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Info-Document :	**AEMH 12-026**
Title:	**"Crossborder Healthcare: a Joint Hospital Conference"**
Author :	**HOPE Secretary General Pascal Garel**
Purpose :	**Info-documents disseminated by the AEMH European Liaison Office do not necessarily reflect the opinion of the AEMH and its Board. Info-documents are meant to inform, to raise awareness, to alert, to launch a debate, to incite taking action,.....**
Distribution :	**AEMH Member Delegations**
Date :	**Sent by e-mail 20 April 2012**

Cross-border care: a joint hospital conference

A report of the HOPE joint conference with the European Association of Senior Hospital Physicians and the European Association of Hospital Managers held in Dusseldorf on 18 November 2011

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On 18 November 2011, the European Hospital and Healthcare Federation (HOPE), presided over by Georg Baum, co-organised a Joint Hospital Conference with the European Association of Senior Hospital Physicians and the European Association of Hospital Managers.

Its goals were to discuss the European policy on health in the morning, and then to focus more specifically in the afternoon on the Directive on patients' rights to cross-border healthcare.

Mars Di Bartolomeo, Minister of Health in Luxembourg, was the keynote speaker of the first session. With his long experience of the European arena, he first positioned the public health policy within the context of the most recent EU initiatives, and in particular Europe 2020 and Digital Agenda. "I fully welcome the bases of the eHealth-Network for the Directive on patients' right to cross-border care", he declared. He then delivered a lively and comprehensive description of what constitutes European health policy, how it has developed over the past ten years and the shape it might take in the future.

Commenting Mr Di Bartolomeo's presentation, Georg Baum, President of HOPE and Chief Executive of the German Hospital Federation, clearly showed how hospitals and healthcare services are more and more impacted by various European policies, several of which have limited regard for the specifics of the healthcare sector. He mentioned, among other things, the working time directive, the late payment directive and the directive on electro-magnetic fields. This was also an opportunity to put into perspective the work of HOPE in recent years. Concerning the major issue of quality for patients, he mentioned the role played by HOPE in several projects, the European Network on Patient Safety being one, as well as in the preparation of the joint action on patient safety and quality. Georg Baum concluded with the major upcoming directive from the EU: that on the application of patients' rights to cross-border healthcare, the focus of the afternoon session.

Dr Joao de Deus, President of the European Association of Senior Hospital Physicians, responded to Mars di Bartolomeao with his views on today's policy in European hospitals. Emphasising the differences, the financial problems and the crisis, he then considered the most recent elements specific to the health sector: privatisation of hospitals, advanced technology, expensive treatments and hospitals (always a good target for cost-saving measures). His focus was clearly on patient safety and quality care, approached from different angles: changes in multiple organisational components, pre- and postgraduate medical training, continuous professional development, working conditions and task shifting. In

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particular, he emphasised the shortage of doctors and quoted the Royal College of Physician (RCP) Press Statement of December 2010: 'The RCP is concerned by the mounting evidence of poor care delivered to patients in hospital out of hours and at weekends". For him, hospital management based on quality and safety needs a larger involvement of doctors in hospital management. Heinz Kölking immediately followed by presenting the goals of the European Association of Hospital Managers and its values.

The afternoon was devoted to the Directive and its current process of transposition. The Directorate General Health of the Commission was represented by Mrs Annika Nowak, who presented the origin and context of the directive as well as current developments of the work with Member States on the transposition.

The context is the impact of existing Regulations on social security systems, with 12 years of European Court of Justice Rulings on patient mobility. (Citizens needing care when temporarily abroad were requested to obtain prior authorisation for planned care). With the removal of healthcare from Services Directive in 2006, the European Parliament and the Council called for a specific health legal instrument. The legislative process started with the adoption of the Commission proposal on 2 July 2008. A first reading between July 2008 and September 2010 was followed by a second reading on 19 January 2011. The final vote in the European Parliament on 28 February 2011 was concluded by the formal adoption of the Council: Publication in the Official Journal on 4 April 2011 and entry into force on 24 April 2011.

