

EPP-ED PUBLIC HEARING

PATIENT MOBILITY in the EU

Rapporteur: John Bowis MEP

European Parliament, Brussels, Thursday 3 March 2005

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¹ The transcript was realised by Michelle Temple, IESE, under 'Europe for Patient', the European research project on patient mobility (www.europe4patients.org)

I. Legal Health Systems and Public Policy Issues.

- **Introduction to the Public Hearing**
John Bowis, MEP, Rapporteur, Patient Mobility

John Bowis MEP:

Now, we have one or two speakers on their way in, including Robert Madelin from the Commission, but we'll make a start and I'll just by way of introduction say a word or two and then hand on to my colleagues who are going to be speaking today. And I would like to say that with the sole exception of the Commissioner, Markos Kyprianou - who wasn't able to come simply because today is the day of the meeting of the Social Affairs Council, but Robert Madelin, who is the Director of the Health Directorate is coming in his place - every speaker who was invited as our first choice has accepted and it's a great pleasure that that is the case, and we warmly welcome our speakers today to help us look at this important subject.

When I write reports for the Parliament, I like to have a little quotation from some part of Europe, it's my sort of signature, and for this report I used Louis Pasteur's words: "*Science knows no borders because knowledge belongs to humanity and is the torch which illuminates the world.*"

I hope I've got that translation right, but it is I think perhaps apt, because we are talking about science, it's the science of health and medicine and treatments and we're talking about borders and we're talking about how we can cross borders and benefit from each others' experiences and skills. And that, I hope, is going to be what the day is about, it's what I hope is a day of optimism and problem-solving. We have the treaties and the Court of Justice which have given us an opportunity as I see it. It's also given us one or two headaches! I hope the flavour of today will be less *why* and more *how*.

Let me stress, this is not about the General Services Directive, which is a separate issue, about how health *services* might cross borders. This is about patient mobility and the rights of individuals. It's "how do I as the patient, find my way through the system and what exactly are my rights now and going to be in the future?" And "how do I as a health budget manager cope with the unplanned demand, the unplanned cost and the reimbursement procedures?" And how do our two systems of Europe interlink? We have what in shorthand are called the "Beveridge System" and the "Bismarck System", the system of health paid for out of taxation and free at the point of delivery, and the system of compulsory insurance, and run, of course, by insurance managers rather than health service managers in budget terms. I exaggerate the simplicity of that, but I don't exaggerate the complexity of matching the two together under this issue.

Then there's the question, of course, of whether we need legislation, or whether we can manage this new opportunity with guidance and codes of practice. But behind it all, I think, is to me – and I highlight this in the report that I wrote - an implied threat: that if we as politicians and governments and Commission and the Council, do not get this right, if we don't manage to come up with a formula, then the courts will do so: they will go on doing so, and it's a strange sort of democracy which leaves its decision-making to courts. I prefer that politicians, governments and commissions should take responsibility for policy, justify it, implement it, interpret it and we have the courts *behind us*, but not *in front of us*.

Now that's where I'm coming from. That's the flavour if you like, the theme, but I'm very grateful first to the person on my left, Magda Rosenmöller, who has been my, ...I was going to say my right-hand man, but my left-hand woman at this moment, except perhaps as the way you look at it, she's my right-hand...whatever! And she's been extremely helpful in helping us put this together and is now going to introduce us to the subject. Magda...

- **Patient Mobility – general overview of the issue, opportunities and challenges**
Magdalene Rosenmöller, IESE Business School, Europe 4 Patients Project (Germany)

Magda Rosenmöller:

Thank you very much Mr. Chairman.

Good morning ladies and gentlemen. It's an honour for me indeed to be here in this house and address this important issue of patient mobility, and I must say, it was a pleasure to work with you, John and your office on this. It has been a really nice experience.

Patient Mobility: I think since my first time as a medical student in Strasbourg, where I actually got the "European virus" one could say, a lot has changed in terms of moving in Europe. And then I moved down to Barcelona – things like the Carte de Séjour, la tarjeta de residencia in Spain, had been made a lot easier. And if we look today at the Erasmus students (I recently had a young girl, daughter of friends of mine, as a guest in Barcelona), a lot has changed. It's much easier for them now to move around Europe and for those who have seen "L'Auberge Espagnol" you probably know what I am talking about – when a crowd of students come together from all over Europe to study. But then if these people move, or the young students move, what happens when they fall ill? There *is* a system of coordination, of social security systems, but it is rather old from the 1970's. We have now discovered - and you mentioned the recent, or not so recent, judgement from the Court of Justice - there are a lot of issues around patient mobility which have not been addressed yet. Let me just mention one: quality for example, quality of services provided. As you probably are well aware, there is a EC Directive on bathing water, on the quality of bathing waters and beaches. Now, I would presume that when I go to a hospital in another country, the risk of contracting something or the danger to me and my life is higher than when I go to a beach somewhere in a foreign country.

But then, let's start first with a short brief overview of the issues – difficult to do in five minutes! – First of all, who *is* the European patient? We have different types of patients in border regions. We have those who move as tourists and fall occasionally ill and then have a need for care; we have long-term residents who move to another country like Spain to pass the "evening" of their lives in Spain; and then we have "purchased care" where there is not only need, but there is a real intention - the move is motivated by the search for care.

Let me say that we see patient mobility as an opportunity, which we explicitly stated, when we started the European Research Project on Patient Mobility under the Sixth Framework Programme, in the part which is called "SSP" (Scientific Support to Policy) (as you have seen in our brochure). What we try to do in this project, is to find evidence in order to identify better policies on the issues of patient mobility. So when we started to conceive this project we thought: let's see patient mobility as an opportunity; let's look for the *benefits for patients*, better access to care, better quality, but as well, *benefits for systems*, for health-policy makers, professionals, providers, in sharing capacities, or in concentrating excellence, or indeed in mutual learning in the field of health and medical care.

Next then is to see, if we want to realise these benefits, what are the issues we encounter? I already mentioned quality, others are legal issues. What's about patient rights? - Is health a fundamental right in the constitution? It's not yet stipulated as such as you are probably well aware. Is there a right to care? Providers: what about professional liability in another country? Financial issues: price-setting: the concepts of care are different from one member state to the next. Contracting arrangements: what is the legal base? What treatment do we include or exclude? How do we monitor contracts across borders, based on what legal systems? What about quality accreditation of providers, health-technology assessment, the effectiveness of care which has been mentioned as well in one of the court judgments. Information to patients - very important, John has mentioned this as well in the report. Is information on different systems readily accessible, is it understandable for patients? What about information on access, on quality, on funding of health care in another member state? And then very important as well: communication between professionals. How do they exchange medical records? The issue of privacy of data,

sharing of clinical data guidelines between health professionals. The technology is readily available as you probably well know, but what is it about the implementation of those systems that it really works across European borders?

In our project, we have looked at what are the opportunities, or the favouring factors, and what are the hindering factors of patient mobility. Preliminary results show quite different factors. As *favouring factors*, there is definitely the patient's choice in cross-border settings: their familiarity with the health system, or their wish to be treated in their own language across the border. Costs or quality can be perceived to be better in the other member state. We have providers being interested in looking for opportunities to attract patients, to provide cross-border services. We have system elements, like the universality of care in Spain. This attracts patients because they see that it is easy to receive care in Spain, on the other side a problem for the Spanish system. Another way of favouring patient mobility is the sharing of capacity, well laid out in the Communication of the Commission: sharing capacity across borders, creating centres of reference across Europe.

On the other side, what are the *factors hindering patient mobility*? Definitely, first of all, there is the lack of information for patients - and I'm very glad that you also insisted on that point in the report - the perceived legal uncertainty, be it for patients or for the provider. Cultural and language contexts are different with a different understanding of home care, for example between the South and the North of Europe: is it the family taking care of an elderly, ill person, or is it a nursing home? And then we have differences in the design of the health system. Many member-state systems are not designed for taking care of European patients. They don't take it into account. And we found in the first project results that very often, countries don't have a strategy for taking care of foreign patients; they do it, but do not really take it into account in the system design. And very often we have a lack of transparency. In Spain for example, private providers step in. In Malaga, hotel clerks and taxi drivers deviate the flow of patients toward private clinics! So even if they come with their E111 they are not able to use it because they are taken the other way. I went to the tourist office and I said, "If I break my leg, where should I go?" and I got a nice list, all of them *private* clinics, and they didn't even ask if I had an E111 with me!

In our project, we have seen a lot of challenges to get a better insight and I think that is fundamental for the future of patient mobility in Europe. We don't know what's really going on. It's very difficult to obtain data on it. There are some data on the E111 as well being elaborated under the Committee for Migrant Workers, but then, these are not really detailed. We don't know the type and volume of care provided, very often, the country of origin is missing, etc. Thus, there is a limited insight, and I think the first step for getting a better view of what is happening is to get better data. There are administrative difficulties – the system design doesn't allow us to have a better knowledge – and then, as you know, in the medical field it is very difficult with the issues such as data security, patient surveys are very difficult to undertake.

Let me now finalise, see what is the future of patient mobility. The former Commissioner, Byrne, started before he left office: to look at what is the future, enabling good health for all. This reflection process on the future of the EU health strategy brought us to think about patient mobility in the future. So let us see ten years from now, what would be the issue of patient mobility? What would we be talking about? So we would have health as a part of fundamental rights of EU citizens, with well defined patients' rights and duties in Europe. We would have a supporting function at EU level, on what is quality and accreditation of providers. We would have an EU network of technology assessment, and I know from the work of the high-level group of health system and medical care that first steps are actually being looked at in order to develop this EU network. We would have an established network of centres of reference in Europe and we would have some kind of EU planning and licensing function, a certifications function of human resources in Europe.

