EPSU Comments on the European Commission (EC) Proposal for a Directive on the application of patients' rights in cross-border healthcare

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Introduction

On the 2nd of July the EC published its proposal for a Directive on cross-border healthcare. This text was presented as a codification-exercise of the Court decisions on cross-border patient mobility. The Commission stated that the proposals would only cover situations of cross-border care and are not meant to affect national health systems. After a thorough reading of the text we, however, have to conclude that these proposals could have a much larger impact on health systems than announced and that it would very likely change the organisation of health care in the European Union (EU). The confirmation of the economic nature of health services in the proposed directive for instance would lead to a direct application of market rules in the area of health services.
EPSU is of the opinion that the main priority for European and national governments should be to develop a health sector that best serves the public interest in terms of accessibility, availability, sustainability, democratic control and universality. According to article 152 of the EU Treaty, Member States should maintain a high level of public health; this includes the responsibility for a well-functioning public health care system. These objectives should always prevail to market or competition considerations. Governments must, therefore, be allowed by European law to maintain or develop limitations to internal market and competition regulations, so that they can guarantee accessible, available and quality health services for the public. EPSU is ready to contribute to the political debate by developing concrete proposals and suggestions for EU-policies and legislation.

Background

1. The present proposal for the health care directive cannot be understood without its context. European Institutions are already debating for many years about the status of health services in the EU. A key moment in the EU debate was the Kohl-Decker Decision on patient mobility by the European Court of Justice, in which the Court for the first time applied market principles in the area of cross-border health services. This decision was followed by similar rulings in amongst others the Watts, Smits-Peerbooms and Van Riet cases and prompted in 2004 a first legal initiative from the European Commission. In the original proposal for the Services Directive Commissioner Bolkestein tried to regulate the application of the internal market rulings on health services. The Parliament and Council, however, decided that health services should be excluded from the Services Directive. As health services serve undoubtedly a public interest, it is clear that other principles should prevail over sheer market and competition considerations. Neither Parliament nor Council, however, stated that health services should altogether be excluded from internal market and competition rulings; after all, the Court decisions did recognize the economic nature of health services. At this moment different opinions exist

whether, how and to what extent internal market (and competition) principles have to be applied to health services.

Aim of the proposals

2. In its proposal of 2 July 2008, the Commission took the Court decisions as the basis on which to regulate the mobility of patients. Of course, the aim of the proposed directive is to create legal clarity, but that is not all. It also confirmed the economic nature of health services, e.g. in preamble number 5. Although not explicitly stated, the Commission assumes that free movement of patients would create health systems better able to meet the needs of patients in the European Union[1]; it is not without reason that the title of the proposed directive refers to patients' rights. Like the Court, the Commission uses market principles as the starting point for its position. The focus of the proposals is therefore on issues such as free choice, non-discrimination and more implicitly, individual responsibility[2]. Even though reference is made to the principles of universality and solidarity, no requirements are proposed in relation to the accessibility, affordability and availability of health services.

Fundamental right to healthcare

3. Nobody contests the right to healthcare in the EU. It is clearly stated in article 35 of the Charter of Fundamental Rights. It also has been referred to by the Commission in its proposal (preamble no.3). According to the present Treaty, governments are obliged to maintain a high level of public health. As European citizens have the right to move freely within European Union borders, this implies that they in principle should also have access to healthcare in other Member States. The right to receive care should therefore not depend on where this individual resides. Even if a person is abroad in another EU-country, he/she should have access to the care needed. The EU-legislation on the coordination of social security schemes (and more specifically Regulations 1408/71 and 883/2004) intends to guarantee this right to access. It, however, does not affirm the right to choose freely your provider across the EU in each and every case.

Free choice versus free movement of persons

4. It has to be clear that the right to freely choose your provider is actually not the same as the right to receive the necessary treatment abroad, because of proximity, family, health or work-related reasons. These two very different principles and aims are being mixed up in the Commission proposals for cross-border health care and create confusion. On the one hand there are the principles of free movement of people and universal access to health care within the borders of the European Union; on the other hand there is the question of the open EU-market without barriers and borders where health services "compete" with each other to receive (paying/insured) patients.

