Comments
by the *Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege*
(Federal Working Group on Social Welfare)
on the consultation on Community action on health services
Communication from the EU Commission of 26.9.2006

In its Communication of 26.9.2006 on Community action on health services, the Commission raised some questions, on which the social welfare umbrella organisations working together in the *Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege (BAGFW)* give their comments below:

The *BAGFW* sees the consultation as an important step in the process of determining what EU measures on health services are necessary and useful. As a matter of principle, it points out that all such measures must recognise and respect the Member States' freedom to tailor their national health and social systems to their national legislation and customs. It was for this reason that the Commission exempted health services and social services of general interest from the scope of the Services Directive.

All the European Union's measures must also be geared to granting access to social and health services of general interest in accordance with national customs and to promoting policies which — as postulated in Articles 35 and 36 of the Charter of Fundamental Rights of the EU — aim to bring about and secure as high a standard of protection as possible.

Social and health services differ from other services, *inter alia*, on the following counts:

– when they are necessary, they relate to existentially important matters,

– they are frequently an integral part of a longer-lasting continuous process of care (healthcare, rehabilitation and prevention of complications),

– people who are ill are for many reasons not normally entirely independent customers (lack of mobility, information, time resources),

– ethical values and principles are very important in the provision of health services because of the need to protect the patient,

– the content, type and extent of health services are very largely determined by the various health insurance systems and the specific performance culture.

Safeguarding and providing health services therefore require that:

– ethical principles and values binding on health systems in Europe, as set out in the Charter of Fundamental Rights of the EU, are complied with,

– extensive arrangements are made to protect patients against a lack of or inadequate care and against any risks involved in treatment,

– continuous care, generally close to a patient's home, is provided,

– arrangements are made in the field of social security systems and planning of care facilities in order to safeguard sustained and nationwide healthcare for all.

The *BAGFW* believes that health services should, in many cases, be seen in conjunction with social services of general interest. Like these, health services are personal services and make an essential contribution to social participation in community life. Voluntary commitment, e.g. in the area of self-help and neighbourly help and support by family members, is also an indispensable part of healthcare. We therefore suggest that, in the consultation process, the interaction between health services and social services of general interest be clarified more precisely, as the Commission itself proposes (page 5). Unfortunately, the Commission does not explore this question in any more depth in the Communication. In this context, the links between health services and services to promote social and occupational participation, and to treat addicts and mentally ill persons must be taken into account, which are partly health services in the strict sense of the word and partly involve social services (counselling, care, accommodation, etc.). We also hope that the consultation process will produce greater clarity on the EU Commission's view on long-term care, which has a great deal in common with both types of services. The consultation process should certainly not confine itself to the more technical questions but trace the underlying common principles which are generally valid for health and social services and for social services of general (economic) interest.

Question 1: 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 *BAGFW* sees cross-border use of health services as a necessary consequence of European freedom of movement and welcomes it. It includes the freedom to use and provide health services in other EU Member States. 10% of EU citizens live in regions close to borders and they may be particularly interested in using services in the neighbouring country. In addition, there is already competition in the field of outpatient health services, which are provided at lower cost than in the country of origin in, for example, dental care or rehabilitation. This freedom is restricted only *de facto* in as much as health services are largely funded by social security systems which

a) guarantee care as necessary and in accordance with the requirement of sound financial management

b) generally lay down detailed requirements for the provision of a service

c) co- plan and fund health infrastructure.

These restrictions are of varying types and must be explained individually:

Ad a) In principle, this restriction, which is common to virtually all health insurance systems, is necessary to prevent excessive or unsuitable care and to make funding sustainable. In the Member States' health services, which have evolved over the years, views differ, however, as what constitutes necessary care in terms of nature, content and extent and this will trigger a process of clarification at European level on the extent of healthcare which is deemed necessary. The *BAGFW* welcomes such processes on two counts: firstly, responsibility for the configuration of social security systems lies exclusively with the Member State and, we feel, quite rightly so. The extent of healthcare services provided is therefore binding on citizens as a result of a democratic opinion-forming process. On the other hand, we are convinced that patients who are seriously ill should be helped if possible, even if they are citizens of another Member State which does not provide for a corresponding treatment in its own national catalogue of services. It must therefore be the task of the European Commission to safeguard as high as

possible standard of health and social protection whilst abiding by the principle of subsidiarity and acknowledging national competence for social and health matters.

Ad b) The health insurance systems — in Germany the statutory health insurance funds — lay down detailed requirements for service providers on how health services should be provided. These rules, which are mainly intended to protect patients and maintain the quality of services, must then be applied in accordance with the principle of equality, even when cross-border services are used regularly. Accordingly, rehabilitation facilities from other Member States, for example, which conclude contracts with the German health insurance funds must meet the same requirements as German facilities.