Concerning e-health, we would have a European health information system which is interoperable. We would have an EU health card. The EU patient record, certified signature, it would be working to facilitate the sending of medical data across European borders. We would have an EU framework for contracting which would be reliable and give a good legal basis for cross-border

contracting – a kind of defined European “basket” of services. I know this is a difficult thing to do. What would be included? And how much would the service cost? We would definitely have advanced in that matter. And, we would have an EU health info point, where we would get information on what our rights and duties are as patients.

And I must say, both the Communication from the Commission from last year, the work of the High-Level Group and as well, John, your report, the "*Bowis Report*", actually made very good steps in the right direction. We as academics and scientists acknowledge that there is a lot of political willingness to go in the right direction and we think that a lot of good ideas are there.

But we will now in the following presentations see more on these issues of what has been done at EU level, the view of the people involved, the policy-maker, the purchaser, the patients. And then some practical accounts on what is patient mobility in different settings. So I very much look forward to today's discussion. Thank you very much Mr. Chairman.

John Bowis:

Thank you very much Magda.

Now it's a great delight that Robert Madelin, who is Director General of DG Health, or DG Health and Consumer Protection, or DG SANCO, if you like that term – which always sounds to me a bit like lavatory wear – but to me DG Health is a lot healthier! So we're going to hear now from the top man in the Commission, who's going to have a lot of responsibility in this area: Robert...

- **Developments in Patient Mobility in Europe**
Mr. Robert Madelin, Director General, DG Health, European Commission

Robert Madelin:

Mr. Chairman, well firstly let me say I'm very pleased to have been able to be part of this platform. I'm sorry that the real top man in the Commission, President Barroso has convened all the Directors Generals later in the morning and therefore I won't be able to stay here throughout. And I think the idea of “DG SANCO kills all known germs” is quite a good punch line, so we will have to sort of re-visit our mission statement!

Let me begin by trying to put this very important issue of patient mobility - on which we welcome the draft report very much - in the broader context, and I think in the broader context I can see four corners I think we should bear in mind.

I think the *first* is *rights*, which have already been mentioned, and it seems to me - not to undervalue the work of those who've produced a draft constitutional treaty - that there is also the political reality. I think that the political reality that health is perceived by our citizens as something they have a right to expect public services to work for... this is a political reality across the enlarged Union. The problem is, we talk about it but then when it comes to setting budgets and so on, somehow we forget and so I think that the first contribution that a debate on patient mobility in Europe can make at the European level is to raise the profile of this right and of what needs to be done about it, so to be a sort of a *political* process.

Secondly, healthy life years: we're pleased that the statistical basis for a structural indicator about healthy life years in Europe is now in place and that underlying the more focussed Lisbon agenda is that indicator of an outcome. Because firstly, Europe will only remain sustainably competitive if we drive up the healthy life years of our citizens and secondly, the gaps within national societies and across member states in the outcomes on healthy life years are a real challenge, I think, for European solidarity. Patient mobility is in a way an indicator of that problem, but it can also be part of the solution.

The *third* issue is *money*. I've mentioned it already, but I think in this forum, I would say, the commission on budgetary authority: look very carefully at the place of health in Rubric 3 in the financial perspectives, because we can talk about this as much as we like, but if we want to have a

sustained debate at European level to support what national budgets are doing in the delivery of health care, then the European budget, as well as national budgets is a focus.

And finally, to get slightly closer to the substance: *governance*. We should always think *why* it is that we are doing this also at the European level. I think that the issue of greater collaboration on these issues at European level is one of the key questions we should always keep in our mind, not because we doubt our legitimacy, but because then we keep focussing on where we can add value. One of the, I may say, pleasures for me in my first year in this job has been to see the coming together of a degree of trust and confidence as a result of the work of the reflection process, with the Health Ministers in June last year giving a mandate to the Commission to convene the High-Level Group and the Member States actively participating - co-chairing working groups among themselves and continuing to drive forward this process. And I think that if we can continue to have this European conversation about patient mobility, then that will clearly help to improve our policies at national level and the outcomes. And maybe I could start on a bit more detail by talking about the work of the high-level group. I think that since June last year, we've made good progress. I think the Council at the end of last year summarised that progress well. But let me just tick through the seven areas that we have identified as being key issues around patient mobility.

The first is facilitating cooperation in cross-border care, not just in the border regions, and providing information to patients about their rights under European Law, and that intersects very directly with the questions of what taxi drivers do.

Secondly, the question of patient mobility and its impact on health professionals. And here I think it's very interesting to look at some recent reports on the levels of workforce provision, which are of course very diverse across the member states. I was in the WHO offices in Geneva two weeks ago talking about this. They have identified, through empirical studies, thresholds of provision of professional support, below which you cannot provide health. Now this is an issue obviously more for Sub-Saharan Africa where those thresholds are consistently undershot. But if you look across Europe, there are pockets of resources poverty here which are very deep and I think also that although this is of course quintessentially the sort of issue that can only be delivered at national level, I think that what we're learning through patient mobility, is that workforce planning can't be done in a vacuum and that whole area then of the provision of professional training and the empowerment of the 'cadre' of professional contributors to health is a second crucial issue.

Thirdly, centres of reference, which has clearly been mentioned and where I think it's very interesting to see Member States keen to participate together on this issue; and if I can talk about the other bit of the job I do, I mean the animal health side and the food chain side, there is a long tradition of cooperation, of networks, of reference laboratories. It doesn't cost very much, it works, it delivers economies of scale for citizens across Europe. I think on the health side, there are the beginnings of the intuition that this can achieve similar good outcomes, so I think that's a very promising area.

Fourthly, technologies and techniques: how do we better assess them? Again, there's scope for economies of scale and there's scope for learning best practice.

Fifthly, the question of using communication technologies and IT, and here I would say the beginnings of the discussion demonstrate very clearly that the new member states are sometimes ahead of the field. I think if you look at just one example: if you look at what Slovenia has done about informatics in the management of its health system, it's a lot better and in a way, a lot more self-confident than some of the work being done in some of the older members states. So I think there's another example where the learning goes in directions that perhaps Brits and French and whatever people would not have expected, so that's good news I think.

Sixth, the question of the impact of other community policies on health systems, which works very well with the emphasis of the Barroso Commission on joined-up policy thinking and policy integration.

And finally, an issue which I know the present and future British presidencies of the Council will do a lot of work on, which is patient safety. Patient mobility sometimes happens by accident because you have acute appendicitis while on holiday, but if it's going to happen in a planned way, then patients want to feel that they can be equally sure of the quality of the outcome somewhere else. Now, in the country I know best, which is the UK, even going to another regional health authority, you need to look at the figures carefully. You can't assume that you're going to get the same outcomes from one hospital to another and I think that that issue therefore is again one where the sharing of national practice between member states can both drive up what we are doing, each in our own country, and help the overall picture at the EU level.

So for me, the most important thing to take away from the draft report on the table and the work of the last year, is that the intuition that patient mobility was a key issue because of, if you like, the threat of the legal environment has turned, I think, into a perception that this is a thread around which you can weave very much *positive* outcomes. I think that the balance between fear and hope has changed in the last years and that we can now see a willingness to work on this issue as one where we're not trying to defend past practices against the evolution of EU law; we're trying to drive forward an issue that can (to get back to that important point of healthy life years) produce better outcomes for the citizens, so I think that it's very timely report, what it says - we like. I think it helps to give focus to the work of member states in this group and I'm very grateful. Thank you.

(Applause)

John Bowis:

Good, well Robert, thank you very much for that and before you came, I referred to the threat hanging behind us which is: if we don't move to get a system in place that works, in which people have confidence, then we'll be back in the courts and the courts will be deciding our policy for us rather than politicians. And I liked particularly what you said about the thread about which you can weave positive outcomes...and that's right if we look at it in that positive way. But at the same time, if we look at that thread and that tapestry as being something that lasts, and not *Penelope's Tapestry*, which she unpicked every night to start again, to make us think we were making progress, but in fact we were back to square one. We actually want to see this process working. And that, I think, is probably why everybody here today is positive and determined to have something out of this which is of benefit to patients, gives them that opportunity, that choice, but doesn't put at risk other patients or indeed the whole systems of health that we have in our different countries.... and thank you for the points about cross-border care too.

(Addressing the audience) Right, your points, your questions, any comments you'd like to make from the assembled company - to either Robert, or to Magda - on what we've heard so far.

Hildrun Sundseth, European Cancer Patient Coalition:

I have a very simple question ...Now, the subject is patient mobility. The patient is clearly the centre of our discussion. Here I come with the old *mantra*, "nothing about us without us", I see no patient group representative on the panel. Is this an indication or how do we patients take that sort of thing? Because I think there are several of the patient groups here that are always wondering why does one talk about us and not include us?

Robert Madelin:

Clearly, I'm not a patient *group*, but I think one of the things about health policy is, we're all patients one day. But I think on your point, in the high-level group for example, it's very interesting that to begin with during this start-up phase, member states wanted to sit together and work out whether they felt confident enough that this group should go forward. We had a six-month period last year when the mandate from the Council was being tested to see if it was useful. I read the outcome of the December health minister's discussion as saying, "Yes, we have a mandate to take the work forward" and in the working groups, we've made very clear that we will bring in patients' groups and professionals groups where the particular issue, one of the seven I've listed, can most be relevant to those groups. In the same way, I think it's interesting, if you look at the way the

Commission is organising its policy debate that our public forum on health, as you know, is very much trying to bring together all parts of the health chain so that patients, as well as professionals and public authorities, are involved. So I'm not sure...I mean I can't speak for those who organised the meeting, but I didn't read it as being just a club of elite up here.