This Directive has three aims: to help patients to exercise their rights to reimbursement for healthcare received in another EU country; to provide assurance about safety and quality of cross-border healthcare; and to establish formal cooperation between health systems (eHealth, European networks of reference, Health Technology Assessment).

Helping patients with information means that they will have access to all relevant information via National Contact Points. Member States will have to set up contact points to help patients make informed decisions. Information provided will include rights, entitlements, reimbursement, quality and safety standards, healthcare providers and restrictions on their right to practice, appeal and complaint procedures and mechanisms for seeking remedies. Healthcare providers will supply information on professional liability insurance, calculation of prices and medical records.

Safeguards for health systems are the conditions of reimbursement. National health authorities will reimburse only for healthcare that corresponds to the benefits provided for in the patient's territory. Member States define the rules applicable to their territory. In case of serious risks for health systems, Member States can introduce a system of prior authorisation.

Prior authorisation will concern healthcare that is subject to planning requirements, that involves a particular risk to patients or population or that is provided by a healthcare provider who raises concerns over quality and safety of care. If the healthcare in question cannot be provided within a reasonable time, the Member State will have the obligation of granting the prior authorisation. Reasons to refuse prior authorisation will be limited to: safety risk for patient or for population; healthcare provider raising concerns over quality and safety of care; healthcare being provided within a reasonable time limit. Member States can take the responsibility of refusal of prior authorisation if there are doubts over quality and safety of a healthcare provider.

"Providing patients with clear information to which they are entitled is a challenge, as is maintaining the ability to plan and prioritise"

The transposition process will last for 30 months, with a deadline on 25 October 2013. Bilateral discussions are taking place between the Commission and the Member States. A questionnaire on the transposition has been sent, bilateral visits are organised in all 27 Member States and a Committee on Cross-Border Healthcare has been set up.

Representatives of the membership of the three co-organisers were then invited to present the current transposition mechanisms and the issues already identified in their countries.

Mrs Elisabetta Zanon presented the detailed analysis made for the UK by the NHS Office in Brussels, working closely with the NHS Confederation (member of HOPE). The directive will reduce uncertainty on patients' rights and provide information on how to handle patients' requests for cross-border healthcare. At a time when the UK Government proposes to extend patient choice and diversify providers, the directive will extend choice beyond national border. Large expansion in the volume of cross-border healthcare is not expected as patients prefer to be treated close to home; this might change should waiting times increase for certain treatments.

The main challenges are in determining domestic prices, especially for procedures not covered by tariff and subject to local variations. Providing patients with clear information on healthcare to which they are entitled at a time when greater variations at local level are expected is also a challenge, as is maintaining the ability to plan and prioritise. As authorisation cannot be refused in case of 'undue delay', there will be implications resulting from health inequality in those instances where patients will receive treatment more quickly than those with greater need.

For providers, this might mean increased demand for NHS providers in clinical areas where there are capacity issues in some EU Member States. There are opportunities in particular for Trusts that provide highly specialised care and that have international reputations. It is important to ensure that sufficient capacity is planned so that treating additional patients will not have a detrimental effect on NHS patients. Concerning the establishment of European Reference Networks, this cooperation with EU

experts in some clinical areas will clearly improve patient care. Hospitals needing to deliver significant cost improvement plans will have to consider new strategic operating models that could include marketing' services to non-UK patients. NHS tariffs are often higher than the cost of healthcare in other EU countries and this could impact on the ability to attract EU patients.

The current NHS reforms and EU Directive share some common founding principles. The implications of the Directive for the NHS is difficult to predict at this stage. The implementation of the Directive for the UK is at a very early stage due to ongoing programme of reforms.

Dr György Harmat explained the point of view of the Hungarian hospital association (member of HOPE), shared by the Hungarian Ministry of Health. The Hungarian EU presidency was indeed a key player in the development of the directive.

