CONTRIBUTION

By the European Confederation of Independent Trade Unions

to the

Commission consultation
Regarding Community action on health services
SEC (2006) 1195/4

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In its communication, dated 26 September, 2006, the European Commission set in motion a wide-reaching public consultation concerning access to cross-border health services which will serve as a basis for legislative proposals, to be presented in the first half of 2007.

The Commission had already attempted to regulate patient mobility within the framework of the directive on internal market services. The aims and principles which underpin this community framework for the internal market reflect a logic which is fundamentally based on factors relating to economic performance. However, this logic does not apply to health services and is therefore neither fitting nor applicable to this sector.

For this reason, CESI welcomes the fact that health services were removed from the directive, since it takes the view, just like the European Parliament, that health services do not amount to a standard service. They are not goods and nor can they be used as a bargaining tool. The healthcare sector is funded by a mixture of public funds, funds from public health insurance providers and insurance contributions. The healthcare sector is not geared towards profit. Health systems are based on the principle of solidarity, universality and equal access for all citizens, which means that they are construed in such a way as to avoid social fractures and preferential treatment when it comes to accessing effective and affordable healthcare provision.

The Commission intends from now on to give a boost to patient mobility in the EU, lend it a legal framework and bring an end to the current legal uncertainty in this area. This said, it is at present the Member States who are responsible for organising and financing health care services.

The challenge ahead lies in improving patient mobility within the EU and, in so doing, maintaining the capacity of individual states to guarantee basic standards when it comes to making sure the healthcare system can function.

The European Confederation of Independent Trade Unions, in accordance with the decision of 30.01.2007, would like to respond to the following questions:

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?

Avenue de la Joyeuse Entrée 1-5, B - 1040 Bruxelles ★ Tel. +32.(0)2.282.18.70 ★ Fax. +32.(0)2.282.18.71
Internet: http://www.cesi.org ★ email: info@cesi.org

At present, unexpected care during a temporary stay abroad is covered by the European Health Insurance Card (what was the E111 certificate). Equally, a citizen can benefit from any kind of out-patient care to which s/he is entitled in his/her Member State in another Member State without prior authorisation. All that is required for the patient to be reimbursed for care received abroad is for the same rules, conditions and formalities to apply as for the provision of out-patient care in the country of origin. Moreover, the E112 form helps solve cases where a patient prefers to seek treatment in another Member State hospital.The patient must not be refused treatment if the care in question is provided for in the legislation of the patient's country of origin and the care, which the patient needs due to his/her state of health, cannot be provided at all or cannot be provided within a medically acceptable time frame in the country where the patient is insured.

As far is the second case is concerned, cross—border healthcare has so far only concerned a very small number of European citizens. There are various reasons for this: cost, language, distance, insufficient awareness of the possibility of receiving care abroad, concerns about the quality of care, etc. Nevertheless, one cannot assume that it is only well-informed, well-off patients who receive care outside their country of residence.

Even though the phenomenon is not widespread, CESI is nonetheless alarmed to note that a certain 'medical tourism' is developing on the back of existing international or bilateral agreements, involving destinations within and outside the EU (Majorca, Northern France, Hungary, Turkey, etc). This could prove a threat to the survival of national health systems and the foundations on which they are based. The most significant risks are as follows:

A greater inequality of treatment when it comes to access to healthcare

The gap between the destitute and well-off social strata, as well as the divide between poorer and better-off regions in the European Union persists, in spite of national and Community programmes to fight exclusion and poverty. If we promote cross-border mobility under these kinds of conditions, there is a risk that we will exclude the very people who do not dispose of the necessary funds to bear the travel costs and additional costs that treatment abroad calls for.

Greater problems in monitoring health insurance fund expenditure

Since inpatient care is directly dependent on hospital planning in many Member States, health insurance funds must bear, via the budgets, the primary costs that are in

the hospital plan. An unmonitored transfer of patients to non-budgeted hospitals would of course have an additional impact on the health insurance funds' expenditure.

The Working Environment

Increasing competition and the considerable pressure to lower the cost of health services will have a negative impact on the quality of healthcare, hospital capacity, as well as leading to longer waiting lists and less desirable working conditions for employees. Furthermore, care must be taken to ensure that no country puts the brake on developing its own structures under the pretext that the services in question already exist in other Member States.

Closure of certain institutions or lower quality of care provided

Visits to national hospitals would become more random were medical tourism to really take hold, which could also have a negative impact on the quality of medical care provided, as the latter depends, amongst other things, on the frequency with which certain treatment is carried out. Should the authorisation procedures be simply abolished, the mass migration of patients from small countries or border regions towards the hospitals of neighbouring countries could have negative effects on the quality and funding of healthcare services.

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?

The European Court of Justice has frequently taken the view that anything that limits cross-border mobility amounts to an obstacle to the free movement of healthcare services on the internal market. Since 1998, it has continued to expand on the possibility of receiving treatment in another Member State and being reimbursed for said treatment by ones healthcare insurance. The court has clarified that the provisions of the treaty regarding free movement also apply to health services, regardless of how they are organised and funded at national level. In this connection, CESI feels that it is important to enlighten authorities and patients on the conditions governing patient mobility in the European area via the creation of a Community framework.