5. It is important to disentangle those two issues. EPSU does not have objections to the principles of free movement and universal healthcare for all persons in the EU. We would support initiatives which would guarantee these basic rights for instance by further cooperation between Member States. Access to healthcare should not depend on the specific place where you are, or

[1] See e.g. page 5, Summary impact assessment
[2] See e.g. p. 40 of the Impact Assessment for references to choice as a means to compensate health illiteracy

the Member state you come from. Ideally, public health care systems should be able to deliver jointly the care needed by all across Europe. EPSU, however, does not want health services to become a market, in which patients buy their services and where market and competition logic would prevail. It does not share the Commission's point of view that a free choice approach in health services would lead to the best outcome for all[3].

Free choice and national healthcare systems

6. When discussing the Commission proposals, the main question is: should patients have a complete free choice of providers, even if those providers are not part of the national public health care system? Would it be desirable to work towards a situation where a national health system will turn into a reimbursement office instead of a publicly governed system? The answer should be no, if we take into account the very important role governments play in the delivery, planning, financing of health care and the responsibility they have to guarantee the quality and the accessibility of care all across their territory. There is ample evidence, that competition-driven health care systems provide neither the best nor the cheapest outcomes[4].

7. The Commission proposals, however, do intend to guarantee this kind of free choice for patients and it will introduce through the directive competition between providers. After all, the patient has a right to reimbursement of costs for treatment abroad regardless of the type of provider. As the Commission says, it is the aim of the proposed directive to provide clarity about the right to be reimbursed, not about the right to receive healthcare.

Accessibility and quality of healthcare

8. The fundamental right to receive the needed health care is in fact not even really touched upon. This right is, however, one of the main reasons why the Court decisions and especially the EC proposal raised so much controversy. Most of the Member States and stakeholders are not so much concerned about the occasional traveller, migrant, tourist or border-region resident that needs care in another country; these are cases that could be taken up in a practical way considering the relatively limited numbers, for instance through an adjustment of the existing coordination of social security schemes (Regulations 1408/71 and 883/2004).

9. Most of the political debates have been centred on patients who cross the border because of poor quality, availability or accessibility reasons in their resident countries, such as waiting lists. Mrs Watts for example was not specifically looking for a French health care provider to treat her; she went to France because the national health care system in her country apparently failed to meet her needs and the French health care provider was able to perform the needed operation.

10. The Court decision, recognizing Mrs Watts' right to be reimbursed, incited lots of criticism, as it was argued that it would limit Member States possibilities to plan their health care. In fact, the Court of Justice did not only affirm the right of a patient to be treated abroad or the right to receive reimbursement, it first of all affirmed his/her right to receive care without undue delay and without prior authorization.

[3] See e.g. p. 63-66 Impact Assessment (accompanying document to the Proposal for a Directive on the application of patients' rights in cross-border healthcare, SEC(2008), 2163.
[4] See e.g. Health care financing in the context of Social Security (London School of Economics)

11. Although EPSU does not consider patient mobility the best solution to meeting problems caused by limited availability/accessibility of services, we do agree that health care should be provided without undue delay. Member States' autonomy in the organisation of health care should not override a patient's right to receive the necessary care within an acceptable timeframe.

Health care as public service

12. However, healthcare is first and foremost a public service. Governments directly or indirectly deliver and finance these services to the people through taxation and/or social security schemes. A failure to meet the needs of citizens through regular means should be addressed by the government through a public debate and as part of the democratic process. It should not diminish the public nature of health care. Unfortunately, the principle of free choice, as it has been introduced by the Court and proposed by the Commission, could have this effect. It might put an additional strain on public systems, leading to a situation where private providers compete with public providers for limited resources.