Ad c) The Member States use taxes paid by their resident populations to provide the health infrastructure in the form of, say, hospital beds. If patients from other Member States regularly use the services, capacity must be planned accordingly and arrangements made to fund the infrastructure. The *BAGFW* expects regional cross-border healthcare projects to issue corresponding regional rules when, for example, planning hospitals at regional level or planning specific care facilities which are geared to the population density.

Question 2: What specific legal clarification and what practical information is required by whom?

It is difficult to specify the "Minimum information and clarification requirements" mentioned in the Communication in general terms. Detailed information about the patient/user is always required to provide health services. This means that information is, by definition, a matter all service providers have to deal with. In cross-border cooperation on health services it is also important to ensure that there is sufficient exchange of information when patients are released and/or transferred to the health system of their country of origin. Here the electronic health identification card (EHIC) and the introduction of a European health portal could be helpful.

Service providers and health insurance systems should be supported in initiatives which help to improve information policy and practice for those concerned, strengthen their rights and take account of the particular requirements of cross-border health services.

Question 3: Which issues (e.g. clinical oversight, financial responsibility) should be the responsibilities of the authorities of which country? Are these different for the different kinds of cross-border healthcare described in section 2.2 above?

The *BAGFW* takes the view that the country in which the service is provided is responsible for authorising the service provider and supervising the provision of personal services. In the event of prior authorisation being required from the body bearing the costs of the patient in the country of origin, as it is, for example, under the law currently governing cross-border in-patient treatment, the necessary criteria should be checked to ensure that they are in keeping with Regulation 883/2004 and the rulings of the European Court of Justice and should be duly adjusted if necessary.

With regard to the four types of cross-border healthcare this means that:

a) For cross-border provision of services (from the territory of one Member State to the territory of another), e.g. when laboratory services in one Member State are provided for treatment in another, the country in which the service is provided

supervises the service provider and the provision of the service, in as far as this is regulated by law (such as health provisions, data protection, etc.).

b) When using services abroad, the arrangements adopted so far (European health insurance card) are to be developed further. Moreover, care is to be taken that health insurance systems require the same standards in respect of, say, quality of all service providers.

c) If a service provider permanently resides in another Member State, the authorisation provisions of that State and the rules of the competent funding body apply.

d) If a service provider resides temporarily in another Member State to provide services, the authorisation provisions of that State and the rules of the competent funding body also apply.

The *BAGFW* believes that more work needs to be done in respect of situations c) and d), taking into account the following political principles:

– The principle of freedom of movement must be upheld; any restrictions on the grounds of, say, public safety are admissible and must be justified.

– In view of the apparent and increasing shortage of skilled health workers in some EU Member States (cf. the 2006 WHO report), action is to be taken at Member State and, if necessary, at EU level to promote sustainable and uniform healthcare in all Member States.

Question 4: Who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm how should redress for them be ensured?

If a person suffers harm abroad — as a result of, for example, infringement of a contract or clinical error — this will give raise claims under civil and criminal law, including claims for compensation. These entail further problems with regard to the enforcement of rights including the availability and costs of legal aid. Many of the questions raised are dealt with differently in various Member States — not least as a result of the different legal traditions. This question cannot therefore be answered satisfactorily.

The *BAGFW* would, however, like to point out the importance of transparency, standardisation and quality assurance in general and recommends that the following aspects should be taken into account in the consultation process in the interests of patients:

a) Patients need to be protected right from the time treatment is planned, whilst they are still residing in their own Member State. In the interests of legal certainty, such protection includes information on medical legal standards of the host Member State, agreements on legal redress and/or jurisdiction and types of proceedings, and information on enforcement of rights. This information should be provided by the competent health insurance fund in the patient's country of residence. During the consultation process, the current information practices of health insurance systems should be examined and, if necessary, uniform European information standards laid down.

b) Under national law, it is the arbitration bodies set up in Germany by chambers of physicians rather than forensic procedures which have proved effective, especially in instances of clinical error. In the course of the consultation process it should be examined whether arbitration bodies are also accepted in other Member States and whether cooperation between such bodies could regulate cases of harm in cross-border services.

c) In order to prevent protracted legal proceedings with an uncertain outcome, cases of damage are often dealt with under insurance law in Germany. Practices in the various Member States should be compared in the consultation process and, if appropriate, an effort made to standardise them by means of a recommendation at European level.

d) In order to solve problems which arise following cross-border provision of health services and which could probably be resolved out of court, a system similar to SOLVIT[1] should be established. Its job should be to deal with complaints from patients by finding practical non-bureaucratic solutions to practical problems. To this end, comparable bodies should be set up in all the Member States. The Commission should look at whether SOLVIT itself could be used as a platform for these problems.

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 service accessible to all (for example by means of financial compensation for their treatment in "receiving" countries)?

It is doubtful whether this task can be solved by a single measure. Health care structures have so far been tailored to a country's residential population. This principle should continue to apply, since health care should, as a rule, still focus on continuous care near the place of residence. In the border regions of a unified Europe, this principle applies across borders: the capacity required in the region should be surveyed, planned in the course of a bi or tri-national exchange process and decided upon in a framework agreement. Sustainable funding of the infrastructure so provided is also to be agreed upon. We do not support the introduction of the cost-reimbursement principle as the basic method for providing sufficient health infrastructure.