John Bowis:

Certainly not, I mean, I'm not elite! Contrary to what I'm sometimes accused of, I'm not a doctor either. I'm certainly not a lawyer – I'm a patient, and I'm a patient with a very specific issue on diabetes, because I live with that, but we're *all* patients, but you're quite right. I mean, that's why we went out of our way to make sure that we had a lot of patient organisations invited to be here, and Angela Coulter - who's done a lot of research on patient issues - will be reflecting some of that compendium of knowledge from that. But let's hear from patient groups now and during the course of the day, please.

Alex, yes...

Alexandre Berlin:

Alexandre Berlin, formerly from the Commission - Let me ask you a question of both for Magda and Mr. Madelin. You mentioned information technologies, both of you, and you mentioned the importance and also that what had been done in Slovenia was involved with the World Bank Project in Slovenia, but my question is a different one. The use of information technology across borders for, let's say ideally, if a patient is in one country but then has travelled to another, the transfer of medical information and consultations between medical professionals from two countries to provide assistance for the patient....how is that dealt with? Because in fact the legal responsibilities in different countries are different. Who is responsible for the outcome of treatment? So how do you envisage that information technology could be of use and how could it help?

Magda Rosenmüller:

Thank you, thank you Alex, I think that's a crucial question. Information technology, as I said, the technology is there, but it needs to be applied. You mentioned very rightly, there are in the transmission of medical information, issues of language, the issue of safety of data, that it is not read by somebody who is not supposed to read it. There are legal issues: Who owns the data? Is it the patient? Is it the professional? In which country? Then we also have a lot of problems with different systems. Different member states, as you have mentioned rightly, Slovenia has advanced a lot and other countries have advanced in different ways. But we don't have the inter-operability of health systems, of information systems in the different member states. I went to the meeting of eTEN yesterday, that's the info day on the eTEN Programme, who exactly works on these issues. But it's very difficult, because it needs very high investment, and it needs a very high political willingness from the member states. So to get both of these and to get the technology right to agree on which technology now to use is an important issue. I think even though there is the eHealth Plan, some more coordination on this issue would be needed and I know that there is one working group as well on e-health in the high-level group. So I would think that what is needed are some guidelines on how to move forward so that the high investment which member states and indeed private providers need to make on this, are made with a clear view of the final outcome and a certainty that the final outcome is actually serving the objective of interoperability and patient mobility.

Avril Doyle MEP:

Could I ask Robert Madelin, the Director General of Health (and I'm asking it now because I'm conscious he mentioned he had to leave before everything was over).

You complimented this document on patient mobility and health care developments. I take it you agree with everything that's in it? A leap of faith on my part! The top table has also referred to the need for us to form our own statute in this area, and for us to lead rather than the courts "drive us" in terms of what we do for patients. Could I be slightly provocative and ask Robert if in fact there would be an appetite in DG SANCO for a stand-alone health services directive to do just what we

all in this room want done? There's no disagreement about what we want to do, it's exactly how we're going to do it some of us disagree on. How would you see the best way of delivering what we all want to deliver here and indeed what the courts have said we must deliver? What is the statute vehicle that you think we should go by? In a sentence....to put it in as a section of a general services directive or a stand-alone health services directive? I'd love your thoughts, before you disappear to better things, on that.

Robert Madelin:

Well let me say...

Avril Doyle MEP:

Sorry Mr. Chairman for being so provocative so early but I don't want to miss the opportunity!

John Bowis:

We expect nothing else of you, Avril, it's the Irish tradition!

Robert Madelin:

Firstly let me say that I'm absolutely convinced that I would have more fun here for the remainder of the morning than anywhere else! Secondly, I'm essentially a pragmatist, so in practice, if you look at how awfully difficult it is to get any piece of draft legislation into the pipeline, I think that our best chance is anything that's on the table. So I would say that going back to the beginning and saying "let's have a stand-alone health services directive", would raise as many questions as it would answer. It would provoke in other communities as much opposition as it might provoke support here. It might become a Christmas tree for all sorts of things that national authorities would regard as inappropriate, or even regional authorities would regard as inappropriate. So, without saying "DG SANCO would be frightened of a health services directive" – because, of course, we're frightened of nothing – I personally think that we need to work on what's on the table and find the answer there. We've got a vehicle and we can move more quickly with what's on the table than going back to some other preparatory process.

John Bowis

Charlotte Cederschiöld.

Charlotte Cederschiöld MEP:

Thank you, Mr. Bowis. Is that to be read that you think that health should be included in the Service Directive? I take it that *that's* what you mean. So you are in favour of most of the things in the paper, but not that little part? Is that right?

Robert Madelin:

Well I mean....you know....(audience laughter) no, no I'm just wondering how *long* I should answer? But firstly, the thirty-second lecture on the way the Commission works: I mean the services of the Commission serve the College, the College as a whole adopted the proposal on the table, so I'm paid to support the proposal on the table! Secondly, I've spent a lot of my time, even before I started this job, thinking about the relationship between general economic law and public service provision, because my previous job was worrying about the same thing at the global level: "will the WTO rules impact on our rules about the provision of public services?" And I have to say that whether it's at the EU level or at the global level, I think a "carve-out" mentality is the wrong approach. And I think that's true whether you're talking about health or water, or audiovisual, I think a healthy society is one where the specific needs of different sectors are recognised and protected by general law. I think, when you have "carve-outs", you're going back to a rather medieval view of society, where there are privileges and where there are black holes in the social structure.

So then the question is: does the treatment of health within the draft on the table appropriately protect the regulatory autonomy of those at national or regional level who are driving health service provision? I would say, my personal answer to that - to be slightly provocative - is "almost". I mean I think the threads are there, to go back to my metaphor of weaving. I think that the debate so far

has demonstrated, and I think Commissioner McCreevy has already said this, that we need more clarity, because it's not just what the law says for an expert lawyer, it's also the message it sends to society. And it's clear so far that even if the expert lawyers are happy, the health community is not happy that we would have enough autonomy at all levels and on all issues under the current draft. So we need to go back and clarify that. But I don't think that the current draft is fundamentally flawed in this respect, and as I say, I have a strong personal conviction that "carve-outs" are a rather medieval approach to life and we actually need a joined-up legal structure.

Charlotte Cederschiöld MEP:

Thank you very much; I'm extremely happy with your answer.

Françoise Grossetete MEP:

I've had a number of things which make me react. I'm convinced that we can promote patient mobility without a binding services directive in the health sector. I don't think the Council will ever agree on that because of the differences in the way our health care systems work within the member states of the European Union. So, I don't think we should have any illusions. It's better, preferable, to work on specific objectives which we all want and where we can make improvements, but when it comes to patient safety in the area of public health, that is essential. What we must pursue is making sure that all European citizens when they move around the European Union can have the same guarantee of quality health care. And we haven't achieved that yet. Let's stop saying that we'll include this in a services directive - that's technocracy! Let's try and work on specific objectives, let's not try and create something which will only lead to tensions, to things snapping in the member states. I think it's much better to work on specific objectives which will be understood by the European citizen.

Robert Madelin: (Interpreter):

Well it's not really a reply to what you said, but let me comment. First of all, what is key to giving quality care in the European Union? The member states in the high-level group have identified...[...] in subject areas. But even there the group agrees that this would not exhaust the package of necessary measures to give such a guarantee. I'm not afraid of anything as I said, I'm convinced that we can end these seven subject areas, find consensus about the best practice to follow at a fairly detailed level. Whether this best practice should become a European directive I don't know, I'm not convinced. There's a minimum legal framework which would be necessary if you're going to have this consensus which would work across borders, so there's a legal part and a non-legal part. But I'm not convinced that European legislation is necessary, be it within the Services Directive or elsewhere. I don't think that's a global solution. I don't mind how we achieve the minimum legal requirements, whether it's here or elsewhere. I'm being pragmatic. If we have something on the table, let's look at it. But I think the key is that we cannot legislate in order to create the guarantee you want. We can do it through coordination. I agree with you. I don't want to legislate in order to achieve this guarantee of quality. Look at the problems we have when trying to harmonise health studies because there are different practices. The practices are so different that it's very difficult. We might achieve it but it'll take a long time. Do I have more confidence in a doctor who's been in practice for 10 years or one who's been in practice for 5 years? That is the knob of the problem.

John Bowis:

Good. Thank you. We have some passion, some debate going on. Just one second, because I'm conscious I want to move on to bring in our next group of speakers if I may. But as I said at the outset, one of the issues we need to look at is whether we need to legislate or whether we can do this by code and by guidance and so on. Or the extent to which we need to. And maybe it follows on later, in terms of legislation, to protect and to increase the opportunities. Now I'm just going to take one more colleague and then if I may we'll move on to other speakers. Mrs Roithova.

Zuzana Roithova MEP (Interpreter):

Good morning. Thank you. I'd like to thank Mr. Bowis for organising this meeting and in response to what has been said so far, I think that we can safely say that everyone sitting here today has a common objective: we want to force the Member States to cooperate better to make safe patient

mobility possible. But it's a very bumpy road ahead, given the treaties, the founding treaties that we have. I think there are two possible courses of action.

One possibility would be to amend the Services Directive to make it clearer for patients and health specialists, what exactly their rights are. Because that directive is in compliance with the founding treaties. But the other possibility is new recommendations, new amendments, we are entitled to make recommendations, we're not able to dictate over and above the founding treaties, but we can make recommendations to the high-level group to encourage the member states to cooperate more on these important issues. I think in our recommendations, in our amendments to the draft Services Directive, we should do as you, Mr. Madelin, have been saying: we should set out these eight areas and we need to make the issues clear because that would give us an opportunity to have clearer legislation in say, ten or fifteen years time. It's a difficult task but it's time to start.