13. For the moment the Commission's proposal only facilitates free choice of healthcare across borders; it does not explicitly cover situations where patients want to go to local private providers instead of local public providers. What will happen in those cases is a big question mark; it would be useful to know what the Court would decide if Mrs Watts went to a private (local or foreign) provider in the UK, instead of travelling to France. Following the internal market logic, we suspect that the Court would rule that these costs should also be reimbursed.

14. The proposed Directive also might lead Member States to transform/reshape their health systems, so that the patient will become him/herself more responsible to find the needed healthcare. The framework for cross-border care as delivered by the Commission, in which the patient has first and foremost a right to reimbursement and not directly a right to care, could of course easily be transferred to national situations. If the health system would indeed change into an open reimbursement system, it might be much more difficult for governments to plan healthcare according to the needs of the population and democratic decision-making. The right of free choice might become then an obligation for the patient to find him/herself an appropriate provider. The duty of Member States to provide the best possible healthcare could also be undermined. The logic might prevail that it is not the duty of a Member State to provide a certain type of health-service for its citizens, since it is arguably better provided for in another Member state. Patients might then be forced to go were the service is supplied; even it is in another country.

Free movement of services

15. These questions regarding free choice are by no means irrelevant, as they are related to the freedom to provide services across the EU. The preamble and introduction of the proposed directive are full of references to this freedom. Preamble no. 18 for instance states clearly that Members States are not allowed to introduce or maintain unjustified restrictions on the exercise of this freedom in the healthcare sector. Cross-border E-health services are mentioned in this respect, but the text proposals refer also to situations of establishment or temporary presence of foreign providers[5].

[5] as mentioned in no. 10 of the Preamble

16. How should we therefore interpret the Treaty and the proposed directive in relation to (private) health care providers from other Member States? What can be considered a justified barrier to free movement and what is not justified? Should national health care systems indeed treat private profit-making companies on an equal footing with public institutions? Is it possible to maintain the existing health care systems, or are major healthcare reforms needed to comply with the European rules?

17. The Commission claims that the proposed directive does not interfere directly with Member States ability to put limitations on the choice of provider or other domestic planning mechanisms including conditions or criteria of eligibility and regulatory and administrative formalities. However, it very clearly states that those limitations need to respect internal market freedoms and that they need to be necessary, proportionate and non-discriminatory[6].

18. We have as EPSU our doubts whether the impact of the Directive and its reaffirmation of the market principles would not extend far beyond the cases of those individual patients that want to be treated abroad. According to the EU-Treaty, subsidiarity does not exist in the area of internal market. The European Community has a full say about the way the internal market should be regulated. Even though Member states have on paper autonomy about the way they organize or finance their healthcare, it is the European Community that regulates the internal market of (health) services. Unfortunately, the Commission does not introduce limitations to the application of these internal market rulings. Instead, the EC states in the proposed Directive that Member States are prohibited to introduce or maintain unjustified restrictions on the exercise of the freedom to provide health services[7].

Investment in healthcare systems

19. Without further legal protection at European level for health and related social services, the proposals for this directive could therefore lead to a further introduction of the internal market in the area of health services. It could even harm existing health systems. Health infrastructures need lots of investment in technology, training of staff, equipment, property and the like. There is also a high level of regulation and planning necessary such as permit systems to ensure that people in rural and poorer regions also have access to a dentist, pharmacist, midwife, doctor or nurse. To ensure a proper service and quality level that meet the needs of the whole population, health systems need a solidarity-basis in the financing of these infrastructures.

20. Organising and financing healthcare is not only about the payment for individual treatments; building and maintaining the services for the public, including preventive health services, is at least equally important. It should be recognized that not all the costs for healthcare can or should be expressed in the invoicing. Health care facilities in developed areas can serve a much larger population and will therefore be cheaper in costs than for instance hospitals in mountainous scarcely populated area. However, it would be highly unfair to charge higher fees to people living in these less populated areas. Nonetheless, we need to recognise that it will be for governments virtually impossible to guarantee the continuation of all these facilities in an open-market situation, where providers could enter and leave the market as they want.

