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CED POSITION PAPER

RESPONSES TO EUROPEAN COMMISSION CONSULTATION REGARDING COMMUNITY ACTION ON HEALTH SERVICES



EXECUTIVE SUMMARY

The Council of European Dentists represents over 300,000 dentists through 31 national dental associations. It was established in 1961 to advise the European Commission on matters relating to the dental profession, and its objectives are to promote a high level of oral health and dental care, and to represent the dental profession in the EU.

The CED welcomes the Commission's decision to consult broadly on the areas of possible EU action in respect of health services and on the place of such health services within the internal market. We would like to remind the Commission that the CED was in favour of the exclusion of health services from the Directive on Services in the Internal Market because of certain specific characteristics of healthcare services. This recognition of the need for a more sensitive approach to health services, where the guarantee of safety and quality is more crucial than for other services, was accepted by the European Parliament and Member States. It should also be borne in mind that it is Member States that are principally responsible for the organisation and delivery of health services. These points need to be taken into account in the discussion on future EU action relating to health services.

There are various types of patient mobility, but in the area of dental care the most common type of mobility is "self-managed" mobility, where patients decide themselves to seek treatment abroad. This decision is not normally based on medical necessity, lack of availability of treatment in the home State or the search for higher quality in another country. Rather the decision is made in relation to the extent of the patient's own financial contribution to the treatment, which may depend on the inclusion and availability of certain treatments within the patient's social security or insurance system. This makes patient mobility in the area of dental care somewhat different to mobility in other areas of healthcare.

By way of summary, we would like to make the following comments:

- 1. No active promotion of patient mobility.** The great majority of patients in the EU want to access healthcare close to home. The CED does not believe that patient mobility in the area of dental care should be actively promoted.
- 2. Continuity of care essential for high-quality care.** The CED emphasises the importance of continuity of care and of a strong dentist-patient relationship to the overall quality of health services. Dental treatment often requires a series of visits to the dentist to properly plan and carry out the treatment, and to provide post-treatment care. Where patients spend only a short time in the vicinity of the dentist – as is often the case where patients receive care abroad – the overall quality of the health service is difficult to ensure.
- 3. Promoting the quality of healthcare through training requirements, ethical codes, CPD and patient safety initiatives.** The quality and safety of healthcare services can best be ensured by having up-to-date minimum training requirements for dentists; by promoting European-level ethical codes; through continuous professional development; and by a commitment to promoting patient safety.
- 4. Patient information essential.** In respect of information, it is extremely important that patients be informed that high-quality treatment depends on properly planned care with scope for post-treatment care. Patients should have access to clear information on the availability and procedure for receiving reimbursements for healthcare costs abroad.

- 5. Support for professional mobility and need for adequate language knowledge.** The CED supports professional mobility as a useful way of easing local shortages of dentists; transferring knowledge between, and learning from, other health systems. Directive 2005/36 on the mutual recognition of professional qualifications comprehensively regulates professional mobility. Given the importance of effective communication to the quality of healthcare, however, it is essential that competent authorities be able to ascertain whether a health professional's knowledge of the language of the country in which he is providing services is adequate.

With these comments in mind, we consider the following action to be necessary within the EU on health services:

- **Legislative:**
 - The CED considers that in order to provide legal clarity for patients and health systems, the reimbursement of healthcare costs should be dealt with in an EU Directive.
 - The CED considers, however, that professional mobility is comprehensively dealt with by Directive 2005/36.
- **Non-legislative:**
 - The EU has a role to play in co-ordinating the spreading of best practice amongst Member States; pooling knowledge to avoid unnecessary duplication of research and health technology assessments; and developing networks of centres of references.
 - The exchange between Member State competent authorities of data on healthcare professionals is very important and will be facilitated through the Internal Market Information System. Healthcare professions themselves have an important role to play in promoting quality through ethical codes and continuous professional development. Quality assurance is principally a national issue.

□ **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?*

CURRENT IMPACT OF PATIENT MOBILITY

// EXTENT

We estimate that the current extent of patient mobility in the area of dental care within the EU is low. As with other forms of healthcare, dental patients prefer to be treated close to home where they better understand the health system and where they and their dentist speak a common language.

However, we cannot be sure that overall patient mobility in the area of dental care is and will remain low. Statistics are very sparse, and this for a number of reasons. Whereas in other areas of healthcare, patients may be transferred from one health system to another ('institutionally arranged' mobility) and therefore clear records on this mobility exist, in dental care it is more often patients themselves that choose to be treated abroad ('self-managed' mobility). Since many dental patients pay out of their own pocket for this treatment, due to certain types of dental treatment not being covered by insurance in many Member States, it is even more difficult to record. So dental patient mobility is impossible to track accurately and assessing its extent relies on anecdotal information.

