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EPSU Critical Analysis on European Commission Communication: Consultation regarding Community action on health services

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Background and Comments

1. Introduction

The Health Services Consultation as published by the European Commission (EC) addresses several different issues. The actions as proposed however are founded only on two pillars;

1. Legal certainty regarding to the application of the European Court of Justice Rulings on the free movement of patients, professionals and health services and
2. Support for Member states

These two pillars will also form the background against which we as EPSU will consider the Communication and Consultation. As the issue of cross-border health care could have the strongest and most direct impact on the national health care systems, we will centre this paper on this one item.

To start the discussion, we would like to make several remarks on health services in the EU. It is important to take these circumstances into account when assessing the Commission paper or answering the Consultation questions.

2. Framework

First of all, it is important to note that neither Council, nor Parliament, nor Commission is actually calling for big health care reforms in the EU-Member States. Although the image of patients freely and happily shopping around the EU to receive (fully reimbursed) health care has been evoked several times, most actors at European level, including the EU-legislative bodies, do not consider this vision very realistic. No institution is challenging the subsidiarity principle of the Treaty, and everyone agrees that the organisation and funding of health care, is a Member States' responsibility and should be regulated at national level. The same applies to the Member States' power to determine the conditions under which social security benefits like health care are granted. The main points of critique of the European Court of Justice (from here on referred to as the Court) on the Member States health systems concern the lack of objective (individualised) criteria and clear procedures, under which reimbursement for care abroad should be provided. Neither the Court, nor Commission has asked the Member States to change their whole systems of health care provision or insurance.

3. Health care, Internal Market and General interest

In addition, the Court has acknowledged that patient mobility could risk the financial balance of national social security systems and that this could be an overriding reason for setting up restrictions to the freedom to provide health services. When deciding that patients should be entitled to have reimbursement for non-hospital health care abroad without prior authorisation, the Court explicitly took the circumstance that the volume of patient mobility is low and is expected to stay low into account. One could therefore assume that the Court does not consider patient mobility as just a positive phenomenon; it clearly recognises the risks that a growing number of patients crossing the borders to receive care represents for the provision of health care in national Member States. It also allows Member States to take measures to protect their health care systems against those risks, provided that they are proportional.

In this aspect, it is interesting to make a link to the principles of general interest.
It is recognised by the Court that the general interest could put justified limitations to the freedom of the provision of services. It therewith also acknowledges that the general interest could very well prevail over market principles. As all the EU-legislative bodies refer to the basic principles and values that should underpin European health systems like accessibility, equity, solidarity and quality; they also should, in analogy to the Court decision, affirm that these principles should take precedence over market principles, if they are threatened.

4. Patient choice?

We should also be aware that free patient choice is not exactly the same thing as the application of free market principles. There is often confusion about the implications of the Court rulings, and the judgments are in our opinion regularly misinterpreted in that respect. The Court is not actually demanding the EU-Member States to let their citizens choose freely between all the different health care providers available. It only states that Article 49 EC precludes the application of national rules, which have the effect of making the provision of services between Member States more difficult than the provision of services within a Member State. The Member States are therefore allowed to set up certain criteria or obligations for patients so as to control the access to certain care services. The Member States just have to guarantee that these criteria would not discriminate between their own providers and those from another Member State, unless that restriction is objectively justified. A good example of justifiable restrictions was found in the case of prior authorisation schemes for hospital treatment abroad.

5. Practical obstacles

Another factor, which has to be taken into consideration concerns the practical obstacles in receiving health care abroad. There are enough indications and examples available, which prove that it is not easy for patients to receive health treatment abroad under the provisions of 1408/71 (and even less so under article 49 EC): health care insurers that do not provide the required information, health care providers that ask for advance payments in cash, difficulties in obtaining the required forms. There are many barriers to overcome for patients to receive the benefits, whether in kind or financially, to which they are entitled. Health care providers also complain that the insurers or health care systems of the competent Member State are not always compensating them.

These practical complications could also hamper the development of cross-border cooperation between health care providers and insurers from different countries. There do not seem to be

any legal obstacles to prevent providers or insurers from different countries from working together. However, many of them are still very hesitant to cooperate at cross-border level, even within border regions or in tourist centres where this would be suitable and probably even needed.