[6] See e.g. p. 15 of the Proposed Directive
[7] See again Preamble 18

21. The statement of the Commission that Member states do not need to fear for the financial sustainability of their services, as the reimbursement of the costs would not exceed the level of costs for treatment in the own Member states[8] is therefore a fallacy and ignores the fact that Member states also need to make costs to maintain the health infrastructure. Financial sustainability does not only depend on the costs as made for the individual treatments, it also depends on the material and immaterial outcomes of long-term investments and the possibilities to influence these outcomes. This is much more difficult in a competitive environment than in a protected one. The government and management of public healthcare systems go thus much further than just deciding on the benefits packages and the level of insurance payments and/or taxes.

Cross-border care for everyone?

22. Although the EC proposals would offer opportunities to patients that indeed want to travel abroad for care, those opportunities still depend to a large extent on the financial means of the patient and the country in which he/she is insured. The Commission does indeed claim, for instance in preamble 13 that the Directive does not allow discrimination between patients, and that patients should be treated equally, but in many cases this will only be a paper reality.

23. As the draft Directive only intends to regulate the reimbursement for the costs of care and not the costs of accommodation and travel, it will enable only those with sufficient funds to cover these costs to actually go abroad. Many less wealthy patients do not have much of a choice; they do not have the means to just take a plane and book a hotel to receive a needed operation. They also do not have the means to insure themselves for these costs. Clearly the principle of patient choice does not apply to them in the same way as to richer citizens.

24. This is even more obvious in the cases of up-front payments. One of the greatest barriers to cross-border healthcare at the moment can be found in the up front payments. Patients abroad are often forced to make cash or credit card payments before they can access the healthcare in the country of destination. Of course, only a limited number of citizens are able to do this, especially in cases of complicated operations or treatments. As patients do not have the right as such to receive pre-payments from their health care systems for treatment abroad, the access to healthcare abroad would still depend on the personal financial assets available[9].

25. The Directive also does not oblige as such providers to accept patients without these payments. Even though providers are not able to discriminate between patients from abroad and patients insured through their national systems, it will be impossible for them to maintain in every aspect the same treatment because of the different insurance and financing schemes and their conditions (e.g. lump-sum vs. invoicing).

26. For citizens of many countries in the Eastern and Southern parts of Europe, there is even much less choice. According to article 6 of the proposed Directive, patients only receive reimbursement up to the level of what he/she would receive if the care was provided in the own country. Citizens from countries with relatively low-priced health services, such as Bulgaria or Latvia would therefore not have access to care services in countries like the UK or Germany

[8] See p. 16 of the Proposed Directive
[9] See for instance impact assessment p. 27, that speaks clearly about reimbursement afterwards

unless they pay additional contributions from their own pockets or through private insurance schemes. The principle of patient choice is for patients from those countries more virtual than real.

Receiving countries

27. According to article 5 of the proposed directive, patients from abroad and "national" patients should be treated equally. Patients from abroad should not be discriminated, and should also not have a preferential treatment in comparison to nationally insured patients. Although this is an admirable aim, the situation in reality will again be different. As said previously, patients from abroad enjoy different insurance schemes with different conditions for payment and registration than local patients. The foreign patient will for instance in most cases be able to visit a private health care provider, this is for a local patient much more difficult and sometimes impossible if this type of care is not covered by the public health system. Foreign patients, who are able to travel, also have more often the financial means to make up-front payments and will normally pay directly for the costs of their treatment either with their own money or through their insurance/health care system. Many public health systems do not pay providers per treatment, but provide a lump-sum-amount to deal with all cases occurring. A foreign patient will thus lead to additional income for these providers, whereas a nationally insured person will only lead to costs for the provider. It would be difficult to imagine how this unequal situation could lead to equal treatment of patients. Receiving Member states should therefore have at least the possibility to adopt legislation in order to regulate the intake of foreign patients in their healthcare systems.