A distinction is to be made between continuous care near the place of residence and the following:

a) Individual services which can easily be separated from other care requirements and can therefore also be taken advantage of outside the care region (such as dental prostheses and minor operations). These are usually elective services which can be planned in advance and the claim on treatment of patients who wish to be treated outside the regular care region is subordinate to that of residents of

[1] SOLVIT is an online problem-solving network (in existence since 7.2002) in which the Member States cooperate in order to solve problems which arise when authorities apply internal market rules incorrectly. There are SOLVIT offices in all the Member States of the EU and in Iceland, Liechtenstein and Norway. They handle complaints from **citizens** and **companies**. The SOLVIT offices are part of the national administrations and their task is to find practical solutions to practical problems within 10 weeks. SOLVIT can be used free of charge. In principle it deals with all cross-border problems which involve misapplication of EU law, between a company and a citizen (private person) on the one hand and an authority on the other.

the care region. As a rule there are no problems of rationing as the service can be planned on a long-term basis.

b) Highly specialised services which are only provided at special care centres. In principle, the conditions set out under a) also apply for these services. However, a subordinate claim to treatment for highly specialised services may lead to a selection process — a direct choice between two patients — if the service is required urgently for both. It is all the more important therefore to define the regions for highly specialised services and to plan and fund capacity (also cross-border capacity) accordingly.

Question 6: Are there further issues to be addressed in the specific context of health services regarding movement of health professionals or establishment of health care providers not already addressed by Community legislation?

The profession of carer for the elderly, which does not exist in Member States other than Germany, is, unlike the occupation of a nurse, not yet covered by the Directive on the recognition of professional qualifications. The Directive needs to be amended accordingly.

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 health care providers and social security institutions — suggest in order to facilitate cross-border health care?

Question 8: In what way should European action help support the health systems of the Member States and the different actors within them? Are there areas not identified above?

Of the measures proposed the *BAGFW* welcomes in particular:

a) European networks of reference centres for rare diseases,

b) steps at Community level to acquire findings for policy making,

c) health systems impact assessment.

Ad a) Resources need to be pooled to conduct research on and treat rare diseases and the EU can play an important part here. The aims, the target groups and the areas of activity must be identified and defined more clearly. The following action is required:

– the procedure for recognition of reference centres must be identified;

– the standards for recognition as a reference centre must be established;

– the relationship of the reference centres to existing cross-border health care projects and existing national and European initiatives in research (such as European networks of excellence, European rare diseases networks, competence centres of the *BMBF* (Federal Ministry for Education and Research), etc.) must be clarified;

– the funding of patient care, research and teaching in the reference centres must be clarified.

In developing the blueprint for the European reference centres, the following must be taken into account:

– The tasks of European reference centres should be restricted to rare diseases and forms of treatment.

– It should remain the exclusive responsibility of the Member States to define suitable quality of health care for the domestic population.

– Exclusive national competence for planning medical health care capacity should not be undermined by the European reference centres.

– The European reference centres should not affect national sovereignty for research and teaching and funding of health care.

– European reference centres should not jeopardise existing national initiatives and structures, such as the reference centres supported by the *BMBF*.

– Reference centres should be selected on the basis of an objective, transparent procedure and in accordance with the principle of equal opportunities. The suitability of the institutions selected should be checked regularly.

– The questions of funding cross-border treatment and research and teaching are to be clarified in full.

Ad b) Monitoring of health policy is in the interest of citizens/patients, particularly in view of the differences in health systems which have evolved historically. The most important instrument here ought to be the open method of coordination for health and long term care. However, as things stand the reduction of indicators that this involves makes no sense. This should be complemented by intensified health monitoring and the systematic comparison of available data (EU, OECD, WHO).

Ad c) An impact assessment of planned measures is needed, partly because an increase in cross-border health services could exacerbate the financial situation of the health insurance systems, which is already critical.

This is reflected in the rulings of the European Court of Justice, which holds that it is admissible to use the health services in another Member State up to the reimbursement ceiling in the country of residence.

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?

In view of the fact that the Member States are responsible for social security systems, the *BAGFW* sees little need for legislation at EU level. What would be useful, would be to continue and intensify the open method of coordination, an integral part of which is, we believe, an intensive dialogue with patients and players in the Member States' health systems. All the relevant players must be urged to participate in all the Member States. The OMC in the field of social protection offers a suitable framework because findings can be exchanged and transferred and it can therefore result in a successful communication and learning process, in particular through joint reports, indicators and guidelines. At the same time, however, every Member State is free to implement the

proposals or to set its own priorities. This strengthens the innovation capacity of health systems in keeping with federal principles.

Legislation should only govern principles, such as general access to as high a standard of health and care services as possible.

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