6. Need for big changes?

This all together creates a picture in which one could state that the EU-legislation already provides patients and providers/insurers with a lot of opportunities to facilitate cross-border care or patient mobility, but one should add that the obstacles to act accordingly in practice are considerable. It can also be concluded that there is actually no real demand to broaden the scope within which cross-border care should be provided. Fundamental changes in health care provision within the EU could even be regarded as inappropriate, considering all the difficult and complicated debates on health care services, which are ongoing within the EU Member States. The need to first tie up all the loose ends by clarifying the Court decisions and providing the stakeholders, including the patients, with the right information and the right means to exercise their rights should be seen as the first priority. This is even recognised by the Commission's choice of legal clarity as the pillar of the Communication.

We would therefore like to put this Communication and Consultation in the right perspective. The objective of the whole initiative on health services is mainly to codify (and maybe to specify or explain) existing Court rulings into Community legislation, not actually to change the existing EU-legislation or breach the subsidiarity principle. Future community action should be based on the wish to improve legal certainty and practical applicability, not on the wish to initiate big health care reforms on a EU-level.

7. European Commission objectives?

However, reading through the Communication, one cannot fail to notice that the European Commission is also trying to serve other objectives in its Communication in addition to the codification of Court rulings or the improvement of the practical application of legislation. According to paragraph 2.1, for instance, the Commission does not only seek legal clarity, but it also intends to define the shared values and principles for health services on which citizens can rely throughout the EU. This goes a bit further than just codifying court rulings. Although we as EPSU would in no way object to the adoption of general interest principles and values at European level, it has to be seen what the European Commission exactly means by this sentence and what the European Commission considers to be the shared values and principles for health services. Is this free patient choice and open health care markets or are we speaking about principles like solidarity and accessibility?

Furthermore, the Commission expressed its wish to initiate greater choice in exercising individual entitlements (also abroad). This statement also goes further than just creating legal clarity. As explained in one of the paragraphs above, the Court does not exactly demand greater patient choice - it leaves that decision up to the Member States-, it just states that national health care systems cannot discriminate between national providers and other EU-providers unless there are justified reasons to do so. It is also highly debatable according to existing EU law, whether patients can always choose between national providers and providers abroad. In the case of hospital care for instance, authorization to receive health care abroad can be refused to patients if the service can be provided without any undue delay in their own country.

So we can conclude that The Commission does not only want to create more legal clarity, but also has some different objectives, one of which is to incite greater patient choice and possibly even to stimulate patient mobility. As EPSU we have some serious doubts about these objectives. It is not without reason that the Court has identified the risks of patient mobility for the financial sustainability of national health care systems. In specific cases, the Court actually considers the obligation imposed by Member States to seek prior authorisation for non-hospital health care as not justifiable, because it assumes that patient mobility will stay at low levels. The Court could decide differently, if high numbers of patients would go abroad for care and therewith threaten the balance of the health care systems. The Commission seems to turn this reasoning around, by presupposing that because there is a free market of services in the EU, patients should go abroad and be entitled to freely pick and choose their providers.

8. Planning and Organisation

Although it is up to the Member States how they organize their care, it is undeniable that patient mobility is linked to the national health care systems themselves and the country in which they are located. Research has proven that patient mobility can be triggered by problems and bottlenecks in the health care provision in national Member States. Long waiting lists, bad quality of care, high costs (for instance in the form of own contributions) all push people abroad. We find this is a very worrying development. As explained by the Commission and the Court, people generally want care near their homes, close to their relatives and friends, but they would choose to go abroad if this option cost less, was better or just more accessible. Growing patient mobility is therefore not only a positive sign, indicating a growth in European cross-border cooperation, it is also a very disturbing signal, underlining that national Member States are not investing enough in their health care systems. The fact that waiting lists could result in undue delay, as the Court has pointed out, should be picked up by Members States as a clear signal that the availability of care services needs to be improved urgently.