It seems from such anecdotal information that, whilst overall patient mobility in dental care is low, there are some regions where it is significant.

Patient mobility from the EU-15 to the EU-10 is particularly noteworthy. We understand that some 500-600 dentists in Hungary treat almost exclusively patients from the EU-15. Patient mobility from Austria to Hungary and other neighbouring countries (Czech Republic, Slovakia and Slovenia) has been considerable since the early 1990s, with an estimate now of some 5-10% of Austrian patients seeking their dental treatment outside of Austria.

Since the enlargement of the EU in 2004, mobility to EU-10 countries from EU-15 countries has increased markedly. In Ireland, tax relief can be received for dental care, whether provided domestically or abroad. Around 1% of patients who sought tax relief in 2006 for dental care had received that care abroad (most commonly from EU-10 or Northern Ireland). However, since we believe that many patients pay for treatment abroad out of their own pocket, the figure of 1% is likely to be much less than the real proportion of patients receiving dental treatment abroad. In order to indicate tendencies in directions of mobility, we would also point out that there is considerable mobility from Finland and Sweden to Estonia. From Italy patients go mainly to Romania, Hungary, Slovenia and Croatia, though no statistics are available. And although there is little patient mobility from Greece, what little there is is to Bulgaria and FYROM. We are aware of contracts between German sickness funds in Brandenburg and Polish dentists, according to which German patients were offered the possibility of being treated in Poland. However, few patients took advantage of this possibility.

We should stress again that the extent of patient mobility is very difficult to assess accurately, and that the information we present is primarily anecdotal and does not represent official statistics¹.

It is important to be aware of the reasons for patient mobility. We have already noted that the most mobility in the area of dental care is self managed rather than institutionally arranged. Patients may choose to seek care abroad because of perceived better quality in another country; because certain treatment is not available or there is a shortage of health professionals in the patient's home country. We believe there may be differences between the reasons for patient mobility in general medicine and in dental care. Whereas in general medicine a patient may seek care in another country out of necessity, because, say, a life-saving operation is available only in another country, that is not the case in dental care. We do not believe mobile patients are looking for better quality dental care or that certain treatment is simply not provided in their country – the range of dental services is very similar from one country to the next. In some instances there may be a shortage of specialists working within the public healthcare system in one country, meaning a longer wait for cheaper domestic treatment (e.g. UK, Finland). For patients living near a border, access to dental care in the bordering country may be easier – this is made simpler in some instances by cooperation within a Euregio (as demonstrated by the cooperation between the Dutch and Flemish Dental Associations, and Nordrhein/Westfalen-Lippe Dental Chambers).

But the primary reason for patient mobility in dental care would seem to be linked to the extent of the patient's own financial contribution to the treatment, which may depend on the inclusion and availability of certain dental treatments under the patient's social security or insurance system. In a considerable number of countries much dental care (e.g. crowns, bridges, implants) is only partially covered, or not covered at all, by insurance. This means that patients often have to pay for the treatment, or make a co-payment, out of their own pocket. As a consequence, countries with a lower cost of living and less expensive overheads become attractive destinations for cheaper dental treatment. Dental patients may combine their cheaper dental treatment with a holiday, thanks also to the increasing availability of low-cost air travel.

// **IMPACT ON QUALITY**

We do not have any evidence that the quality of healthcare systems per se are affected by dental patient mobility. The quality of the healthcare services themselves may be affected, however. Where a patient travels long distances for the treatment, there are more challenges relating to quality than when a patient living close to a border receives treatment in the neighbouring country.

This is because dental treatment often requires a series of visits to the dentist to build a trusting dentist-patient relationship and so better ensure a safe outcome. By spending only a limited time at the place of treatment – as is often the case when patients receives treatment abroad – the quality of treatment is harder to guarantee. As an example, for complicated

¹ The lack of statistics on patient mobility is recognised by the Observatoire social européen in their "literature review of cross-border patient mobility in the EU" from September 2006.

treatment, like implants with crowns, several visits to the dentist over a number of months may be necessary. After preliminary consultation with the patient, the taking of x-rays, planning of treatment, very often periodontal treatment may be necessary, because the mouth may be in a neglected state. After this first stage, provisional restorations are often needed before then progressing to the final phase of treatment. Follow-up and post-treatment care are necessary and important components of the whole treatment plan.

Where long distances are involved, post-treatment care cannot properly be provided. If complications resulting from the original treatment arise when the patient has returned home, the patient cannot easily visit the same dentist again. There is also a risk that local dentists may then refuse to correct the complications for fear of legal action against them if the complications become more severe. This would put the patient in a very inopportune situation. Treatment close to home enables more thorough treatment and reliable post-treatment care.