John Bowis:

Okay. Thank you for those points. All I would say on the Services Directive is that is exactly what it says: it's a directive for services – services able to cross borders and operate in other member states. Central to our discussion today is the other end of that telescope which is the patient's rights to go to other member states to benefit from the court judgements that we've seen. But the debate will carry on, and I'm very grateful for both Magda and Robert for starting us off so well today. Robert said that he's frightened of nothing, and he said it in French as well! So I've got it down twice.

(Audience laughter)

I don't know.... when I used to have responsibility in the United Kingdom for mental health we had the issues of personality disorder.

(Audience laughter)

And one of the symptoms there was frightened of nothing!

(Audience laughter)

So I was pleased to see Commissioner Kyprianou's initiatives on mental health and I very much support that. I'm not suggesting for a moment that there are any problems inside the Commission. We look forward to working with you and finding solutions for this fear or lack of it, but also for finding opportunities for patients across the border in Europe within the scope of the treaties. We have the treaties, nobody's proposing (nobody's going to succeed in proposing) to change the treaties, I suspect, for some time yet, on the competence for health, even though some of us might like that. But there are ways of using what we have to make things work. And as I said at the beginning, if we don't make it work, the courts will make it work for us and I'd much prefer in a democracy that it's we who are taking those decisions.

But thank you both for starting us off. And now I'll move on if I may to our next group of speakers and you've heard quite a lot of references to Slovenia and who better than my good friend Dorjan Marusic, who is, I say, he runs Slovenian health, is Mr. Health in Slovenia. Don't let the ministers there tell you otherwise. He is the continuity and we're very pleased to hear him starting off by talking about the policy maker's view, and then we'll move on to the funder, the provider and the patient's views. Dorjan.

II. The view of the Involved: Policy Maker, Funder, Provider Patient

- **The view of the Policy Maker at the National Level**
Dorjan Marusic, Ministry of Health (Slovenia)

Dorjan Marusic:

Thank you for the excellent presentation, but I will take the opportunity to speak in my native language since this was one of our wishes to become member of the EU.

Dorjan Marusic: (Interpreter):

The possibility of enjoying medical services in another member state is one of the major challenges for the European Union and for countries at the national level. I'd now like to go through various aspects of health care from the point of view of national health policy and also from the point of view of patient mobility and then I'll say something about patient mobility across borders.

Firstly, from the point of view of national health policy, there is no doubt that cross-border health care needs to be integrated in overall health care planning and the legislation on organizational solutions. The expectations of users in terms of access to safe health care must take centre stage. In developing a safe health care system in Slovenia we're aware of the fact that patient mobility is an issue and that it has financial considerations. ECJ law and current legislative proposals on the reimbursement of costs in cross-border health care arise from the principle of freedom to provide services.

In Slovenia we believe that public health care provision must be based on solidarity, equality and universal access. This is what makes a difference between public health care services and market driven health care services. What has to be avoided are negative consequences, for example in terms of the financial stability of national systems. In Slovenia we aim for a balanced approach whereby the state seeks to provide at a certain level and make medical care accessible to all citizens within the framework of the national system and at a European level where this is required for medical reasons.

We are a small state (only Malta is smaller than us) and Slovenia would fit into France twenty-six times; we really are a small country, and therefore it is understandable that our citizens will want to look for health care outside our borders whether or not doctors recommend it. This is because we have long waiting lists for certain medical services and people believe that in other countries they can receive better health care. I do want to stress this point that there are not linguistic problems in Slovenia's case in the border areas. There is an obvious danger of major costs being incurred by the sickness insurance schemes.

There are also consequences for health care planning and the planning of universal health care provision. In Slovenia the state is responsible for social security contributions and health care planning. In our case this would mean a transfer of responsibility from the state to the individual user but this is unrealistic. We also cannot ignore the consequences on the actual nature and results of treatment. Our doctors at the lowest level, our gatekeepers, play a huge role. They essentially look after the health interests of the nation as a whole. They are the guarantors of the inclusion of citizens in health care provision.

The following questions will have to be dealt with. How to secure safe treatment for citizens when this treatment can take place in several countries? How is it possible to have control over the whole process? How is it possible to guarantee information exchange between all stakeholders? How is it possible to guarantee that the rights of patients are respected as they cross borders? All of these issues require cooperation between member states on the basis of previously agreed common positions.

Obviously it is the health interests of patients that must be the centrepiece of any discussions on patient mobility. Patient mobility in the EU is a fact. We have to recognise that there is going to be better access to better health care as a result. It will provide people with access to specialised

health care, it will promote competitiveness, there will be comparisons drawn between different member states and it will be a stimulus to more rational use of staff and medical resources. Hence, we cannot be surprised that people expect access to better health care somewhere. And that is why we need to have a clear vision, a clear strategy at national and European level in response to this.

At national level in Slovenia, we are currently thinking along the following lines: there will need to be a network of public health care provision which is better organized than at present. We also need better qualified health care for patients with better horizontal integration. There will need to be quality safeguards along the lines of the quality safeguards in other member states. Licensing procedures and cost reimbursement procedures will have to be harmonised with those in other member states. We'll be looking in particular at the following areas: the exchange of experiences in cross-border health care provision, especially between member states. The key issue is more effective use of available resources and cost-efficiency. The setting up of European reference centres and the provision of top-quality medical health care are obvious objectives. It enables member states to focus on areas of excellence which can be extended, which can be made available to other member states. We also believe in increased cooperation in the evaluation of medical technologies and last but not least this should lead to automatic increased cooperation between health care systems.

Slovenia is ready to play its role in the area of patient mobility, it's willing to meet the challenges. But we're in favour of a circum-spectre approach – looking for balanced solution which are focussed on quality, safety for patients and which ensure that stable, long-term, sustainable health care systems exist in all member states. Thank you.

(Applause)

John Bowis:

Thank you very much Dorjan. That's an excellent introduction to some of the issues of a smaller member state, but also as you say, shining through, is that message of making more effective use of available resources. And that of course is where we can share centres of excellence and so on. Good. That's excellent.

Now we'll move on to the funders, and another good friend, Willy Palm from AIM, is going to be our funder for the day.

- **The view of the funder/purchasers**
Willy Palm, AIM (Belgium)

Willy Palm:

Thank you Mr. Chairman. Thank you for inviting us to this session. Sorry for being late this morning but it seems that my King is in the house and this caused some problems to get to the Parliament.

To start with, very briefly, AIM the International Association of Mutual Health Funds groups non-profit health insurance institutions in fifteen member states. In six of these member states, our members are administering compulsory health insurance and therefore are also involved in reimbursing cross-border care.

Let me start by saying that AIM member organisations fundamentally take a positive step towards patient mobility. As also is mentioned in the draft report on patient mobility of the European Parliament, despite the increased attention, patient mobility remains a limited phenomenon with low financial impact. And if the financial impact is low, this is always nice to hear for health insurers. But the fact remains that even if there aren't too many people wanting to go abroad for treatment this cannot be an argument to ignore those who want. And already in 1990, in a study that AIM did for the European Commission, it warned that a true restrictive policy was undertaken by member states in authorising health care in other member states. And AIM at that time already advocated a more proactive policy, especially for people living in border regions, and for highly

specialised care delivered in reference centres. And since then, several of our members have been starting to develop corporation and pilot projects in border regions, the so called EUREGIO's in order to facilitate access to health care across the borders for people living in those areas.

It is with the same positive attitude that AIM took part as a stakeholder in the 2003 high-level reflection process on patient mobility, and actually we welcomed this process especially since it was based on the intention to develop a coherent vision on how to go forward after the court rulings of 1998. These court rulings created some divergence between member states and also some legal insecurity about how cross-border care should be covered. AIM contributed and supported the recommendations which were made at the end of this process because they are a good basis to stimulate cross-border cooperation on health care and to gradually develop a genuine EU health policy.

Having said that, we were less satisfied on some of the other goals that were set for this high-level reflection process, and which are also very dear to health funds, namely creating legal security regarding the reimbursement of health care provided outside the home state and also reconciling national health policy within EU internal market obligations. On these two objectives, the members of the process could not really conclude to very concrete recommendations. On the question of regulating cross-border access to health care, member states generally considered during this process that the outcome of the court rulings on patient mobility were sufficiently taken into account through the modernisation of the chapter on sickness and maternity benefits in the regulation on social security coordination, the so called Regulation 1408/71 which was tackled under the Danish presidency in the last semester of 2002.

Apparently the Commission was not of that opinion because only one month after the conclusion of the reflection process, Commissioner Bolkestein in his draft Directive on services integrated an article that translated the principles set by the Court. Let me also state that although the Commission in its follow-up communication to the high-level reflection process presented this Article 23 as one of the main outcomes of the high-level reflection process - actually this Article was never discussed, not even presented in this high-level reflection process.

This new situation is for many reasons not the best solution to go forward on patient mobility, we are still confronted in Europe with the dual system of coverage by statutory health system of health care provided outside... in another member state. These two procedures are based on distinctive rules and distinctive reimbursement levels. This is not likely to improve the clarity for the patients nor for the insurance institutions that have to administer it. In the same line, several of our members who are very concerned by the way the European health insurance card was presented to the public – this is not a free ride... a free ticket to ride or to shop around- it is simply replacing the E111 form for care which becomes medically necessary during a temporary stay in another member state.

To conclude, AIM is not necessarily convinced that by simply opening borders and by establishing free movement of goods and services, patient interests are best served and patient mobility is really promoted. I think we need a more coordinated approach. Let me provide some thoughts on that. Essentially health funds are interested in two things: that is ensuring quality of care for the insured members and that it is ensuring cost-effective allocation of collected funds containing costs, in other words. And from that perspective, effective procurement of health services are vital in national as well as in an international context. Now, AIM members are concerned that the Services Directive might weaken their procurement policies as they would be compelled to reimburse care delivered by non-contracted providers outside the member state according to the same conditions as for contracted providers at home.

