Future EU strategy on health services

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Background

Health systems are primarily the responsibility of the member states, and those responsibilities are explicitly recognised in the treaty establishing the European community. Nevertheless, European action on health services is increasingly called for in order to support the member states. The European Commission is therefore consulting on possible community action on health services, focusing in particular on uncertainties around the application of Community law to health services.

Evolution of health services in member states

Health services have evolved and are organised in widely varied ways in each European Union (EU) member state. This reflects different national cultures and approaches to healthcare, such as insurance-based systems versus integrated financing and provision as in the British NHS, or different regional responsibilities and powers within different member states. But there are some common elements and challenges in all health systems which stem from the enormous achievements of medicine over the last 50–100 years. Costs of healthcare (the costs of any individual provision of a service) have decreased over this period of time, but the scope of medical intervention is now so much greater. The central challenge facing health systems throughout Europe and indeed the world is that 'we can do much more and so we expect more, but we must pay more, too'.[1]

Contribution to the European debate

What might a European contribution to this debate look like? The European Commission might provide a framework for better healthcare cooperation between member states. If the nearest hospital to someone living on a national border is only 20 km away but is in another member state, the patient could be given access to the healthcare in that local hospital that just happens to be abroad. Enabling the provision of specialist care in another country is also one of the benefits of increased mobility within the EU using Community law. Indeed, the European coordination of social security systems has been in place since 1971, and provides for people to travel from one country to another and to take their social security and healthcare benefits with them. This is normally the case when people are moving for reasons other than healthcare. However, sometimes people are seeking healthcare in another country because of their view of the quality of the healthcare itself.

I do not subscribe to the view that there are some member states that have high-quality health systems and other member states that have low-quality health systems. Rather, all member states perform well in some things but less well in others, and the pattern of what is better or worse is different for each country. Every member state is good at some things and less good at others. There are, even within member states, variations in outcomes of different healthcare in different places within that country. So how could a patient know where they could go to have good quality outcomes for their hip operation or dental care? That kind of information is not often available, particularly to prospective patients.

Cancer care is a good example of progress; through the Europe against Cancer programme launched by the Commission in the 1980s, we were able to gather comparative data about outcomes across Europe and to identify variations and different quality within and between countries. This prompted particular concern within the UK, as these and other analyses showed a concerning degree of variation in cancer outcomes for the UK, leading ultimately to a re-examination of cancer services overall. The subsequent Calman-Hine Report in 1995 resulted in major changes within the NHS. Europe only needed to provide the reason to ask the question and offer help to provide the results and the comparisons. It was then up to the authorities within the UK to act. This is a powerful example of how Europe can contribute simply by providing the relevant comparisons about health differences.

Europe might also offer specific practical proposals to address particular local difficulties in providing certain types of care. It could supply an information context that allows member state health systems to see where they fit in an overall continuum of possible outcomes, to know where they could learn from other member states, and where they could also help other member states learn from them.

Political developments

In a series of recent judgements,[2] the European Court of Justice stressed that health services are 'services' within the meaning of the treaties establishing the European Communities, meaning that they are subject to Community law and in particular the free movement provisions of the internal market. It has taken a few years, however, for the European institutions to recognise that these were not just a series of individual cases, but judgements that raised wider issues and had wider implications for health services. This led to the high level reflection process on patient mobility and healthcare developments in the EU convened by the Commission in 2003. This brought together all but one of the 25 health ministers with patients, professionals, insurers and care providers and sought to present a political orientation for the next steps. In particular, it was recommended that greater legal certainty was needed to clarify how the general principles arising from these judgements should be applied. The European Commission responded by bringing forward the proposed directive on services in the internal market, otherwise known as the 'Bolkestein' directive. However, this proposal was not universally accepted. The Commission therefore agreed to the withdrawal of health services from that directive, on the basis of bringing forward separate specific sectoral proposals. This is the basis of the current consultation document.[3]

Consultation proposal

The first pillar addressed in our consultation document is about legal certainty. If patients or professionals believe that in their specific circumstances the healthcare they require might be better provided in another member state, what legal framework needs to be established in order for there to be no legal barriers to doing so?

The second pillar is about providing practical support to the efficient and effective operation of health services. For example, this includes the idea of mutual learning and exchanges of best practice between member states as discussed above. How can we best support member states in their objective of providing high-quality healthcare to their citizens?

The Commission does not believe that it would be desirable, or appropriate, or consistent with the treaties for us to be taking steps towards harmonisation of the different health systems of the EU. The benefits to which citizens are entitled and the conditions attached to those entitlements are, and should remain, the primary responsibility of the member states. Different member states have different capacities to pay for different benefits. The EU is not 25, shortly 27, member states at an equal level of development. Different states also make different choices about the level of funding that they want to invest in healthcare and the entitlements of their citizens.