Treatment can also be more complicated where the dentist is not fully aware of the medical history of the patient. Evidence suggests that changing dentist frequently (whether cross-border or not) can lead to unnecessary treatment and also complicates the issue of liability. Incomplete information about medical history also presents a challenge in relation to medical data and data protection. Further investigation is required to find a means of ensuring safe and confidential transfer of patients' medical data.

Since communication between patient and professional is fundamental to health services, the quality of the care can be impaired by the inability to communicate in a common language. Patients may put themselves at risk by seeking treatment from a dentist with whom they cannot effectively communicate. (The issue of language in relation to professional mobility is discussed in our response to question 6.)

Patients have the right to choose to be treated abroad and for some patients this may be an appropriate option. It is very important, however, that they have access to full information on these disadvantages of treatment abroad (see also our response to question 2).

// **IMPACT ON ACCESSIBILITY**

We do not have evidence that patient mobility has an impact on accessibility.

// **IMPACT ON FINANCIAL SUSTAINABILITY**

Dental patient mobility has little impact on financial sustainability. There is generally little insurance cover for the types of treatment for which patients tend to go abroad (e.g. crowns, bridges, implants). There may be an impact where treatment abroad has caused complications, and follow-up treatment is needed in the home state. If private dentists refuse to treat patients for fear of legal action against them if the complications become more severe, patients may be referred to the public system and it would then be the public health system that has to foot the bill.


// EVOLUTION

As long as dental services remain easily accessible throughout the EU we do not expect patient mobility to continue to increase. Given that differences in the size of co-payments seems to be an important factor in dental patient mobility, the incentive to go abroad will become less as prices become more comparable between countries. Patient mobility may continue where access to services in a neighbouring country happens to be easier.

CURRENT IMPACT OF PROFESSIONAL MOBILITY

The CED supports professional mobility as a useful way of easing local shortages of dentists; transferring knowledge between, and learning from, other health systems. We do not have evidence of an adverse impact on accessibility or financial sustainability. The phenomenon of 'brain drain', where there is a trend of professionals leaving a particular country in search of better pay or work elsewhere, can be a factor, but we cannot see a role for the EU in addressing this. One solution would be for governments of affected countries to take action to improve domestic working conditions, fees or career opportunities.

Professional mobility can have an impact on quality of services in relation to language skills, training standards and communication between competent authorities. These will be discussed under question 6.

 **Question 2:** *what specific legal clarification and what practical information is required by whom (eg: authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?*

The ECJ case law on patient mobility leaves a number of areas in need of further legal clarification. These include the definition of hospital care and undue delay. However, these are not normally of especial importance for patient mobility in the area of dental care, so we will not comment further on this.

Practical information is required, however, from and for different parties in order to improve care. Information requirements and obligations vary depending on the type of mobility. In the case of institutionally-arranged mobility, the patient is entitled to be given information on the conditions of the agreement between cross-border partners, be they healthcare insurers, health authorities or national health services; and information on the provision of post-treatment care in the home State. In the case of self-managed mobility, which represents the majority of dental patient mobility, the responsibility of the patient to fully inform himself is higher – patients have to bear in mind themselves, for example, that language barriers may hinder communication with a dentist in another country.

However, Member State authorities should provide clear information on how and to what extent patients can be reimbursed for different types of treatment abroad. Information on the procedure for making complaints should also be made easily accessible to patients by the Member State authorities of the country of treatment. It is also extremely important that patients be informed that high-quality treatment depends on properly planned care with scope for post-treatment care.

Information on the quality of dental services might be useful for patients but the issue is problematic. Quality is very difficult to assess even on a country-wide basis, but on an EU-wide basis it is even more difficult because of the varying traditions, cultures and treatment philosophies within Europe. Also, the borderline between appropriate information provision on quality and inappropriate advertising is not a clear one.

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

The CED would like to stress that the competent authorities of the host country – that is, the country in which the treatment is provided – must be responsible for clinical oversight. We made this point strenuously in relation to the country of origin principle in the context of the first draft of the Services Directive. Supervision from the country of origin is neither practicable nor realistic. This applies to both patient and professional mobility.

We do not have any comments on the issue of financial responsibility – this is an issue that should be addressed by each Member State itself.

□ **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?*

In the area of dental care, it is the dentist who is primarily responsible for ensuring safety. This is the case in both the domestic and cross-border context. The competent authorities of the country of treatment are responsible for ensuring the safety of the system within which the dental services are provided: e.g. complaints procedure. It is important to recognise, however, that the mobile patient himself carries a certain amount of responsibility in cross-border healthcare: in dental care it is most often patients themselves who *choose* to be treated abroad. They are responsible for that choice and for informing themselves of the benefits and disadvantages of treatment abroad: e.g. being able to communicate with a dentist who does not necessarily speak the same language.

An effective way of ensuring patient safety is by promoting the quality of healthcare services. In this regard, dentists have an ethical obligation to engage in lifelong learning and to remain clinically and professionally up to date through continuing professional development and education. It is important to note that the form that this CPD takes may differ from country to country and, in the interests of subsidiarity, this should remain so.