On the other hand, cross-border contracting of health services is actually something which needs to be further developed and promoted since it provides good guarantees that health care providers also outside the member state would be committed to the same quality assurance and cost containment rules as inside the country. But this actually requires a whole new set of standards and mechanisms - a reference framework as we call it – to make European wide coverage of

health care practical and secure and this work is something which would well fit in the open method of coordination approach.

Patient mobility requires more than removing obstacles to free movement and it requires a proactive approach of member states to cooperate or create the basis for cross-border cooperation. And a good example in this respect is the framework agreement that is soon going to be signed between the Belgian and the French health ministers, because it provides a legal basis for different kinds of collaboration projects between actors in the French/Belgian border region, to benefit for the people living in that zone. It provides some stability and continuity to cross-border collaboration which today is still mainly run on a project basis. Through these kinds of initiatives (which of course should also include cross-border cooperations on centres of reference) member states can engage in a process of coordinating health systems, completing each other, rather than competing with each other or even exporting problems.

Let me end by saying that these issues and these concerns, we find them well reflected in the draft report that you have made and we thank you for that. Thank you.

(Applause)

John Bowis:

Thank you Willy. Thank you for that last comment but also for the work that you are already doing. I should perhaps... I was a little bit abbreviated in my introductions. I should not only have explained that Dorjan Marusic is not just the State Secretary of Slovenia, but is a distinguished doctor in his own right, internal medicine is your specialty. Willy is director of AIM and that is the International Association of Mutual Benefit Societies and by training, I think a lawyer. Is that right? You admit to that? Yes, yes. And has come through various backgrounds within the Institute of Social Security Law in Leuven?... Thank you... and through Belgium's largest mutual health fund.

But, thank you for those thoughts, and we'll come back to you, if we may, both, in a moment. But we'll move to our other two speakers in this section on the view of the involved and come to Dr. Bernhard Grewin who is from Sweden and has come through the Karolinska Institute and is here wearing his European hat as President of the CPME, which for those who are not aware what CPME is, it's the Standing Committee of European Doctors.

- **The view of the Provider/Professional**

- Dr. Bernhard Grewin, President, CPME – Standing Committee of European Doctors (Sweden)***

Bernhard Grewin:

Thank you very much Mr. Chairman. And thank you very much for inviting us and letting me present the views of the CPME - Standing Committee of European Doctor's, also representing the medical profession in the Union.

To us, equal access to health care for all European citizens, with the highest possible quality safety and professional performance is fundamental. To achieve this goal, free patient mobility is, as said, absolutely fundamental. We have already seen the positive impact of patient mobility on health care development in the intensive, already mentioned, border region/cross-border care throughout Europe. We also see it when individual patients cross borders in order to get better or faster access to health care insisting on having it reimbursed by the home country. This has actually started a positive development for all patients because every country now has to strengthen and develop its health care to better meet demands of citizens already at home.

We will also, as we see it, in the near future see another kind of patient mobility. In order to meet demands, which all member states have for a sustainable health care system, in particular for the most specialised and expensive medical care, patients will have to move. Are we going to uphold efficiency, quality and safety for our patients in much of today's very specialised medical care? Many, today, domestic centres will have to be replaced in the future by European centres of

excellence. Therefore, CPME supports not only the principle of free patient mobility but also the right to reimbursement according to the rulings of the European Court of Justice on ambulatory as well as hospital care. At the same time CPME sees that it's absolutely necessary for a truly functioning free patient mobility for all, that these rights are regulated in one way or the other in legislation on the European level.

On the other hand, individual patients who cross borders today to get better health care or access to health care according to their needs, do not have the time to wait for the legislative work on patient mobility and health care reimbursement. Nor should, as we see it, responsible member states have the time, who already face the problems of financing, system sustainability, future demographic changes, and demands on better welfare in general by citizens. This reflects the fundamental reasons why the member states' cooperation through the European Union is so important on health care issues. The necessity of cooperation is also the reason why CPME, who took an active part, strongly supports the work by the high-level process of reflection and the establishing of the high-level group on health services and medical care. CPME sees the high-level group as a major way forward to achieve, within reasonable time, a well functioning, free patient mobility.

CPME would like to take an active role in the work of the group and also sees it as fundamental that the high-level group is given a clear mandate and a concrete agenda prioritising, as we see it:

- Easy access to information and clear rules and conditions on patient mobility.
- Access for all to information on health and health care possibilities such as centres of excellence in the European Union.
- Optimal professional mobility through a well functioning directive on recognition of professional qualifications which in itself is a cornerstone of patient mobility.
- Common standards on quality of health care, especially on patient safety where new and shared attitudes on a new thought basis in combination with active preventive safety-work and a patient insurance scheme is needed.
- Equally important is guaranteeing a high level of performance by all health care professionals through cooperation in the field of continuing professional development.
- Exchange of best evidence through clinical guidelines and implementation of evidence base medicine as a core of health care through a structured EU cooperation in health technology assessment.
- Development of e-health as a communicative support in health care.
- And finally, establishment of a network between competent authorities for exchange of information on health care professionals crossing borders to work without a central EU register on individuals.

Thank you very much.

(Applause)

John Bowis:

Thank you very much for that, and for highlighting in a way the momentum which is...(I won't say unstoppable) but there's a movement there where we should catch it and develop it. You also rightly added a caveat on the terms of the high-level group: that it should do its work within reasonable time, which is what I think we're conscious of wanting all the time that these things are not just "long grass" they are moving towards an end which will bring the benefits and again, avoid those court decisions later. Thank you Dr. Grewin, that's very helpful.

And now Hildrun Sundseth would be pleased to know we're moving on to the patient's angle. Angela Coulter, who's Chief Executive of the Picker Institute of Europe and if I explain to you that that is an education charity which aims to improve the quality of health from the patient's point of view. You're looking through patient's eyes at these issues...and she's written two books: one is called *The Autonomous Patient* – I'm not quite sure what that means, but read the book and you'll

find out – and the other is *The European Patient of the Future* and that is very germane to what we're discussing today, so Professor Angela Coulter.

- **Do patients want more choice?**
Angela Coulter, Chief Executive, Picker Institute Europe (UK)

Angela Coulter:

Thank you very much. Yes, my organisation is not a patient member organisation but we do specialise in measuring patient and public experiences and expectations of health care throughout Europe. We're based in the UK where much of work is but we also have a European focus. And the patient's organisations (some of whom are represented here) do an excellent job of representing the views of their members. But of course, the majority of European users of health services don't join patient's organisations. So that's where we come in. We aim to use rigorous social science methods to learn more about the experience and expectations of patients. And in talking to you briefly this morning, I'm drawing on the research we've done both in Europe (and I'll be referring in particular to the study that John Bowis mentioned, which took place in eight European countries) but also to work we've been doing looking at patient mobility within the UK, where many of the issues are actually pertinent to cross-border mobility, such things as what kind of information patients want and need.

Our European study took place in Germany, Italy, Poland, Slovenia, Spain, Sweden, Switzerland and the UK, and it demonstrated a number of important things. One was that actually, what was most striking is the similarity of views between patients in these different European countries was more striking than the differences. And in a nutshell, what patients throughout Europe seem to want is more involvement, more choice, more information and more control over their own health care. European patients on the whole don't want to be like passive victims. Sometimes if you're very seriously ill you have no option. But in most cases they want actually to have much more say, both over treatment decisions and also over who to consult and where to be treated. One of the questions we asked in our study, in the European study, was: Do you think you ought to have a free choice of provider? And overwhelmingly patients in all European countries (there were very few differences between them) said "yes they did". So for example 92% said they wanted a free choice of primary care doctor, 85% wanted a free choice of specialist, 86% wanted a free choice of hospital. We then asked them whether they had sufficient information to make an informed choice and that revealed very great gaps. So, a majority said, "No they didn't have sufficient information to make the choices".

When we looked at opportunities for choice within countries we found very big differences between the countries. So people in Spain and Switzerland were pretty satisfied with the amount of choice they had. People in Slovenia, the UK and Poland were pretty dissatisfied with the amount of choice they had. But mobility within countries, which actually raises all sorts of difficult issues as well as mobility across borders, *is* on the increase. And the evaluations we've been doing on the choice schemes in the UK which are encouraging mobility, encouraging patients to choose providers, to a limiting extent in other countries, for example in Belgium, but for the most part other parts of the UK show that uptake is much, much higher than anybody predicted. Two-thirds of patients offered a choice of going to a different hospital than their home hospital for elective surgery actually decide to do that. And we were looking at the kind of information they wanted, and what is very interesting is that although avoiding long waits is undoubtedly one of the important factors to patients, it's not the most important factor.

European patients are becoming an awfully lot more aware of policy issues and these are at the top of their concerns. So in asking about what information they want, people say they want information about safety, they want information about the experience of the surgeon who is going to carry out their operation, how many hip replacements has he or she done in the past, what were the outcomes like, and so on. So, I think, encouraging signs that patients in Europe are becoming much more discriminating. Although almost everybody says it would be great if every hospital was equally good, they know in reality there *are* variations in quality and they want that kind of

information. On the whole, we've discovered a lot of dissatisfaction with the amount of information that people currently have access to.

Now, just in my last minute, I wanted to raise a few other key issues that came out of our European study. First of all, mobility of professionals is pretty important to patients – it has all sorts of implications. People want information about the doctors who are going to treat them, they also want to know about their competence, but they also want to know that they will understand issues of cultural diversity – differences in patients' experience. And that has to be highlighted not only in medical education but also in continuing education and revalidation or re-certification if patients are going to feel reassured.