The Directive is an opportunity for a detailed examination of national legislation. Regarding reimbursement, some rules already exist on the basis of the implementation of case law, for example, the reimbursement of out-patient care on domestic cost level. But the system of prior authorisation has to be reconsidered. No major increase in outflow is expected, because the mobility of Hungarians is low even within their own country, but it is nonetheless on the increase. Patients prefer to be treated in Hungary and waiting lists are still relatively moderate. Low level of foreign language knowledge and information, upfront payment and low level of reimbursement will also be important factors to keep people in Hungary.

The low level of domestic costs, the high professional level of service provision and the relatively moderate waiting lists could create a significant inflow, but on the other hand the Directive declares that nothing should oblige healthcare providers to accept planned treatment patients from other Member States or to prioritise them to the detriment of other patients. The inflow can be kept within limits. As waiting lists are basically of a financial nature, the possibility of offering non-publicly financed free capacities on market prices – at the same price level as for insured Hungarians – can provide opportunity for receiving patients from other Member States, if the price is still lower or at least not higher than the domestic costs of the sending Member State.

Dr Miek Peeters of Zorgnet (member of HOPE) made a very precise analysis of the legal challenges for Belgium. Article 8.2, which lists healthcare subject to prior authorisation, will need Member States to define which treatments necessitate hospital care. This would necessitate the implementation of article 81 of the Belgian Hospital Law. The Directive gives much attention to quality and safety. What will this mean for Belgium: changing legal standards for quality of care in hospital care? Creating standards for non-hospital care? Concerning the non-discrimination on the basis of nationality of patients, the Belgian law on the promotion of patient mobility of 4 June 2007 is now debated: should it be necessary to reconsider hospital financing/tariffs for all patients? Concerning access, an 'Observatory on patient mobility' has been created in 2010, with the objective of gathering data on patient mobility (amount, origin), including contracting data and measuring impact of foreign patients on hospital capacity (measurement of waiting time).

Dr Thomas Zilling shared his views on the situation in Sweden. The Swedish government is very much in favour of the Directive. Today, Sweden has Europe's most liberal rules regarding patients' rights in this aspect. For Swedish citizens, there is no requirement for prior authorisation to reimburse the costs for hospital care in other countries. The government will not require in the future any prior authorisation and will cover the costs for care given according to internationally recognised medical science and good medical practices. This means that even now Swedish patients can go abroad to any other EU country and seek healthcare according to the Directive.

The Swedish government is unafraid of any economic consequences. The government also sees opportunities for Swedish hospitals to be competitive players in the provision of highly specialised healthcare in Europe.

The total costs for Swedish patients seeking healthcare abroad today are negligible. In 2010, 770 patients visited another EU country with the purpose of receiving hospital care without prior authorisation. Out of them, 595 were granted economic compensation to a total cost of €1.5 million. Another 272 patients asked for prior authorisation. Only 55 (20%) were allowed economic compensation, as patients asking for prior authorisation are told by Swedish health providers that the care can be given in Sweden within a reasonable time.

"The Swedish Ministry of Health and Social Affairs is preparing a proposal for a new law f or implementing cross-border healthcare"

What will happen in Sweden? It is quite clear that the Swedish government will keep its liberal opinion regarding cross-border healthcare. There will be no requests for prior authorisation. The Ministry of Health and Social Affairs is preparing a proposal for a new Swedish law for implementing the EU directive on cross-border healthcare.

Finally, Professor Robert Nicodème gave the perception of the French Medical Chamber. He regretted that the healthcare professionals were somehow absent from the Directive, even though some reflections started with the Green paper on the European Workforce for Health and the Directive 2005/36 on professional qualifications. For him, the main points of interest in the Directive are the concept of medical competence and in the European networks of reference. On the last one, he raised several questions around what is innovative, and which quality and patient safety norms within networks will it be possible to produce.

The closing words by Dr Raymond Lies, past president of AEMH, captured the essence of the afternoon by identifying the challenges ahead of us. ✦