Quality can also be promoted across the EU through Europe-wide ethical codes. The CED is currently revising its ethical code which provides a framework based on shared principles within the profession. It is important to note that quality is also affected by the ability of the dentist and patient to communicate effectively in the same language, as to which more is said in our response to question 6.


Quality assurance systems, as exist in many EU Member States are also valuable in assessing and ensuring quality. These systems may vary greatly from country to country and are connected to each individual health system. Such quality assurance systems should remain a national issue.

In respect of current EU action on patient safety, we would like to highlight the work of the 'patient safety' working group within the High Level Group on Health Services and Medical Care, which the CED actively supports. It is important that this work continue.


Within the dental profession, rules on professional liability insurance vary from Member State to Member State. In some countries it is compulsory; in others, whilst it is not compulsory, the vast majority of professionals have such insurance. Given these differences the CED does not see a role for the EU in this area. Dentists should ensure that they have insurance equal to the risks of their services.

In relation to mobile patients suffering harm it is important, as mentioned in the response to question 2, that information on the procedure for complaints and redress should be made easily accessible to patients by the Member State authorities of the country of treatment.

An EU-wide mechanism for non-fault-based compensation for damage caused in the context of cross-border treatment, as proposed by some stakeholders, seems complicated to implement and disproportionate to the actual extent of patient mobility, especially since we do not expect mobility in the healthcare sector to increase considerably in the future.

 **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)?*

The CED has no evidence that suggests that dental patient mobility impacts on the provision of balanced medical services accessible to all. Dental care, to a greater extent than general medical care, is generally provided by professionals in private practice, so patients from abroad do not burden publicly funded infrastructure. Also, we believe that many patients seeking dental treatment abroad pay out of their own pocket, so 'health systems' as such are not greatly affected by the patient mobility.


 **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?*

Professional mobility for dentists is regulated comprehensively through Directives 78/686 and 78/687, which will be superseded by Directive 2005/36 on the mutual recognition of professional qualifications in October 2007. The Directives set minimum training

requirements in order to enable mutual recognition. In order to reflect contemporary standards of dental education and training the CED supports a revision of minimum training requirements for dentists. The document “Competences Required for the Practice of Dentistry in the European Union”, produced by the Advisory Committee on the Training of Dental Practitioners shows that dental professionals, competent authorities and teaching establishments are able to agree on how the minimum requirements could be updated. Updated minimum requirements with which European universities are obliged to comply would raise training standards throughout the EU.

Directive 2005/36 also leaves the question of knowledge of languages unsatisfactorily resolved. Whilst it is said in Art. 53 that mobile professionals ‘shall have knowledge of languages necessary for practising the profession in the host Member State’, it is unclear what action competent authorities may take to assess a professional’s knowledge of host State languages. Judgments of the ECJ suggest that systematic testing of language skills is not permissible. A trusting relationship between dentist and patient is fundamental to dental care, and the ability to communicate is fundamental to this trusting relationship. One need only consider the importance of obtaining informed consent from the patient to understand the importance of effective communication. The quality of a healthcare service is considerably diminished if this communication in a common language is not possible. Clarity is very much needed on this issue.

Given the considerable degree of mobility of professionals, better co-operation between competent authorities of different countries is extremely important to ensure clarity on a mobile professional’s status/fitness to practise and thereby to better guarantee patient safety. The CED strongly supports, in this regard, the Health Professionals Crossing Borders project, in which competent authorities of health professions from all Member States have collaborated to develop, amongst other things, a common template for a ‘certificate of current professional status’. The Edinburgh Agreement from October 2005 represents a consensus on the need for proactive sharing of fitness-to-practice information amongst competent authorities. Connected with this, the Commission’s proposed Internal Market Information system (IMI) is commendable for providing a superb tool for facilitating this sharing of information.

 **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?*

We do not have any comments on this issue.

□ **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?*

Since the health systems of the Member States often face similar challenges, European action can help to pool knowledge and avoid unnecessary duplication of research and health technology assessments. Also, a European network of centres of reference could be a cost-effective way of providing high quality specialised care. In considering appropriate European action it is important that the principle of subsidiarity and the right of the Member States to take its own decisions be upheld.

□ **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?*

Since patients and health systems need legal clarity on the reimbursement of healthcare costs, legislation – in the form of a Directive – would be the most appropriate tool to tackle that issue.

Other aspects raised in the above responses – notably issues relating to quality, CPD and patient information – should better be dealt with by the Member States or the dental profession itself rather than by the EU, in order to respect subsidiarity. The open method of coordination, whereby best practices can be spread across the EU and policy convergence between the Member States achieved, has proved to be a valuable tool in the area of health care and long-term care and should continue to be used.

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