Procedures Prior authorization

28. Prior authorisation schemes would only be allowed in cases of hospital and specialised care if this care would undermine either the financial sustainability of health and social security systems overall or the organisation, planning and delivery of health services. The Commission assumes that non-hospital and non-specialised care would never fall in this category[10]; According to the reasoning of the Commission (and the Court), an open cross-border market in non-hospital healthcare apparently would not harm healthcare systems. The definition of hospital care as given in article 8 is very limited; it only includes health care, which requires overnight accommodation and healthcare, mentioned in a special list, controlled by the Commission. The fact that the list is developed through a comitology procedure and not by an autonomous decision from the individual Member States themselves, defies the subsidiarity principle and member states' authority in organising and defining their health care.

29. But even in the case of hospital or specialized care, article 8 of the proposed Directive puts a heavy burden of proof on the Member States. Before they can set up a prior authorization scheme, they need to provide evidence that the consequent outflow of patients is undermining or is likely to undermine the financial balance and/or the planning and rationalisation in the sector. How governments would be able to do this remains a mystery. Member States supposedly need to demonstrate that great numbers of patients would leave the country to go abroad for this particular type of care. This would of course be at least very difficult and may be even (depending on the criteria which will be used) virtually impossible. Obviously, the Commission wants to make it difficult for member states to maintain their authorization schemes.

[10] See §7.2 of the introduction of the proposed directive

However, in line with the Treaty, it should be the Member States themselves that decide for which treatment (hospital or not) prior-authorization is required.

Medical versus non-medical services

30. The scope of this Directive only includes health services that are provided by or under supervision of health professionals of one of the regulated professions[11]. This very strict distinction between "medical" and "non-medical" care defies the current situation, where different disciplines work together to improve and maintain the health of individuals within society. There is more and more evidence that a holistic approach to health, combining physical, psychological and social aspects, has the best results in terms of public health and individual treatments. Services such as social support for chronically ill people, rehabilitation services or health promotion activities should be an essential and integral element in health policies and systems; they are however not always performed by medical professionals.

31. In addition, most patients need besides medical treatment also a certain amount of social care and support services. This does not only apply to patients who stay at home, but also for patients in a hospital. Feeding, washing, changing the sheets, cleaning the floor are all services, which are strictly speaking not healthcare services, as defined by the draft Directive. These services of course can be performed under supervision of for instance a nurse, but often they are not.

32. It is not clear what effect this distinction between "medical" and "non-medical" services would have in practice. The situation is especially complicated, because it also involves the implementation of the services directive with its vaguely defined exclusion of social services. The different legal regimes governing all these services would create a lot of confusion and legal ambiguity, and the risk is not unimaginable that it will go at the expense of a holistic and coherent approach to health.

Principles and Quality Standards

33. The proposed Directive introduces in article 5 some kind of hierarchy in principles and standards. It is important to note, that Member states are obliged to define clear quality and safety standards for healthcare, but that they only need to take account of principles of universality, access to good quality care, equity and solidarity. As EPSU we would support the Commission initiatives to make quality and safety standards in health care mandatory. Even though not much is said about the content of these standards, we regard this point as a positive element in the proposals. And indeed, patients should also be able to make complaints and have access to important information and surely there needs to be a mechanism to guarantee practical implementation.

34. We, however, would like to extend the Member States' responsibilities and obligations also more clearly to issues such as universality, equity and solidarity. These principles and other relevant principles, e.g. democratic control or affordability and availability, do not materialize at all in the proposed Directive, they are mentioned in article 5 but they do not have any status. This is to our opinion an impermissable omission in the present text. To offer people healthcare as needed, governments need to assume their public responsibilities and make health services

[11] See article 4 of the proposed directive.

accessible and accountable. Implementation of these principles obviously would involve limits to an open market in health services. However, this Directive or any other applicable on health services should make sure that these limits would be considered justified and appropriate and that Member States will be made responsible for accessible and universal health services. We wonder why these issues are missing in the present proposal.

