HOSPEEM Position Statement on the Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare

The European Hospital and Healthcare Employers' Association (HOSPEEM) was formed in 2005 in order to represent the interests of European Hospital and Healthcare Employers on workforce and industrial relations issues. HOSPEEM was created by the members of the European Centre of Enterprises with Public Participation and of Enterprises of General Economic Interest (CEEP) who felt that there was a need for a separate, distinct voice on health workforce issues at European level. As CEEP has a remit covering the whole public sector, CEEP's hospital and healthcare members established HOSPEEM as a sectoral association. CEEP has an observer status within HOSPEEM. HOSPEEM is a full member of CEEP.

HOSPEEM has members across the European Union both in the state or regionally controlled hospital sector and in the private health sector. HOSPEEM members are health employer organisations with the powers to negotiate on pay and on terms and conditions of service with their respective Trade Union partners. HOSPEEM members are also concerned with ensuring good employment practice for healthcare staff.

Since July 2006, HOSPEEM has been officially recognised by the European Commission as a European Social Partner in the Hospital Sector Social Dialogue alongside the European Federation of Public Service Unions (EPSU). The Sectoral Social Dialogue Committee was officially launched in September 2006.

The Directive

On the 2nd July 2008, the European Commission published its proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare. This follows the open consultation that the Commission ran between September 2006 and January 2007 which came in response to a series of European Court of Justice (ECJ) Judgments on health services in the European Union. The ECJ-Judgements stated that, under certain conditions, EU citizens were entitled to access healthcare in another Member State and be reimbursed for this treatment by their national health systems. The judgments have created uncertainty surrounding the interpretation of case law at European level for patients and for the national healthcare systems.

HOSPEEM supports the desire to establish legal certainty regarding patients' rights in relation to healthcare treatment in other EU Member States, thus avoiding the situation whereby the ECJ exercises political authority in the field by virtue of its rulings in individual cases. However, the Directive goes beyond the rulings of the ECJ, both in relation to the scope and the content of the Directive, most notably in relation to prior authorisation systems.

HOSPEEM questions that Article 95 of the EC Treaty, relating to internal market harmonisation, is the proper legal basis for a Directive on the application of patients' rights in

cross-border healthcare. In contrast to the view of the European Commission, HOSPEEM sees a fundamental conflict between Article 95 and the principles enshrined in Article 152 of the EC Treaty which outline the responsibilities of the Member States to fund, organise and deliver health services.

Subsidiarity

HOSPEEM members believe that the principle of subsidiarity is very important in healthcare in order to ensure that patients receive the best care and that healthcare is available to everyone. Healthcare was originally included in the Services Directive but was removed following strong representation from many quarters including European citizens, European health organisations and other interested parties. At the time of negotiations on the Services Directive, the specific character of social and health services was an important argument for excluding these services from the Directive.

In HOSPEEM's view, it was right that health was recognised as a complex arena and different to other services of general interest that are offered throughout the European Union. According to Article 152 of the EC Treaty, the European Commission has always had limited competence in the field of health. The funding, organisation and delivery of health systems has been in the competence of individual Member States. Whilst acknowledging that there are issues to address in relation to cross border healthcare following the series of judgments by the ECJ, HOSPEEM fully supports the principles established in Article 152 of the EC Treaty.

HOSPEEM believes that any action which appears to undermine the principle of subsidiarity could have long term, serious, unintended consequences for the health sector in the respective Member States. In line with this argument, HOSPEEM takes the strong view that developments in healthcare should be based on political consensus rather than on an expansion of internal market rules.

Member States should be able to retain the right to plan services and manage resources in order to ensure the financial viability of their health systems. HOSPEEM members believe it is important that when patients go abroad for treatment then their home health system, as the financer of the care, is able to decide what treatment is most appropriate. HOSPEEM members believe that if European health systems are not able to plan the provision of services and the workforce that is needed to deliver this healthcare, then patients may suffer.

HOSPEEM is pleased that the draft Directive states that for cross border hospital care, Member States will be able to impose the same conditions that apply domestically (for example, consulting a general practitioner) before receiving hospital care. We do however feel that there is work to be done on the definition of what constitutes hospital care.