Rather, the consultation is about addressing an additional set of uncertainties which have been identified by stakeholders, including health ministers and the European Parliament, and about putting in place a framework that enables healthcare to be provided in other member states where appropriate. Healthcare outcomes are not improved simply by treating patients in different countries. In principle patients should be provided with healthcare as close to home as possible but there may be some occasions where the healthcare that patients need is best provided elsewhere. Our objective is simply then to ensure that the decision is made on health grounds by clarifying the applicable legal and financial rules and avoiding unnecessary obstacles to such healthcare.

Legal constraints

The first area identified under legal issues is the information required to enable cross-border healthcare. Do patients need to have a right to access information on the outcomes of the care provider they are considering? Do the regulatory bodies need to disclose information about the good standing of health professionals who temporarily move to another member state to provide services, even if only for a weekend? This could also cover situations where neither the patient nor the professional changes country, but where care is provided across borders through telemedicine, through remote diagnosis, or through developing protocols at a distance. What information is needed in order to help that take place? This could include clarifying some of the specific terms that the European Court of Justice has developed and used. This includes for example that authorisation should be given for care to be provided in another member state where that care cannot be provided within that patients' own member state 'without undue delay'.[4] How do we decide what is 'undue delay'?

The second area is about identifying competent authorities and their responsibilities. If cross-border healthcare is being provided either because the patient or the professional has moved, the quality of that healthcare has to be ensured by someone, but which member states framework applies? Who is responsible for creating and monitoring the necessary systems and for ensuring the quality and safety of that healthcare?

A third issue concerns responsibility for harm caused by healthcare and compensation arising from cross-border treatment. One of the key themes of the recent Luxembourg and British presidencies of the EU Council of Ministers was the topic of patient safety. We all know that healthcare is intended to benefit the patient, but occasionally harm is caused. For patients considering moving to another member state what might the consequences be? How will this issue be addressed? Whose compensation system will apply? Furthermore the professional needs to know what set of rules apply in terms of compensation. If they have professional insurance, for example, covering them in terms of liability for treating a patient from their own member state, does that insurance also cover them if they treat an individual from another country? If not, what liability are they exposing themselves to?

The fourth point considers maintaining a balanced medical and hospital service open to all, which the Court recognised, in a 2003 judgement, as a general objective which could justify limits to the principle of free movement.[5] A hospital which expects to treat a certain volume of patients may fear being overwhelmed by

cross-border healthcare. How do we ensure that providing healthcare opportunities to people from another country does not undermine the ability of a member state to provide healthcare to its own citizens?

Practical issues

In terms of support to member states, there are some practical issues to consider. Could we develop a mechanism for some rare specialised treatments whereby centres might provide care to patients from more than one member state? There is clearly scope for economies of scale through cooperation at the European level to provide benefits to patients from across the EU, and to help health systems as a whole function more efficiently.

Evidence base

More generally, there is the question of the evidence base for making best use of health innovation. From recent discussions between senior healthcare officials from the member states brought together at European level, it emerged that no fewer than twelve member states had recently evaluated the same health technology. Greater European cooperation could help to overcome this duplication of resources.

Conclusions

We are all familiar with the demographic and economic challenges ahead as the European population ages and the balance between people in the workforce and those who have retired changes. The scale of variation in quality outcomes across the EU is of a similar order of magnitude to the scale of the additional funding that will be needed to meet the challenge of an ageing demographic. If all health systems in all areas functioned according to existing best practice, that would offer the scope for saving money and for the better allocation of funds to help pay for the challenges of demographic ageing in the coming decades. One key part of our shared European social model is our commitment to the common values of solidarity, equity and universality. By helping health systems work better and better together, the European Community can support member states in meeting these future challenges while retaining our commitment to these shared values.

The ruling that health services are to be considered as services within the meaning of the Community treaty gives us an opportunity to use European Community law to facilitate the provision of health services. The Commission's intention in setting forth this consultation is to start from that point. How can the European Community help to provide better health services? We talk much about removing barriers to allow free movement. The barriers that we want to remove are the legal barriers to the movement that is appropriate for health. And, in doing so we can provide a framework that helps member states to achieve effective, efficient healthcare, to the benefit of individual patients and professionals and in support of health systems as a whole.

References

1 Organisation for Economic Co-operation and Development. *Towards high-performing health systems: summary report.* Paris: OECD, 2004. www.oecd.org/dataoecd/7/58/3178551
2 *Kohll* [1998] C-158/96.
3 Commission of the European Communities. *Communication from the Commission: consultation regarding Community action on health services.* Brussels, September 2006. www.ec.europa.eu/health/ph_overview/co_operation/mobility/docs/comm_health_services_comm2006_en.pdf
4 *Smits* and *Peerbooms* [2001] C-157/99.
5 *Müller-Fauré* and *Van Riet* [2003] C-385/99.

Further reading

For further information on the European Commission's consultation paper on future EU action on health services please see: www.ec.europa.eu/health/ph_overview/co_operation/mobility/community_frame work_en.htm