Secondly, patients want information about the treatments they're going to have, the risks as well as the benefits, and so in thinking about a coordinated approach to health technology assessment, it's very important to remember that patients are users of the products of that information as well as professionals, and they want this in a standardised and accessible form. The Internet is meaning that people are very much more aware of variations in quality and will become increasingly so. They will become more choosy about where they're treated. But it also allows the opportunity for consultation across borders without going there. Tele-medicine, e-mail consultation, with the issues that we talk to European patients about, and there was a lot of interest in the potential of consulting "the world" specialist or the "the European" specialist about your particular rare disease.

And finally: smart cards. That was another issue we discussed in this study. And people were rather surprisingly positive about smart cards, not just as a kind of European health card, a kind of electronic E111, but the possibility of the smart card actually containing clinical information, which for patients overcomes some of the difficulties they face about remembering – people get very concerned about remembering to tell the doctor all the right things about my medical history, and so on. So there was quite a positive response to the idea of smart cards actually becoming the core patient record and the patients themselves being able to hold this and take it with them...which actually would greatly facilitate mobility and consulting different providers.

So, on the whole, our study suggests that there is going to be, I think, a greater demand for mobility, even a cross-border mobility, than perhaps we're assuming at the moment, although most people would prefer of course to be treated as close to their home as possible. But nevertheless in certain circumstances people *will* travel for their health care and they want all sorts of guarantees and reassurances that that health care is going to be of good quality and safe and effective. Thank you.

John Bowis:

Excellent. Well thank you Angela. That covers a lot of issues in a very compact but helpful way. What patients want is important. What they can have access to, why they want it. The fact that actually they may not just be opting to choose another hospital in another country, they may actually prefer a different type of setting for their operation – maybe a day-surgery, it may even be hospital at home schemes, if these are available. But also the point which perhaps we haven't given adequate attention to is the future of tele-medicine and tele-psychiatry too, because that (with centres of excellence) will open up a lot of opportunities cross-border and that will be an interesting one to add into the mix. Thank you for that.

Now, can I invite any questions or comments that you may have on any of those issues, but we've been particularly looking at the view of the involved: the policy maker, the funder, the provider and the patient. Anybody like to...contribute anything? Yeah. Let's take one back then I'll come to you....

Rebecca Taylor, Pharmaceutical Group of the EU (PGEU)

Because of the professional recognition directive that cover pharmacists and doctors, pharmacists are obliged to dispense a prescription that has been written in another EU member state, but there is, at the moment, no harmonisation of prescriptions.

John Bowis:

An expert on...No. Well that point will have to be absorbed and we'll take that away and look at it.... harmonisation of prescriptions - interesting one.

Rebecca Taylor, Pharmaceutical Group of the EU (PGEU) :

Sorry, I should have said harmonisation of the format.

John Bowis:

Yes absolutely. Not necessarily what is prescribed yet.

(Audience laughter)

That *would* be a European health service. Avril.

Avril Doyle MEP:

Just to pick up a point on the last speaker. There is also a difficulty in terms of the trading of the different pharmaceuticals under different names in different EU countries, to be honest with you. It's not just the format of the prescription. But if we're going to treat medicines – I mean if I bring a prescription from Ireland and present it at a Belgian pharmacy (they disappear inside, they're rooting through books, and they're getting the generic drug, and then they're finding out what the equivalent Belgian one is), I mean it *can* be done, but there's a lot of... harmonisation needs to be done around *this* area, I would think too if we want really free patient mobility and to be able to access health.

Sorry, I indicated to know if through you I could put a chair to the CPME president: I understand, from correspondence, that CPME represents what? 27 European countries as distinct from just EU states. You represent 2 million medical doctors across the EU and beyond and that unanimously - now I want you to correct me if I'm wrong on this – unanimously, the view of the CPME is that you do not want health services in the General Services Directive. Yet you said here today that the rights must be regulated one way or another across the EU. Could you square the CPME's thoughts on that? What you want, how can we deliver on what we *want*, number one, and what the European Court *obliges* us, number two, in relation to patient mobility other than through the General Services Directive. What is the view of CPME? You represent *all* our doctors, at *all* levels, in and out of hospitals I believe. What would you like us to do in this area? Thank you.

John Bowis:

A direct question!

Bernhard Grewin:

Thank you very much. Firstly we represent 26 of the 27 countries of the Union. There's one still missing. Hopefully it will soon be a member as well. I won't tell you which one it is. Anyways.....

John Bowis:

You actually increased the European Union. It's...we think...

Bernhard Grewin:

No! no, no no! I do beg your pardon. You're quite aware, (I mean, being well informed) that I did by mistake include the EEA countries as well. Now we've straightened that out. Fine.

Now concerning the Services Directive, what the CPME is saying is that we *do* want, we are *for* the patient mobility, and we are *for* the principle of reimbursement, we are *for*, actually, having it regulated – we have no objections to having it regulated through the Services Directive. That is not our objection. Our objections are that there are things in the Directive, about seven various points that we have critical views on, and we are saying unless these things...these question marks, are straightened out, these things are changed or these things are better defined, until that is done we think that health care should be left out, for the time being, of the Services Directive. Once all those

things are straightened out and our demands or hopes or wishes are met, when that's done, we will reconsider our situation. Does that clarify things? Fine thank you.

John Bowis:

And you're not going to name the one?

Bernhard Grewin:

No I won't!

John Bowis:

Johan.

Johan Hjertqvist, Health Consumer Powerhouse

Johan Hjertqvist, Health Consumer Powerhouse. I have a very short question to Madame Coulter: would you say that it's necessary for the Union to take action in standardising what kind of patient information that ought to be delivered to make that kind of choice and comparison you refer to more easy to the individual consumer or the patient?

Angela Coulter:

I think it would be wonderful if there was...first of all, if there was an accessible sort of central resource of information. The extent to which it would be possible to standardise it, I'm really not sure because the kinds of information that patients want about providers is really quite detailed and complicated and some countries are further down the road than others in collecting it. Many of them are going down similar roads, for example patient feedback surveys - we have those now in the UK on every provider, they're not at all accessible to the public yet but they ought to be and they will be I think soon. Patient safety measures, (you know the experience of doctors and so on) I mean, in some future utopia perhaps maybe we should be thinking of some standard system. At the moment, it would just be great to have access to whatever there is around even if it is in different formats I think.

John Bowis:

Cristina Gutiérrez.

Cristina Gutiérrez MEP: (Interpreter):

Well first of all, thank you for organizing this meeting and I think you've made a very good selection for speakers. So thanks for that.

My position, I must say, is very close to that of the Commission. The thing is that our health systems are extremely complex. We have a great deal of diversity throughout our countries and that's why we have to sit down at the table and start working. We have to take into account above all the rights of patients, the rights of the consumers, and put public and private effort into serving the patients, the customers. That's the first problem. That should be the priority. Putting the patient first and not the fear of individual countries that somebody might come in and somehow threaten their system or upset their system. This institutional egotism, I think, can be highly problematic. We also have to be aware that as Europeans we do have enormous problems in getting our economy working better, becoming more competitive. More than 20%, let us not forget, of European services are dedicated to health services, to health. And there's an area in which we have to become competitive as well. Not just in terms of technical and academic knowledge, knowledge of health, but also we have to be more aware of the social models we have to share, the public/private social models in each of the member states, we have to be aware of the differences and how we have to fit them together, how we have to combine all these systems across Europe.

In Spain we have a mixed system – public/private health system. You can receive money from a private insurance company to go to a public hospital for example, this sort of thing. We have to understand the differences between systems so when necessary we can build bridges between them. At the same time, we have to make it possible for private services, for example private

university services, they should be able to flourish as well. Because a lot of medical research in Europe is being done privately in universities and that knowledge has to be made available, especially when it's pushing back the borders of medical knowledge. So we shouldn't be afraid: our public health services in individual countries shouldn't be afraid of one another because they have to work together, there has to be coordination, they shouldn't be jealous, they shouldn't be fearful of being invaded and upset. We should have some more successful coordination especially in specialist areas such as cardiac medicine and so on and so forth – our sharing and pooling of knowledge and cross-border coordination, open coordination. But above all, above all, our priority should be the patient. Thank you.

John Bowis:

Thank you very much. An important point there about the way the different systems will work together and you mentioned public/private, but of course in terms of if we're going to have a system of reimbursement, how they work together between the tax payer system and the insurance system. And I don't know if... would you like to say a word on that?

Willy Palm:

I could, in a sense be a little bit provocative and I could say well patients, they actually don't want choice, they want good treatment in the first place. And if they think they cannot get it in their own country then they will look across the borders, but in the first place, patients are not interested to cross borders to get treatment. At least I think we have to take into account...to ask ourselves, why is it that patient mobility has become such a topical issue over the last ten years? I think it's much linked to the problems that health systems are facing actually, because of long waiting times, because of quality problems, under-funding, raising of out of pocket payments for patients – these are drivers for patient mobility. And so in the first place, member states have an obligation to provide good treatment, to provide good health care in their country.

And of course, in the sense that health care expenditure is constantly rising and is putting member states in danger as regards to stability pact and other criteria (economic criteria) then there is an issue to think "why should we not collaborate/cooperate on health care? Why should we not better share our resources in order to cope with these problems?" But I think the responsibility is first to develop good health systems and this organises in cooperation. I don't think that a good alternative is to open the borders and let patients go out and shop around. I would provocatively like to say that health care is not a service – it is a process. Especially since health care becomes more and more linked to chronic diseases, it's not about an individual...consultation of an individual doctor. It's about treatment of a disease. And then you have to take into account all kinds of issues like quality, like continuity of care and if you cannot guarantee that in a cross-border situation, well then you should organise this first before you open the borders.

John Bowis:

I like people being provocative. If I was going to be provocative on top of that I would say "and you can't have the health care without the social care so therefore you need to look at the relationships between health services and social services". But that's perhaps for another day.

Dorjan.