Developments in most European Countries means, that more and more treatments which previously required admission to a hospital, are now being done as one-day treatments. Moreover, there are great differences between the Member States both in terms of definitions on the national health baskets but also in relation to treatments, which are done as one-day treatments. This means that the technical list of other treatments which can also be defined as hospital treatment, that the Commission intends to develop, potentially will be very difficult to complete and update. On that basis, HOSPEEM finds that it should be left to the individual Member States to define what can be regarded as hospital care and is therefore subject to prior authorisation procedures.

The draft Directive proposes the introduction of an implementing committee which will, amongst other things, define what constitutes hospital care in the European Union. HOSPEEM feels that this committee could further erode subsidiarity. Again, HOSPEEM members feel it is important that each health system defines what constitutes hospital care.

The draft Directive also introduces the concept of reference networks which will share expertise on highly specialised care. HOSPEEM would like to see more information on how the reference networks will be defined and how they will fit with the principle of subsidiarity. If not properly managed in practice, the concept of reference networks could indeed become detrimental to social and territorial cohesion.

Prior authorisation procedures

HOSPEEM takes the view that further clarification is needed about the authorisation process for cross-border healthcare. For healthcare to be delivered effectively, HOSPEEM believes that patients should be required to go through prior authorisation procedures in their home state before seeking hospital care in another Member State and then asking to be reimbursed for this care. The Directive makes it very difficult for Member States to ask for prior authorisation for hospital treatment abroad.

At a first glance, the possibility of getting treatment in another Member State without need for prior authorisation could be seen as a greater choice for the patient. In reality, this choice could result in a lowering of healthcare standards for other patients. While the referral process ensures that the patients are properly diagnosed and that there is a need for treatment, the need for prior authorisation procedures is related to Member States ability to plan the delivery of services - the management of the workforce needed to deliver these services and keeping track of the development.

As healthcare employers, HOSPEEM members know the importance of workforce planning. It is important to understand how long it takes to train doctors, nurses and other healthcare professionals and that any significant increase or decrease in the numbers of patients in any Member State is likely to create serious problems in managing the workforce. If, due to the affects of the Directive, the workforce of health systems can not be managed properly, then it could mean that patients have to wait longer for certain treatments or that certain treatments will not be delivered at all. This will certainly not benefit the patients in that country.

HOSPEEM is concerned that the Commission has underestimated the impact its proposals will have on human resources, financial planning and the training of the workforce. The movement of health professionals requires a strong set of measures. EPSU and HOSPEEM launched in April 2008, a code of conduct and follow up on ethical cross-border recruitment and retention in the hospital sector to tackle some of these issues. We believe the Social Partners remain the best placed to deliver adapted solutions in this field.

Prior authorisation procedures also provide an opportunity for patients and their healthcare funding organisation, to assess the risks of treatment abroad, determine what the care package will involve, what it will cost and what the outcomes potentially will be. It is important not to undermine such a system that could result in a worsening of quality of services provided to both local and foreign patients.

HOSPEEM also believes that when patients are granted prior authorisation to go to another Member State for hospital treatment, then they should pay for the care directly and then be

reimbursed by the home healthcare system, rather than the home healthcare system reimbursing the cross-border provider directly.

For HOSPEEM, the Member States' right to ask for prior authorisation for hospital care is essential both for the healthcare providers and for the patients.

Health inequalities

As hospital and healthcare employers, HOSPEEM welcomes any action which will benefit patients within the constraints of affordability for each Member State and which does not threaten the viability of health systems. However, HOSPEEM does not believe that patients will necessarily be healthier as a result of this directive.

While patient's rights to treatment abroad have been enshrined in European law, HOSPEEM believes that the Commission's proposals have the potential to create health inequalities. The Commission estimates that currently about 1% of public healthcare budgets are spent on cross-border healthcare with over 90% of healthcare provided to patients being delivered by their domestic healthcare system.

Although all patients have the right to access healthcare in other Member States, only the mobile and well informed patients will be able to use this right. For many patients treatment abroad is not a real option, either because they are too sick to travel, they can not afford it, language problems, or they prefer to stay close to home and family etc. As a result, HOSPEEM fears that these benefits will not be available to all patients and will create inequality in healthcare. On current figures, that means over 90% of EU patients will not make use of the new rights. HOSPEEM's view is that only strong patients, who have the financial and social capacity to move between States, will benefit as a result of this directive.