(Semi-)Forced Patient mobility?

35. The EC proposal does not explicitly mention situations, where the healthcare system/insurers/providers themselves send patients abroad for care or refer patients to providers in other EU-member states. However, this might become a more regular situation in the future. Cross-border patient mobility does offer some advantages for health insurers or health systems, e.g. in terms of cost effectiveness. It is doubtful whether this kind of patient mobility should be encouraged. From a patients' perspective we would be very careful about this. In emergency cases or for very specific treatments, the option to go abroad would indeed help the patient, but in cases of chronic illnesses or for more regular types of care proximity treatment should have priority, even when this would be more expensive.

36. Patient choice after all does not only mean that a patient can be treated abroad if he/she wants, it should also imply that a patient can visit a health care provider nearby and stay close to their home, family and/or friends during their treatment. Taking into account the need for follow-up treatments and check-ups and the risks of relapse, patients should be able to quickly reach their health care providers and avoid where possible extensive travelling. The first priority for health care systems is after all to serve patients needs and interests such as proximity treatment.

37. The issue of forced/semi-forced patient mobility is also important in questions of quality, liability and redress. The present text of the Commission does not make a distinction between patients who are forced to go abroad to receive health care, and those who choose themselves to receive the care in another country for personal/practical reasons. In all these cases, the quality regulations of the receiving Member States would apply. This would, however, not be correct in cases of forced patient mobility. On the basis of the national legislation, patients may expect a certain level and quality of care if they are treated in their own country; this responsibility should not change and certainly not be diminished if those patients are sent abroad. It is not on the basis of their free choice that they would give up their rights; it is because there is no other realistic option available.

38. It is thus very important that national health care systems/health insurers/health providers are responsible for the quality of the services delivered to the patients who are sent / forced abroad. In our reply to the consultation, we emphasized as EPSU that national health care systems are responsible for delivering quality health services to the all people staying in their territory. As the quality levels of health care would still differ from country to country, this responsibility should not stop in cases where the patients are sent (or forced) abroad to receive the needed care.

Redress – professional liability

39. This proposed Directive chooses in many instances a very simple approach to the complex world of health services. This could lead to unwanted situations. This is for instance the case with the provisions concerning redress and professional liability. It is of course important to consider the options for redress and include the issue of professional liability insurance. It is also

logical that the provider that causes harm should offer remedies and compensation. However, the present directive assumes almost automatically that this would be the health professional. However, the reality might be much more complicated. The health professional might for instance not be able to fully control the conditions in which he/she delivers the treatment. This is especially the case when there is an employment relation. Even a relatively simple case of redress might therefore end up in a long chain of compensation procedures. A cross-border situation would make the situation even more complicated because of the application of different legal and social security systems. Long and complicated legal procedures are of course something that needs to be avoided. The proposed Directive also does not clarify cases of follow-up, after-treatments, liabilities of the provider, compensation procedures or any other legal procedures**.** This particular subject therefore needs more consideration and research into the different national and cross-border compensation systems in the EU, especially in the field of health and healthcare. In this context we also ask attention for the fact that it is for health professionals at the moment often very difficult or even impossible to obtain professional indemnity insurance. A requirement for healthcare practitioners to hold professional indemnity insurance should only apply if such insurance is indeed available, reliable and affordable to practitioners.

Mutual Recognition of Prescriptions

40. The Directive forces Member States to recognize the prescriptions for medicinal products issued by health care providers in other Member States. As there is not as such one policy on the recognition of pharmaceutical products, this could lead to great problems. Patients may be prescribed medicines which are not even available in the Member State they live. It also may happen that these medicines, which can be very costly, will not be reimbursed by their insurance or health care system. It is impossible to ask the provider of these prescriptions beforehand to check the pharmaceutical regulations of the Member State before issuing the prescription. Also on the practical side, we have to acknowledge that there is no electronic European-wide system where prescriptions are recognized. The reality is far from that even nationally. This is therefore a subject that can hardly be implemented without further additional measures. It would also make the implementation of cross-border mobility of patients practically impossible.

