Health and Consumer Protection Directorate-General, European Commission

Summary report of the responses to the consultation regarding "Community action on health services" (SEC (2006) 1195/4 of 26 September 2006)

SUMMARY

This report summarises the responses received to the Commission's public consultation launched on 26 September 2006 regarding Community action on health services. Given that replies were received from a wide range of stakeholders, the report does not aim to provide a statistically representative survey of opinions. The views of respondents described in this report do not necessarily present in all cases the opinions held by the majority of stakeholders of a certain sector of the society or of a certain group of the population. It is important to stress that this report only attempts to give an accurate summary account of the responses as they were presented to the Commission's services. It does not take position on the comments received and does not seek to correct any of the misunderstandings or factual inaccuracies, which occasionally seem to underlie the views expressed by some respondents. Therefore, the report does not express the views of the Commission services, nor do the Commission services necessarily agree with all the views expressed therein.

Despite some additional examples, there is a clear lack of up-to-date and complete data on cross-border care. Many contributors concurred with the estimate in the Commission consultation communication that about 1% of total healthcare expenses was spent on cross-border care and is expected to increase. This phenomenon can be significantly larger in certain circumstances, in particular for border regions, smaller Member States, rare diseases, and areas with high numbers of visitors from abroad. The mechanism used for cross border care (through the regulations on coordination of social security systems, or through internal market rules) has different financial impacts for public funds and citizens depending in particular on the relative levels of the cost of care in the patients' home country and the cost abroad. And of course, though overall numbers of citizens using cross-border care remain relatively low, its importance for individuals can be high.

Contributors see a need for more and clearer information to patients with regard to cross-border care, and made a range of practical suggestions for achieving this. Greater clarity was also sought over instruments to control patient flows in cross-border care and in particular over the conditions under which prior authorisation for cross-border care is justified and can be refused. Suggestions by contributors for improvements include clear information for patients; effective and transparent decision procedures; a patient-centred approach; evidence-based standards; the right to appeal against refusals; and exceptions for border regions.

Greater clarity was also sought over pricing for cross-border care, and the definition of 'health services' within the scope of any Community action.

There is broad consensus that responsibility for clinical oversight should be with the country of treatment. However, cooperation with the relevant authorities in the patient's home country is important, and particular cases highlighted include managed cross-border care and international patient transport. There will also be particular cases where any division of responsibilities will leave difficulties in practice, such as with control of hospital-acquired infections. Many contributors also saw value in European support to national authorities in achieving a high level of quality and safety in healthcare, such as through developing guidelines and indicators; or the introduction of a no-fault patient safety reporting system. Practical suggestions for ensuring continuity of care included systems for exchanging patient data, an EU standard discharge letter and Europe-wide prescriptions. Many contributors also argued that there should be greater clarity over patients' rights.

There is also broad consensus that the provider of treatment should be liable for harm and any redress arising. Contributors were divided, though, about the need for more legal clarity regarding liability issues for cross-border healthcare beyond that already provided by international private law. However, there were many practical suggestions made, such as putting in place alternative dispute resolution systems for cross-border care (perhaps building on existing networks such as SOLVIT), requiring mandatory insurance for healthcare providers, or the establishment of the Europe-wide no-fault compensation system.

Some contributors were concerned about the potential for cross-border care to undermine the provision of healthcare within their countries, in particular with regard to how to prioritise different patients and setting fair prices for cross-border care provided. On the other hand, some contributors felt that increased cross-border care could have a positive effect on domestic care provision.

Many contributors felt that there was a need for better monitoring of health professional mobility. Issues were also identified in relation to Community rules on recognition of professional qualifications, but many contributors felt that the implementation of Directive 2005/36/EC should be awaited before taking any new action. How to manage the impact of health professional mobility was also identified as an issue, in particular by contributors from the newer Member States. Greater clarity about the rules governing the establishment of healthcare providers in other Member States was also sought by a few contributors, with particular regard to pharmacies and dentist. However, most contributions were more concerned about practical issues in cross-border pharmacy services, and made suggestions such as developing ePrescriptions. Information and communication technology solutions in general were identified as a key area for the future by many contributors, though teleradiology was seen as a priority challenge where more analysis was needed.

In addition to the issues identified elsewhere in the report, some contributors identified some particular issues related to the practical operation of the existing regulations on coordination of social security systems, and made a number of suggestions for improvements. Also in addition to the other suggestions for practical support covered elsewhere in the report, contributors highlighted the scope for practical support on areas including European networks of centres of reference; an observatory for comparative data and indicators; health technology assessment; better sharing of healthcare innovations; and support for making effective use of potential investment in healthcare through the structural funds. However, many contributors

argued for a rationalisation of activities and resources concerning healthcare at European level; others also argued that Community action should also involve regional authorities.

Overall, contributors welcomed the initiative of the Commission regarding Community action on health services in general. The majority of national governments and many other stakeholders expressed the wish that any proposal of the Commission on health services should be based on the "*Council Conclusions on Common values and principles in EU Health Systems*"[1]. Many contributions (in particular from national governments, unions and purchasers) emphasised that any Community action that affects the health systems should respect the subsidiarity principle, referring in particular to Article 152 of the Treaty establishing the European Community, although others argued that the principle of subsidiarity should not prevent the application of EU fundamental freedoms. On the overall approach, the majority view of contributors was that a combination of both "supportive" tools (such as practical cooperation, or the 'open method of coordination') and legally binding measures would be the most efficient approach, although some contributors did not see a need for any legal measures. In terms of the preferred approach for any legal instrument there were clearly two main approaches preferred by different contributors. Some contributors preferred to include any changes within the Regulations on the coordination of social security systems, while other contributors preferred a new Directive on health services.

[1] 2733rd Employment, Social Policy, Health and Consumer Affairs Council meeting, Luxembourg, 1-2 June 2006