9. Forced Patient mobility?

It is therefore also important to study the other side of the coin. In most of the discussions, we assume that patients want to go abroad to receive their health care, but what if the patient is sent abroad by the health care provider or insurer against his/her own wishes. Can a patient demand health care near his home or within his own country, and if so would this right apply to all services or should there be exceptions e.g. in the case of highly specialized types of care or small countries? Although it is for the EU-Member States themselves, according to the subsidiarity principle, to define what type of care would be delivered to the patients and when and in which cases patients could be sent abroad, there is no doubt that forced or semi-forced cross-border patient mobility is undesirable, and should be avoided as often as possible. In our opinion, involuntary patient mobility clashes with the principle of availability. Patient mobility or cross-border delivery of care may never be an excuse for any Member State to neglect its own national health care facilities. Taking into account the financial and social costs that are involved in patient mobility (travelling, administration costs, distortion of planning), this is not an efficient, let alone a social way of organising care at European level, even though this could be a cost-effective option for individual health care providers.

10. Mobility of health care workers

We also want to remind that planning and investment includes a good management of human resources. Although the Commission briefly touches on the issue of health workers' mobility, this subject has to be picked up much more seriously. Several reports point out that personnel shortages in the health services in the EU could reach disquietingly high levels. It is predicted that this HR-crisis could incite even more workers' mobility in the health sector, It has to be said that here as well, the mobility of people (in this case workers) is not only a positive sign; it is also a symptom of fundamental problems. We could mention in this respect: great disparity of wages across Europe, difficulties to attract and retain workers in the sector, lack of investment in health care services, insufficient infrastructures for training and career development et cetera. We should in addition not ignore the fact that some employers consider foreign workers as cheap labour force, and pay them less than their colleagues with similar qualifications would receive, even if they would do the same work officially or unofficially. Instead of trying to attract workers in their own country to work in the health sector by improving working conditions and training opportunities it is sometimes regarded as easier to "import" new workers from other countries.

This is however not a solution. Apart from the highs costs involved with the integration of foreign workers in the receiving countries, there is no doubt that high emigration levels of health care workers could have disastrous effects on frail health care systems, for instance in Eastern Europe. It could even lead to the closing of necessary health care facilities. Therefore, it is very important that national Member States invest in their own health care systems and this means that they also have to invest in the health care staff. This could prevent health care workers from leaving their professions or leaving their country and could attract new workers to these services. It is of course clear that to be effective these measures have to be taken on a broad level and not only on an incidental basis.

11. Impact of patient mobility on receiving countries

First of all it has to be acknowledged that the Member States are not always obliged to give health care to patients abroad under their social security systems. The only situations under which Member States are required to deliver care to patients abroad under the conditions of their own benefits packages are those described in 1408/71- 883/2004. In these cases they obviously cannot discriminate between patients from their own countries and patients from abroad. To keep this type of cross-border care financially sustainable, cooperation mechanisms should be set up by the Member States involved so that receiving Member States are in a position to invest the money they get from the sending countries in their own health infrastructure, and that foreign patients could sufficiently be taken care of without harming the accessibility and availability for the patients of their own country. In general, the amount of care that should be delivered under 1408/71 should be relatively predictable and this kind of mechanisms should therefore be able to provide enough financial compensation to receiving countries for maintaining the quality of their health care systems.

The situation is completely different regarding health care in situations as described in the Kohl or Watts cases, or in situations in which the patients themselves pay for the health care without any involvement of their national health care insurers or providers as often is the case with dental care.

The amount of care asked for by patients under these circumstances is in general difficult to predict, and is potentially much more dangerous for national health care systems. These patients often pay in advance by cash, bank transfer or credit card. Health care providers could

develop a preference for this type of patients, as the patients from their own countries fall, for instance, under much less reliable reimbursement or flat-rate systems. The same could apply to health care insurers or providers from abroad that would like to contract care in other EU-Member States. Here as well, care providers could choose to first treat the patients from abroad because they are better paid for this service. This type of patient mobility could therefore seriously harm the accessibility of health care to patients in the receiving countries.

12. Health care insurance packages

Most of the debates regarding patient mobility or cross-border care are about the basic social insurance policies. This is obviously not the whole story. The relative size of publicly insured health care in comparison to all health care services is diminishing. And it is exactly in the area of non-public health care that patient mobility is growing. One important reason is that the whole package of health benefits to which the citizen is entitled, has become relatively limited compared to the whole range of health care services that are on offer and that citizens consider necessary. Especially dental care, physiotherapy, psychological care, optic care, and plastic surgery are areas in which most European citizens take supplementary insurances, or for which they pay the providers out of their own pocket without any reimbursement. It becomes then much more opportune for patients to shop for the cheapest provider.