Conclusion

41. The proposed Directive poses many questions to us. Most urgent are those related to the future of health and social care systems. As pointed out in the previous paragraphs, the implementation of internal market rulings would only be reinforced with this Directive. Unfortunately, we do not know to what extent. We also are in the dark about what governments need to do to make their health-care systems compatible with these regulations.

42. What we however do know, is that the impact of these Commission proposals will extend far beyond its direct purpose, i.e. to regulate cross-border patient mobility and that this proposed directive would affect the organisation of health care in Europe. As it might endanger the availability, accessibility and quality of health services, EPSU cannot give but a negative assessment of this Commission plan.

43. We also question the necessity and proportionality of this directive in relation to patient mobility. As the European Community already facilitates cross-border patient mobility through its legislation on the coordination of social security schemes, in particular Regulations 1408/71 and

883/2004, it would be more logical to amend these regulations and support Member States with Community quality and cooperation programmes instead of developing a completely new system and bureaucracy around cross-border care. Considering the fact that only 1% of the public healthcare budgets is spent on cross-border care[12], the proposed directive seems to be disproportionate.

What should then be done?

44. Member States should have the full responsibility and autonomy to organise their healthcare according to the public interest and democratic choice. To guarantee this, it is first of all necessary to effectively restrict the application of internal market and competition rules to health and related services. These rules should be fundamentally adjusted, so that Member States are allowed to create limitations to free movement of providers and allowed to subsidize services (providers) if that is necessary to maintain accessible and high quality services. The criteria regarding what can be considered justified or not should take much more account of the specific conditions under which health providers need to operate. For the moment the Commission uses very, very restrictive criteria and favours internal market considerations to public interest principles. However, with regard to health services the objective and aim should not as such be the opening of the market; the objective should be to develop a health sector that best serves the public interest in terms of accessibility, availability, sustainability, democratic control and universality.

45. For good functioning health systems, it is therefore necessary to allow governments to develop further limitations to internal market/competition regulations on the basis of these general interest principles. Legislation should be put in place to regulate this. Clearly, the present Treaty and the Court decisions do not provide sufficient protection for Member States to organise and maintain their health services without taking into account of market and competition considerations. To address this unwanted situation, EPSU proposes to develop legal provisions based on the public interest principles in order to guarantee the prevalence of these principles over market considerations. We also urge the European institutions to integrate these principles on the promotion and protection of the public interest in all existing and future proposals and initiatives in the area of health and/or social services.

46. In addition, Patients should be given more guarantees about the accessibility, affordability and quality of the treatment they need. Even though these principles are mentioned (as values), there is no obligation in place for Member states to apply them as such. Real patient choice implies that patients first of all have access to the services needed. This is as we know still not the case for all people in Europe. Many regular health treatments such as dental or preventive care are either excluded from the public benefits package or come with such high amounts of co- or up-front payments that they are practically unaffordable for poorer people. The situation in some EU-12 or Mediterranean countries also shows that problems concerning corruption and bad governance are not yet effectively under control. Waiting lists and poorly equipped health facilities are also to be found all across Europe. It should be clear that priority should be given to the improvement of health care management in the existing national systems, instead of the creation of open-markets.

[12] See p. 8, EC Communication (2008) 415

47. Specific provisions can then be made for the limited numbers of patients that want to cross borders for care because of proximity, family or work-related reasons. This could best be regulated in the framework coordination of social security legislation; focusing on the care-needs of the individual. The coverage of the E111-112 forms could for instance be extended to a larger number of situations, such as borderregion or family/work considerations. Mechanisms should also be created to prevent situations where large amounts of money need to be paid up-front.

48. It is of course not possible to be exhaustive in this paper about the options to promote accessible and quality health services in Europe. Many better alternatives to this proposed health services directive are available, and EPSU is ready to contribute to the debate by developing in cooperation with the ETUC concrete proposals and suggestions for EU-policies and legislation