CESI attaches great importance to safety in treating patients. In addition, the subsidiarity principle, as it currently stands in this field, seems for CESI to be best suited when it comes to guaranteeing the best possible consideration of European citizens' medical needs as well as high-quality healthcare for all. It would appear that this cannot be guaranteed through setting up joint standards at European level.

In order to provide patients with high-quality and transparent information, and in the light of the fact that it is the Member States which are responsible for organising their social security systems, Member States should be prompted to set up information centres, which provide information on procedures to be followed when applying for treatment, sources of information on medical staff and healthcare institutions, methods of payment for treatment, support modalities during the journey and linguistic support, the terms under which treatment is pursued, convalescence and rehabilitation once the patient has returned to his/her country of residence, how to submit a complaint, etc.

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

At present, Member States are responsible for organising and financing healthcare services, laying down quality and access criteria and accreditation, professional qualification requirements for medical staff, the minimum number of employees, prescribed rates, stocks in relation to population density (e.g. the number of hospital beds to number of residents ratio in the region in question) or the acceptable maximum distance to the next healthcare service.

Due to existing differences in the 27 Member States when it comes to funding, organisation and the standard of systems of healthcare provision, sound sanitary, medical and financial monitoring of healthcare institutions can only be carried out by the Member States themselves at national or regional level. They are the guarantors for efficient and sustainable healthcare services, accessible to all.

In contrast, CESI believes that establishing a minimum amount of joint monitoring standards for national authorities could make it possible to maintain a high-quality level of treatment, in spite of emerging competition between healthcare institutions due to the promotion of patient mobility in the EU.

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?

For CESI, patient safety comes within the remit of the institution providing the care. As in the answers to earlier questions, CESI also takes the view here that setting quality standards and taking the responsibility for monitoring hospitals is incumbent upon the national authorities. As a consequence, these authorities are the guarantors for

the quality of treatment, regardless of whether or not the patient is a national of the country in question.

Any patient who is not satisfied with the care s/he has received in a country other than his/her country of residence, must make an appeal in the country in which s/he was treated, as is already currently the case in the event of treatment received in a third country following an accident. CESI does not see the need to introduce specific national or European jurisdiction for such types of litigation.

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?

Different systems of reimbursement or disparities in purchasing power could lead to competition which endangers the patients' possibility to continue to benefit from quick access to high-quality healthcare provision in an institution near their homes. In such a case, the task would fall upon the Member States to implement all measures needed to remedy the situation in order to guarantee access for all to high-quality healthcare. This said, any measures aimed at setting up quota systems would undoubtedly be incompatible with Community law.

CESI feels that obstacles to cross-border mobility can arise from compelling reasons related to matters of welfare, of which Member States must take account, and that the principle which states that in the event of tension between the market and welfare, the latter must take precedent, must apply in this case. Mobility must be based on cooperation between the Member States and focus on the specific nature of regional solutions, adapted to the needs of the population. Where this closer cooperation between health systems takes place, respect must be paid to the specific nature of healthcare services, the role and responsibilities of employees and competent authorities as well as Member State competence, in line with the principle of subsidiarity.

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?

CESI rejects any introduction of the country of origin principle when it comes to social services, including health services.

Directive 2005/36/EC on the recognition of professional qualifications represents, in CESI's opinion, a necessary and adequate framework to guarantee the freedom of establishment for healthcare providers. All EU Member States attach great importance to maintaining quality standards for certain jobs, such as, for example, professions in the field of medicine.

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?

The Commission communication is in favour of connecting up European reference centres. Although CESI can but welcome the linking-up of these kinds of reference centres with a view to improving the care on offer, it would prefer to refrain from commenting on the matter at this stage, since little has been said about the concept behind the project. CESI holds the view that fundamental strategic matters, such as goals, tasks, selection of sites and their funding as well as access conditions for patients must first be looked into. At any rate, these types of reference centre in a neighbouring country only make sense for very rare diseases and cannot unburden Member States from the task of maintaining their own progressive health service.

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?

The rise of cross-border healthcare will leave a possible rise in sources of conflict and difficulties for individuals and authorities in its wake. CESI feels that, in line with the subsidiarity principle, it is the Member States who are best placed when it comes to introducing mechanisms amongst themselves to settle disputes. However, should the competent authorities not be in a position to make an independent and concerted effort to create the necessary regulatory instruments, legislative intervention will prove unavoidable. In the event of the competent national authorities failing to find a solution amongst themselves, CESI is in favour of Community action, in order to offer European citizens the greatest possible legal security. CESI is of the view that the open method of coordination, in particular in the social field, is a fitting tool to react to cross-border challenges on the horizon.

If CESI were to take the view that legal certainty in the case of cross-border health care needs to be improved, the question also has to be asked as to whether it would not be more logical, or at least more fitting, to include the transposition of the

principles governing patient mobility, as laid down by the European Court of Justice, directly in Regulation 1407/71 EC on the coordination of social security systems rather than in new legislation.

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Valerio Salvatore	Helmut Müllers
President	General Secretary