Dorjan Marusic:

I can just add that I fully agree with you in the sense of that we have to put the patient in the centre of every health system. This was the main goal of our reform which started four years ago. I can illustrate that our citizens, our patients are still not prepared to enter the centre of the EU health system. Let me just prove this with two examples: we had very long queues for heart procedures. We made a telephone audit, we asked the first 200 patients on the waiting list. We allowed them to go to countries in the EU. Only 10 out of 200 chose that opportunity. They said, "We will prefer to wait on our waiting list and then pick our doctors". In Slovenia, there is free choice for choosing specialist treatment. There are, let's say from 5-25 percent of citizens that do choose doctors in other regions. So in a way we still do want to...we prefer to choose specialists in Slovenia.

And the last and very important proof is that we had a very bad, let's say, strategy in buying linear accelerators so we had very long queues for cancer patients. We wanted to diminish the waiting time. So we made a plan. We contacted three very important reference centres in Italy and Austria. We established a team of experts to guarantee patient safety. But only 23 patients out of 2200 on the waiting list picked the opportunity to go to Italy not in Austria. And some of them are very near the border.

So in a way, we are well aware that this is, in a way, a problem which we have to face. We started a lot of projects. But the journey is a very long one.

John Bowis:

Very long journeys in many respects: both mental journeys but also physical journeys.

Now, I'm going to ask our other two speakers to come up and join me, but just while you do, there are two other comments, I think, that we have. Straight over and then from the back.

Zuzana Roithova MEP (Interpreter):

Thank you. I'd like to put a question to Mr. Palm: Is there a document listing the problems that there currently are with sickness insurance under Regulation 1000/04/082 or whatever it is? Now that this system is in place, is there a list of the problems that arise? So, that's also a question to the Commission, and it's a question of political control. One of the speakers (this is another question now), one of the speakers referred to a "pocket" of poorer countries with a lower standard of health care. I'd like to know what these areas are because we need to deal with that problem if it exists. So can you name some names?

And now a question on mobility. There are two kinds of patient mobility: active and passive. Active patient mobility is something which I think the CPME are familiar with, with this centres of excellence, whether national or European, because both doctors and patients know, *where* in individual member states and *where* across the EU there are places where extremely difficult medical treatment can be given. And the more patients these centres have, the better quality treatment will become and this is something we should be supporting and promoting because it's in the interest of patients. There has to be accessible, high-quality health care across the EU which saves lives in these particular centres. Active mobility can also take the form of targeted, deliberate, cross-border cooperation organised between neighbouring regions.

And then there's passive patient mobility which we need to be aware of and respond to. This is where people work in other member states or they're on holiday in other member states and they require adequate health protection.

What about the question of the standardisation of processes within hospitals? These are procedures which are not dictated by the member state, not by the EU, but this is independent accreditation. This is something which I think is becoming increasingly favoured.

John Bowis:

Ok. Well thank you for that. Some of those issues are going to come up in our next group of speakers in terms of cross-border and bilateral arrangements, so we'll leave those to one side. But there's a direct question to Willy Palm.

Willy Palm:

Yes, on your question on the situation on the regulatory process, there are actually some documents which I can provide you. I could also refer you to our position statement that we took regarding the Services Directive, and actually about the whole issue about having these two different procedures, basically one procedure under the new revised Coordination Regulation which is still making a distinction between E111 care, so temporary care, while staying in another member state, and the situation where a patient deliberately goes to another member state for which he still requires an authorisation. When we compare this with Article 23 of the Services Directive, there was another distinction made in that Article. There the distinction is made between

out-patient and in-patient care. For out-patient care you don't need any authorisation anymore; for in-patient care you do. This is creating a lot of different kinds of problems. But let me give you just one example: under the revised Coordination Regulation, now for E111 care, the new health insurance cards are going to be used for care which becomes medically necessary during a temporary stay in another member state. Before, it was linked to the condition of urgency. It was only for immediately necessary care. The point here is that it will become very difficult to make the decision whether a patient went deliberately to another member state, for which he still would have to need an authorisation, or the situation where a person was on temporary stay and asked for some care. These kinds of things are going to even perhaps create more legal insecurity than before. So, what we would have liked is that the whole new situation created by the court rulings would probably be integrated into this Coordination Regulation rather creating a procedure next to this Coordination Regulation. But I can refer to documents that I can provide to you.

John Bowis.

Thanks Willy. From the Commission, Nick Fahy also from DG Health wanted to add a comment.

Nick Fahy:

Thank you Chairman. Just to come back on the point about where these "pockets" of poorer health care are. Let me just give you some examples. We have had cooperation at the European level on cancer for many years now. And so we have some statistics from that area in particular. Let's take 5 years survival rate for breast cancer: these range from 81% in Swedish women to 58% in Slovakia and Poland. Or for skin cancer, or malignant melanoma: the five year survival rates go from 89% in Sweden and 86% in the Netherlands, to 62% in Estonia, 64% in Poland, and 68% in Italy. So the point here is not to point fingers, but the point here is to show that through variations in practice, not necessarily linked to amount of resources (although that's obviously an issue), but through different practices and through different techniques there are really quite significant variations across the European Union. Now we have these figures for cancer, as I said, because we have a long history of cooperation in that area. We don't have that history of cooperation on health systems and health services in general. And so to come back to the point that my boss made earlier when Mr. Madelin was speaking – this is the positive agenda on patient mobility and health care. There is the ability to...(through cooperation and through the kind of initiatives which many speakers have already described)...to begin to level up these inequalities across the Union through sharing knowledge and best practices. Thank you Chairman.

John Bowis:

Absolutely right. Thanks Nick. Now lastly in this section... yes, please.

Flaminia Macchia, Eurordis:

Yes, I represent Eurordis, which is the European Organisation of Rare Diseases. What our families and members get back to us is that it is very difficult for them to get the prior authorisation to go abroad for treatment, diagnosis, second opinion, eventually third or fourth opinion. So I would like know whether it would be possible or totally utopic to imagine that in your report there would be a word about the conditions to deliver this prioritisation in certain cases. Thanks.

John Bowis:

Well I think that's an important area which we do need to devote attention to – this is the rare diseases. Parliament has a responsibility on that as well as the Commission. And of course we together put through the orphan drug proposals which speeded up some of the drug authorisations in these areas. But I suspect the answer is going to be in what's being discussed by this panel in terms of some of the centres of excellence, and so it's not every country trying to do everything. Some will be able to specialise. And then we need to make sure that for rare diseases we can find a way of enabling people to go, which would be partly member states' willingness but maybe partly whatever system we put in place and codes of practice and so on.

Don't know if anybody wants to add to that...I think that's probably where we will leave that. But thank you to Eurordis.

Now, thank you then to our panel to date, particularly to Dorjan, Willy, Bernhard and Angela for their presentations which have been excellent and stimulated a lot of thought and discussion. So many thanks.

Can I then move on to our next and final round which is what we've described as practical accounts on patient mobility illustrating the challenges and opportunities. This will come to some of the points about bilaterals and cross-borders that were referred to just now. But we're going to start where, if you like, the opportunity started (I don't know if you see it as an opportunity, or didn't at the time) but it started in Luxembourg of course with what I used to call the "Black and Decker ruling" but it's actually the Kohll and Decker ruling (it's just easier to remember) and all those others. There's one that I always thought was a Dutch beer, Oranjeboom but it's Peerbooms and somebody or other.

Anyway, I'm not going to try and get my tongue round those. I'm going to pass across quickly to Robert Kieffer who has come from Luxembourg - by training, not a doctor but a mathematician – and has worked in the Inspection Générale de la Sécurité Sociale in Luxembourg and perhaps more important, is President of the Union des Caisses de Maladie, which he's held since 1992.

III. Practical Accounts on Patient Mobility illustrating the challenges and opportunities.

- **The impact of Kohll and Decker rulings on national health care systems: example from Luxembourg.**
Robert Kieffer, Président de l'Union des Caisses de Maladie (Luxembourg)

Robert Kieffer: (Interpreter):

Thank you. Well first of all I'd like to thank you for giving me this opportunity to describe the impact of these different health systems in Luxembourg. I'd like to tackle two points first of all. First of the protocol consequences for mobility of patients and secondly, another point, the consequences on relations between insurance companies or organisations and doctors. Now, to understand the impact of these rulings, you have to understand the Luxembourg situation. The Grand Duchy of Luxembourg does not have a complete health care system within its own territory. We don't have a university hospital centre nor do we have a number of specialist centres, for example rehabilitation. Our health organisation in Luxembourg has always had to transfer patients out abroad using the E112 form. And this applies obviously to the services we can't provide in Luxembourg. Now in 1997, the year before these rulings, the number of transfers abroad approved by our medical authorities was 8033 patients. This number of transfers is fairly high because it makes up 2% of the insured population in Luxembourg. We had less than 300 refusals when transfers were requested.

Since the Kohll and Decker rulings, our health insurance organisations reacted by publishing a communiqué in which we accepted that with immediate effect there should be refunds according to Luxembourg tariffs without prior authorisation for out-patient services carried out abroad outside our hospital sector. Following the Smits and Peerbooms rulings, our insurance administration confirmed that there still had to be prior authorisation for in-patient treatment abroad. So as Luxembourg accepted immediate transposition of these rulings in a very liberal way, without waiting to amend its own internal legislation, you could have expected a reduction of E112 transfers with prior authorisation and an increase in transfers outside the country with refunds according to the Luxembourg tariffs. That didn't happen. In fact there was an increase, a substantial increase, in E112 transfers between 1997 and 2003 going from 8,032 to 12,000+. That's an increase of 8% a year.

The increase in the refunds according to Luxembourg tariffs for services provided abroad, although we don't know what the figures are, because the Decker-Kohll ruling means that refunds...now mix up refunds given to people receiving treatment within Luxembourg with those receiving treatment outside Luxembourg are on the Luxembourg refund scale. Together, they don't take more than .5% of the services provided to out-patients in Luxembourg, this is for tourists coming into the country.