HOSPEEM takes the view that serious consideration should be given to the fact that an increasing number of the patients currently not moving across borders (over 90% of EU patients) is made up of older people, meaning not strong patients. Demographic change and the ageing population in Europe means there will be a growing number of older people in the years to come. This seems to contradict the effort deployed by the Commission and strongly supported by HOSPEEM, to invest in solutions to the problem of the ageing EU population. Moreover, being the provider and employer in healthcare services, HOSPEEM members increasingly experience the need to create a proper infrastructure for long term and elderly care and would see a political effort in that sense at EU level, much more effective than in the field of patients' mobility.

It is essential to deal with the threat that cross-border healthcare could reduce the healthcare offered to citizens in Member States if a high number of patients 'exit' a health system to seek healthcare abroad. This could lead to a situation where offering certain treatments is not possible because there are not enough people requiring the treatment to make it viable, both in terms of medical expertise and finance. Although the treatment may be available quicker and to a high standard in another Member State, patients may not be able to access the treatment close to their home and family.

Overarching values

HOSPEEM fully supports the joint statement made by the EU health ministers in June 2006 about the shared overarching values of universality, access to good quality care, equity and solidarity. However, HOSPEEM has specific concerns about putting these values in a cross-border healthcare directive. HOSPEEM is particularly concerned about the issue of universality because as healthcare employers and providers, we know how challenging it is to deliver a universal system in individual countries, let alone in the whole EU. There is a great danger that this could lead to future ECJ cases, when the aim of this directive is to resolve issues raised by previous ECJ Judgments.

National contact points and the collection of data

The directive foresees the establishments of contact points for cross-border healthcare in the Member States. This will cause heavy administrative burdens and high costs for healthcare providers as well as for the institutions organising domestic healthcare systems. Even though these contact points seem to be essential for the management of increased cross-border healthcare, the administrative and financial impact have to be fully considered. These additional costs are likely to take away funding from patient care.

The Commissions proposals also require Member States to collect new data on cross-border healthcare. Collecting data is also time consuming and expensive. The burden to collect this will fall on employers and HOSPEEM is again concerned that it will also take away precious resources from already overburdened health budgets. HOSPEEM therefore questions the necessity of collecting new data and how it will be used.

Patient safety and additional cost issues

HOSPEEM believes that the safety of patients is paramount. It is therefore concerned about the situation a patient might find themselves in when things go wrong with their treatment. We have concerns about after care services, for example homecare, physiotherapy, further hospital care where the patients have returned to their home state, after treatment in another Member State. HOSPEEM asks for further clarity on the issue of aftercare services, continuing care, malpractice etc., including the issue of how the home state will be reimbursed for the potential additional costs.

HOSPEEM takes the view that cross border healthcare could raise issues around patient safety which may not necessarily benefits patients. We would therefore like the Commission to consider action on the movement of dangerous professionals crossing borders. In countries that are receiving healthcare staff, there are issues for employers around the protection of patients and action to prevent dangerous healthcare professionals moving from one Member State to another. HOSPEEM finds this issue to be of great importance and recommend that the Commission should address this in future initiatives.

An increase in cross-border healthcare treatment will raise issues about the communication and the training of staff. Increased patient mobility will result in increased demands on the healthcare professionals. If staff do not speak the language of the patients they are treating this could lead to an increased need (and therefore increased cost) for language and interpretation skills. During patient care it is imperative that good communication exists and language could be a barrier to this happening successfully. Staff may also require increased training and new skills in order to better treat patients from different cultural backgrounds

which will all be an additional expense for employers. HOSPEEM finds that more clarity is needed on how these additional costs can be met.

Conclusion

HOSPEEM supports the Commissions efforts to provide legal clarity on patients rights on cross border treatment and believes that patient safety must be paramount. It is imperative that existing health systems which are already under pressure are not overburdened by any new proposals that come from the Commission to resolve the issues created by the ECJ judgments. HOSPEEM considers it essential that high quality healthcare is available to all Europe's citizens and not just to those who have the ability to exercise their rights.

HOSPEEM wants to ensure that all the ramifications of the Commissions proposals are properly considered so that patients really do benefit from them. HOSPEEM will look to work closely with the European Commission, the Council and the European Parliament so that the views of European hospital and healthcare employers are taken into account. In that respect, HOSPEEM hopes that the co-decision procedure will provide a text that will be genuinely helpful to all EU patients and healthcare providers.