This situation raises our concern on the content of public health care provision. Although it is in the Member States' power to define the conditions under which care will be reimbursed or granted, there is definitely a lot left to be desired about the scope of public health insurance. We feel that these shortcomings in the present health packages in many EU Member States could create a division between rich and poor in Europe in relation to health. A discussion on the availability and accessibility of health care should therefore, in our opinion, also address the size and contents of the benefits package. Even though this is in essence a Member States' responsibility, the cutbacks in the size of the packages could endanger the general level of health care provision in the EU and could also encourage certain types of patient mobility that are undesirable and thus further impairing the accessibility and availability of health care in general. The same logic can be applied if health care benefits packages in one EU Member State would cover certain types of care, which are not part of the public health care system in other Member States, because of, for instance, the lack of financial resources, or ethical reasons. This situation could also encourage patient mobility and endanger health care provision. Therefore the issue of benefits packages should also be discussed at European level.

13. Reform of health care systems

Finally, we want to point out that we are worried about the way the EU Member States are now reforming their care systems. Under the cloak of the free EU- internal market of services, health care systems are being privatised, liberalised and sometimes even downsized. As said before, according to the Court, the Member States are well allowed to protect their health care systems against certain market influences, especially if these would endanger the provision of health care. There are however some limitations. The more liberal a national health system is, the more it has to follow the EU competition rules and the more vulnerable it will become to unwelcome market forces.

We have the feeling that EU-legislation in this aspect is in some occasions deliberately or conveniently explained in a biased way in the internal Member States debates. Now, the EU-law has sometimes become the banner under which national or local health care reforms, like the introduction of public private partnerships, outsourcing, and liberalisation, are being introduced

in the Member States. In our opinion, this is a dangerous development and often not necessary according to EU Law.

Conclusions

14. Legal framework for services with a general interest

Commission, Court, as well as Council agree that general interest considerations are a justifiable reason to limit the freedom of patients to get health care abroad.
It is for instance, explicitly stated that there needs to be a balance between the objective of free movement of patients and overriding national objectives relating to the management of the available hospital capacity, control of health expenditure and financial balance of social security systems. These objectives permit limits to be placed on the right of patients to seek care abroad at the expense of the national health care systems.

The acknowledgement that general principles like accessibility and continuity could prevail above market principles is in line with our own call to protect the general interest by adopting a general framework in the EU on SG(E)I, which also includes health care services. It is to be noted that the general principles (including patients' rights) as mentioned by Commission, Court, or Council regarding health services correspond to or follow from the other general interest principles. As stated in our campaign, it is very important for EPSU that these principles of general interest are put down in legislation and that they apply to all services with a general interest.

15. Adjustment of legislation

We also recognise that the existing Court Law should be incorporated into the existing legislation. To achieve this aim, Regulation 1408/71 and 883/2004 (or the regulations which will replace it) and, in particular, the sickness and maternity chapters should be amended. The revision of this chapter and the considerations in the introduction of the regulation should fully reflect the concerns about the general interest regarding the safeguarding of high quality, accessible health care as expressed by the Court.

It is important in this case that close attention is paid to the fact that all the Court rulings are specific to one individual case, and cannot always just be generally applied without any proper assessment of the implications. It is therefore essential that all future European policies and initiatives on health care, including any amendments in the sickness and maternity chapters of Regulation 1408/71 or 883/2004 should include an impact assessment on national health care systems in which specific concern is given to the accessibility, solidarity and quality of the health care. The planned Health systems impact assessment should include these elements as well.

16. Application of legislation

It is also necessary for the EU and national Member states to improve the practical applicability of the legislation. This means, for example, not only that insured persons are provided with the necessary forms and papers, but also that sufficient information be given, for instance, on the different Member States health care systems, and of course most importantly, that reimbursement procedures should function properly so that patients and health care providers/systems receive the financial compensation to which they are entitled.

