Proposal for a Directive on the application of patients' rights in cross border healthcare

HOPE position

HOPE is the acronym of the European Hospital and Healthcare Federation, an international non-profit organisation, created in 1966. HOPE includes national associations of public and private hospital and where those do not exist, owners of hospitals. Today HOPE is made up of organisations coming from 26 Member States of the European Union and Switzerland as observer member.

HOPE welcomes the European Commission proposal's aim to improve legal clarity over patients' rights to cross border healthcare. HOPE broadly supports opportunities for EU citizens to access healthcare in another Member State when it is clinically necessary and in the best interest of the patient. To facilitate this, HOPE is in favour of sharing experience between healthcare systems and of coordinated action throughout the EU.

HOPE believes however that any action taken at European level must fully recognise the differences between healthcare systems and not undermine in any way the capacity of the Member States to plan, fund and organise patient care for their citizens.

In order to achieve this HOPE asks EU decision-makers to take into account the following key principles in their negotiations on the Commission's proposal.

- **Common values and principles -** HOPE supports the common values and principles in EU health systems as agreed by national governments in June 2006. Values such as universality, access to good quality care, equity and solidarity are key principles in the HOPE's constitution and are at the heart of its activities. However, HOPE believes that the fulfilment of these high-level principles is the responsibility of Member States.

- **Universal access to health care –** There are certain advantages for some patients in cross border healthcare. It should be recognised however that the promotion of cross-border healthcare should not be an aim in itself.

  All patients are entitled to receive safe high quality healthcare in their own Member States. The majority of people wish to be treated as close to home as possible.

  It is essential that Member States ensure that systems established to provide for and facilitate cross-border healthcare should not be disproportionate in scale and cost to the level of cross-border activity and should not have wider, unintended, consequences for health systems as a whole.

- **Health inequalities** - Patient mobility which is not subject to any clinical evaluation of need or system of prior authorisation runs the risk of exacerbating health inequalities.

- **Eligibility criteria** – In several healthcare systems in the EU, decisions on eligibility for treatment are taken at local or regional levels and there is not a nationally-determined "basket of care" to which all patients are entitled. It is essential to ensure that the Directive will allow for these variations in eligibility criteria within a Member State to continue if we want to preserve the capacity of the Member States to organise patient care.

- **Prior authorisation –** The Directive should recognise that prior authorisation systems are valuable for patients because they offer an opportunity to discuss issues such as what treatment options are available in the Member State and in other Member States, what reimbursements patients will be eligible for and what costs they will have to meet themselves, arrangements for after-care and what will happen if anything goes wrong.

- **Hospital care -vs- non hospital care -** Many medical procedures do not require an overnight stay in hospital and can even be carried out in a non hospital setting. A number of these procedures can be high risk, high cost, and require planned follow-up care. To minimise risk, ensure appropriate continuity of care and preserve the best interests of the patient, it is Member States, on the basis of their organisation, which should decide which treatments, hospital or non hospital, should require prior authorisation.

- **Continuity of care -** Continuity of care is vital to patient safety and should be more fully considered in the Directive. Linguistic issues and national differences in clinical procedure for certain conditions can complicate and even jeopardise the quality of the follow-up care a patient receives once they have returned to their home country.

- **Financial and capacity planning -** Unpredictable flows of patients to and from countries may seriously jeopardise the ability of Member States to organise, plan and fund their health systems. Member States must retain the ability to prioritise resources. The Directive should not create a situation where national authorities can be presented with large bills for treatment abroad of which they had no prior knowledge.

- **Administrative burdens -** The Directive may impose large new administrative burdens on both providers of healthcare and those responsible for managing national systems in areas such as providing information to patients on their cross-border care rights and collection of statistics and data. The impact of these additional burdens should be fully considered, as the requirement to allocate funds to new areas of work will inevitably divert core resources away from patient care.

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