckee M., Rosenmoller M. (2006): Pateint Mobility in the European Union – Learning from Experience. The Cromwell Press, UK.

[5] Baeten R., Mckee M., Rosenmoller M. (2006): Patient Mobility in the European Union – Learning from Experience, p. 185., The Cromwell Press, UK.

[6] According to a Eurohealthnet study on charges of a hip replacement service in private hospitals in various European countries (November 2002) the cost of a hip replacement (including specialist fee, stay, surgery, prosthesis) varied between 1754 Euro in the Czech Republic and 10 640 Euro – 14 840 Euro in the United Kigdom, in McKee M., Mclehose L. And Nolte E. (2004) Health Policy and Euroepan Union Enlagement, Open Univesrity Press, UK.

[7] "Examples include health information networks, electronic health records, telemedicine services, personal wearable and portable communicable systems, health portals, and many other information and communication technology based tools assisting prevention, diagnosis, treatment, health monitoring and lifestyle management" COM/2004/356 p. 4 e-Health – making healthcare better for European citizens: an action plan for a European e-Health Area.

[8] Euopean Commission (2005): Connected Health: Quality and Safety for European Citizens. Available at: http://www.age-platform.org/EN/article.php3?id_article=308

Sustainability of Healthcare systems

There is an imbalance in efforts made by Member States to set up adequate health structures; increased patient mobility can result from this imbalance if Member States do not all provide adequate and high quality health services to their populations. Some Member States spend on health structures whilst some refer their patients to Member States where treatments are cheaper rather than invest in their own health structures and services. With more and more patients seeking treatment abroad to avoid waiting lists and "to obtain care that is perceived to be of more quality or more convenient[9]" there is also a risk for the receiving country as the amount refunded by the sending Member State to the receiving country does not include the investment made by the receiving country to set up the health structures and train staff. It only covers the cost of treatment which is claimed to the health and social security systems. With the increasing number of older people moving to another Member State when they retire, this could put the health services of some regional and local authorities under pressure if they have to heavily invest in their health structures to meet the needs of older people migrating from other Member States without receiving any additional support (for example from income taxes). The imbalance in patient mobility flows needs to be further researched and addressed to ensure that all Member States invest the necessary means to ensure adequate and high quality of health services.

Even though some of the arguments of patient mobility are to ensure better access to care for the population by optimising healthcare supply and containing costs in relation to an ageing population, AGE highlights that the Commission should look at other factors beside the age structure to determine healthcare expenditure, such as excessive consumption of drugs, price setting mechanisms and prescription behaviour of the medical community[10]. Therefore, a better management and rational use of health care resources by Member States and health prevention and promotion measures developed at EU, national and local level are needed to maximise the number of years of life spent in good health and ensure the financial sustainability of healthcare systems.

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?

Other issues requiring clarification

Member States must address the current "brain drain" of health professionals that move from their home country to search for better working conditions. Member States should invest in their own health systems and develop better working conditions, better training opportunities and higher remunerations for the health sector. With the ageing of the population, the healthcare sector is going to need more skilled workers. The EU should not rely exclusively on importing health professionals from other Member States or third countries to fill their staff shortages. Although the recognition of qualification and free movement of health professionals are already largely addressed at Community level legislation[11] health professional organisations in each Member State must also continue to ensure that the level of education and training received by the health professionals in their own country obeys common standards of quality and safety for the patients. This would benefit not only the health professionals but especially the quality of treatment received by patients and ultimately the health of the entire EU population.

An issue that was not mentioned in the Commission's consultation document, but of extreme importance, are the ethical questions and the confidentiality of health professionals involved in accessing care that might arise regarding cross-border care (e.g. documents send over the border, medical diagnoses, etc). A level of patient safety and protection must be guaranteed.

[9] Baeten R., Mckee M., Rosenmoller M. (2006): Pateint Mobility in the European Union – Learning from Experience, p. 180. The Cromwell Press, UK.

[10] Please refer to a Publication by Scoenmaeckers R. and Kotowska I. (2005): from the Council of Europe "Population ageing and its challenges to social policy" that notes that the debate rising from healthcare expenditure in relation to an ageing population such as over-consumption, price setting mechanism and prescription behaviour of the medical community. The report calls for a more rational use of health resources.

[11] Directive 2005/36/EC on the recognition of professional qualifications, OJ L 255, pp 22-143 of 30/09/2005.

Healthcare providers must be clear about national regulations and quality standards in the Member State where they are willing to provide services.

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?

1. European Networks of Centres of Reference (ENCR)
In an enlarged European Union the suggestion of the European Commission to establish ENCR is most welcomed especially when there are increasing differences in size, cultural, economic and healthcare systems across EU Member States. A clear definition of aims, objects and competences of this ENCR are therefore, needed. A clear commitment to ensure universal access to these ENCR to all whose health condition require it, is also needed. Access to the ENCR should not be restricted to those who can afford to cover the resulting travel, accommodation and other related costs.

2. Realising the potential of Health Innovation
The challenge of health innovation across the EU is to ensure that decision makers are backed by evidence or better "the best scientific evidence", when financing and implementing new technologies and therapies that can improve the quality of care. In this case, not only the medical effectiveness but also the cost effectiveness of new health technologies should be taken into account[12].

In this context, the Commission should enable the exchange of best practices of evidence based research at European level to avoid the duplication of resources and develop common information frameworks and techniques that can be used by all Member States to help them make best use of new technologies, therapies and techniques.

3. A shared based evidence for Policy-Making
Even if the framework conditions of the EU healthcare systems differ widely, developing healthcare indicators and common research methodologies as well as improving the availability and comparability of healthcare data are essential to improve the delivery of healthcare across Europe. The suggestion to develop an Observatory is most welcomed.

4 Health system impact Assessment
The health system impact assessment proposed by the Commission is a welcome suggestion. The Commission should also ensure that the results of the health system impact assessment are implemented within the appropriate EU legal framework while respecting the objectives of each national healthcare system.

Question 9: what tools would be appropriate to tackle issues related to health services at EU level? What issues should be addressed through Community legislation and through non-legislative means?

- The Commission should develop a clear legal framework and provide additional clarification, draw concrete recommendations from case-law in this area, as well as from existing legislation that has been implemented in Member States. "There is a consistent demand from providers involved in cross-border contracts for more legal certainty about what they are allowed to do, which procedures they should use, what prices they can charge, and what happens when things go wrong"[13]. This information should also be easily available to citizens.

[12] For example: Poland has developed an agency for Health Technology development to ensure that new therapies and technologies are introduced taking into consideration their effectiveness and cost. Busse, R.; Zentner,and Schellette, S (2006): Health Policy developments – Issue 6: focus on Continuity in Care, evaluation techniques, IT for Health. Verlag Bertelsmann Stiftung, Germany.
[13] Baeten R., Mckee M., Rosenmoller M. (2006): Patient Mobility in the European Union – Learning from Experience, p. 183. The Cromwell Press, UK.

- There is a need to clarify the distinction between health and social care as in many Member States; especially older people's care, is delivered within the social care sector, i.e. outside the scope of this consultation.

- The Commission should also establish a mechanism to ensure adequate standards of healthcare quality throughout the EU to ensure patient/consumer protection.

- The Commission should engage in a sustainable dialogue and involve and consult patients/consumers in the follow-up to this consultation on cross border health services. AGE – the European Older People's Platform would be happy to offer its support and cooperation.

* *
*
END