17. Member states' responsibilities

Although, there is no discussion about the subsidiarity principle in relationship to health care services, Member States should be aware that the Court criticised the lack of objective criteria and procedures in for instance authorisation schemes. It is, in our opinion, not only the responsibility of the EU to provide legal certainty to their inhabitants regarding their entitlements, but also an obligation for the national Member States to provide clear criteria in which cases benefits like (reimbursement of) health care are granted within but also across the borders and including within which timeframe these benefits should be enjoyed.

As patient mobility could have its impact on receiving countries, Member States should also take measures in these situations. Obviously, it is for the Member States in the receiving countries themselves to "protect" their health care systems against the risks related to a growing influx of patients from other countries. Health care facilities could be used in an inefficient and also unsocial way, especially in situations in which patients pay for the care themselves (with or without reimbursement from their insurers). Member States should be aware of the possibilities to manage and shield their care. These protective measures could for instance consist in adopting legislation or adjusting their health care systems. The Kohl and Watts cases are not addressing the receiving Member States and do not require Member States explicitly to treat the patients under article 49 EC. However, under EU-law, Member States cannot just close their borders to foreign patients, even if they come without the protection of 1408/71 and 883/2004. To address their problems Member States of receiving countries have to adjust their systems, so that, for instance, foreign patients do not pay directly to the providers but to the administrative bodies of the health care systems. These administrative bodies could then, for instance, prioritize the care according to objective and solidarity-based criteria and invest the money in reinforcing health care infrastructures.
The European Commission should, in our opinion, inform the Member States about the possibilities under EU-law for protecting their health care against the effects of patient mobility (including that under 49 EC)

In relation to this, we would like to call on the Member States from sending and receiving countries to invest in their health care systems, so that they deliver high levels of care, accessible and available to everyone on equal terms without undue delays. They are obliged to deliver a high-level of health care in their country; that means that they have to live up to these obligations. National governments thus need to look critically at the organisation and availability of health care services and where necessary invest in them. They also need to have a good look at the benefits packages, and where necessary enlarge them.

18. Health care work force

Proper investment in national health care systems also means that Member States have to invest in their health care work force. They have, amongst others, to improve working conditions for health care workers, develop effective recruitment and retention strategies, combat unethical recruitment of migrant work force, provide decent terms of employment and set up suitable training and career infrastructures. The EU could assist in this process by supporting the EU Social Dialogue in this sector, setting up European labour market policies for health sector workers, and supporting the social infrastructures of the countries with limited resources.
It is also for the EU to support the weaker countries in their attempts to strengthen their health care systems. To us, it is therefore somewhat striking that the EU has picked this subject up in

the area of development and foreign relations, but that it does not get the same attention (at least not visible) within the EU.

19. Information on EU law

We finally want to call on Member States to properly inform their citizens about the content of EU law and also fully assess the effects of any planned health reform in the context of EU-Law. We want to emphasize that it is the responsibility of the EU Institutions, in particular the Commission, to give a clear and correct picture of EU-law in which the general interests are giving the importance they should receive. Member States should not be able to "abuse" EU-law for their own purpose.

20. Involvement social partners and stakeholders

Considering that this whole cross-border health care debate has so many different angles (the abovementioned issues are only the tip of the iceberg), we welcome the EC's decision to enrich the discussion with an open consultation. We regard it as important that the different NGOs and interest groups are being involved in the discussions and that they are able to share their views and information with the broader "health community". We hope and request the European Commission to continue this democratic process and to take account of the stakeholders' opinions when drafting their policies and proposals.

We also want to point out the role of the social partners in this field. As stated in the Commission Communication 322 (1998) on Social Dialogue and the Commission Decision to set up the Sectoral Social Dialogue of the same year, the sectoral dialogue committee shall be consulted on developments at Community level having social implications. As the follow-up activities of this Consultation could have significant implications for the hospital sector (the working conditions, but also the economic and competitive position of this sector) we find it crucial that the Social Dialogue Committee in the Hospital Sector will be involved in the follow-up process. In this respect, we want to add that the Committee has included the issue of recruitment and retention including cross-border mobility of workers in its work plan and set up a working group on this subject. HOSPEEM and EPSU have both also identified the new Community action including legislative initiatives on health care services as top priority and announced that they want to cooperate with each other on this issue by developing policies, and setting up activities. We are therefore of the opinion that the Commission should involve the Social Dialogue Committee in the hospital sector in any further activities in the field of health services according to EU-legislation.