So the new procedures have not had a very great impact. We can say though that mobility of patients has increased in Luxembourg thanks to the Kohll and Decker rulings. But this is because we are now combining E112 procedures with our regulation or with Regulation 1408.

Now the reason we've had some success here is because there's a great deal of uncertainty as to how much will be refunded by the health insurance system when the services provider abroad risks being more expensive. If you go to a doctor without an E112 form abroad you risk being treated of course as a private patient, not as a socially insured patient. That means that prices in such cases will be higher than the approved prices for services in Luxembourg. Also people are worried that bills, doctors bills from abroad will not be approved as easily as bills issued within Luxembourg. There is the risk also, and a real risk, that such doctor's bills will not be given favourable treatment when presented in Luxembourg to the insurance organisations. That's why we recommend that patients should demand that they pay the official price in the country when they go abroad from Luxembourg by using their E112 form.

As regards our relation with the medical profession now. In each country of the European Union the health services market is subject to very strong regulations in each of our countries' health systems. For example, prices are fixed, the types of treatment refunded are limited, the type of person authorised to work in the health system is limited, there's a quantity of limits on the number of services you may receive per year. The Court of Justice rulings mean that we now have to have free provision of services across border in the health sector, whereas at national level of course, these services are highly regulated. So there's a contradiction there. This means that health insurance systems have to pay for services provided abroad, provided by service providers who are not recognised in Luxembourg, whereas in Luxembourg you can only have refunds paid if the doctor you are visiting is on the official list in Luxembourg. That means that when patients go abroad they are in a completely open market as regards prices, whereas Luxembourg doctors have to charge the official prices if patients are to receive a full refund in Luxembourg.

The Luxembourg doctor has pointed out that this is a discrimination against Luxembourg doctors *vis a vis* foreign doctors abroad. Negotiations on this in Luxembourg are now blocked. The doctors are digging their heels in. In fact, our health insurance systems in Luxembourg cannot impose the same conditions on doctors offering treatment abroad as they can on doctors in Luxembourg who are on an official list. This led to a strike in November 2000 of doctors in Luxembourg. They were calling for an opening up of the market in Luxembourg, calling as it were for the official list of doctors to be done away with – a system we've had since the 1930's. Now here the doctors were not successful because all the political parties in our parliament were against them. What the government did do though, it made a number of concessions saying that doctor's prices could be adjusted in line with the cost of living index. These changes were approved by Parliament in July 2003 against the views of the social partners represented in the health insurance funds organisations.

So we can conclude then, that these rulings, which basically say there should be a free market in health services, risk worsening the relations between doctors and managers in health systems. However it's important for there to be clarity in the relationship here between the medical profession and the medical administration. In my opinion, it would be essential for health systems to restrict access to foreign doctors, doctors abroad, without official authorisation. Only access should be allowed with prior authorisation if a patient goes abroad to approved doctors in the other country on the official list. Thank you.

John Bowis:

Thank you very much for that, Robert. That's the practical reality of how we put this into practice and some interesting aspects which I certainly hadn't appreciated in terms of doctors' reactions to other doctors and necessary changes in domestic patterns and systems. But that's very helpful.

Now I'm going to move to the other end of the table here and come to Philippe Harant who's responsible for European affairs at the French Ministry of Health in Paris and is by background a hospital manager from Mery sur Seine, *je crois*.

- **Bilateral co-operation**

Philippe Harant, Department of European and International Affairs, French Ministry of Health

Philippe Harant: (Interpreter):

Thank you Chairman. You asked us to set out the challenges and opportunities offered by patient mobility using practical examples and so I'd like to talk about bilateral cooperation and patient mobility concentrating on the question of border regions, an issue that has already been raised a number of times this morning. Other colleagues are going to be talking about purchasing treatment in other member states.

If you live in a border area and you need health care, the nearest hospital is often on the other side of the border. There are already cooperation agreements between border area hospitals to meet this challenge. So there is cooperation between health care institutions and this is of benefit to the patient. It means that the patient can avoid frequent long journeys especially in the case of chronic illnesses, for example, which require regular stays in hospital. And obviously we're talking not just about the patients themselves but also their families.

It is also of benefit in other ways. It can help to cut waiting lists and to increase the quality of services. So it is certainly in the patient's interest but the health care systems also benefit because it means that economies of scale can be obtained by eliminating duplication of resources and equipment. For example, French legislation currently provides for local health care planning to take into account services available across the border in order to prevent unnecessary duplication at local level. So cross-border cooperation in border areas does help, it is useful, and this European contribution clearly is value added from the patient's point of view.

In 2003 I worked with the European Hospital Federation and we carried out a study on cross-border cooperation between border regions in order to map out what cooperation was taking place. What we found was that there were about 170 different cases, which illustrates how widespread this is across Europe in different countries, some more than others. These were very specific, bottom-up initiatives responding to grass roots demand in the regions themselves. Now the responses were very varied in nature as a result and there's a whole series of forms of cooperation. For example, sharing workload: hospitals in close proximity of one another can combine their services. For instance, one concentrates on dialysis the other on communicable diseases; you can also have cooperation in accident and emergency; you can have shared procurement in order to make savings. There are also cases of staff exchanges in order to promote good practice.

And there are some areas where there are very few hospitals. There's a border area on the French and Belgian border, for example, where there are very few hospitals. And there there's a form of cooperation in place to make access to health care easier. So these are local initiatives scattered across Europe. They are not in any way harmonised. They often run into difficulties, administrative obstacles, linguistic problems, problems arising from different health care systems. There are problems with the question of prior authorisation for stays in hospital and so on.

As Willy Palm was saying, the objective is to remove the barriers, and with a view to removing the barriers, France has entered into bilateral cooperation with its neighbours to make this cross border cooperation easier. An agreement with Belgium has been initialled – I hope that it will be ratified as soon as possible, both in Belgium and in France. Negotiations are underway with Germany. Spain is also interested in an agreement of this kind. And I want to stress that the aim is to facilitate cross-border cooperation.

Now very briefly I'd like to say something about the future prospects for this form of cross-border cooperation. Clearly one very positive issue is that Article 3-278 of the Constitution on Health is designed to promote health care cooperation in border regions. The text there in the constitution is very clear and the objective is to promote cooperation. Robert Madelin was talking about the high-level group on health services and I have to say that many Member States believe that cross-border cooperation in border regions is an issue to be dealt with bilaterally. But we need to think about the possible value added offered by Europe. Perhaps more can be achieved. On top of the bilateral cooperation, there is the funding through the INTERREG program for example and there are other issues too. I think one of the interesting things to look at is the possibility of networking these local cooperation arrangements. Back in 2003, a conference was organised and I was struck by an Italian speaker's contribution who was talking about cooperation with Slovenia and who was surprised to see how many projects there were in Europe, whereas he thought that he was a pioneer! He thought this was the first time it had been done – cross-border cooperation. And so it makes sense to make it possible for these people to talk to each other, to share their experiences because they *are* so diverse. I think that in the new member states there is a great deal of interest in this form of cooperation because in the past there was no question of INTERREG funding for them, and now that is a possibility. I think that is something which could help towards an efficient use of resources in areas where there are shortcomings in medical care.

One very innovative area is a project which is currently being developed by France and Spain. It's in the Pyrenees region, a fairly isolated area, and the objective is to build the first cross-border hospital. It wouldn't be a French hospital; it wouldn't be a Spanish hospital. It would be a true cross-border hospital. Now this is a major legal headache. At the moment this is in its early stages but the aim is for the foundation stone to be laid before the end of this year, of 2005. It's certainly a very interesting project.

Another project which illustrates the problems of cross-border cooperation and the opportunities of it, is the project that Ulla Schmidt has launched together with the French minister, the objective being, in Baden-Württemberg and Alsace, to draw up an intelligent map of health care services. This could subsequently lead to other things but the idea would be to pool information including information on things like...[...]. There are all sorts of possibilities, very specific ways of making significant progress on the basis of a first, sort of, test case in a border region. Thank you.

(Applause)

John Bowis:

Well thank you very much. I suppose if we look at the example of Andorra, which (if I remember rightly) has or did have co-presidents: the President of France and a Bishop from Spain. There shouldn't be a reason why we couldn't organise a hospital. It might be a Basque hospital, I suppose, if it's both sides of *that* border...if it's the top of the Pyrenees, whatever that may be.

But there's some interesting points there and the idea that when planning one's health services, one should look across the border to see what's available there so we don't duplicate. And I should tell that to my colleagues in Dover, that they should have a look and see what's in Calais, because it's probably quicker in the traffic system to get across on a hydrofoil than it is to go up the road. But certainly, at the moment I gather it's all under snow anyways. But thank you for that.

There's interesting points there about managed opportunities and we've had a number of those: how we manage these opportunities for the benefit of all. And the question perhaps then is the extent to which one can cross over into managed choice, where there's more choice for patients perhaps to go beyond those chosen areas and so on. But that's for further discussion.

So let me now move to Rita. No surprise that the King of Belgium has come into the building today, we've not just Willy accepting responsibility, but now Rita who's also from Belgium, but more importantly she's from the Observatory – the Social European Observatory – which is a policy oriented research activity on the impact of integration on social issues, and is going to talk about purchased care in Belgian hospitals. And one of my first site visits when I started looking at this

subject from the Parliament, was to Brugge to see how patients were coming from my country to receive treatment on a bilateral arrangement, and what they saw as the opportunities beyond that. So I look forward to hearing what you have to say.

- **Cross-border contracting: Purchased Care in Belgian hospitals**
Rita Baeten, Researcher, Observatoire Social Européen (Belgium)

Rita Baeten:

Thank you. In Belgium indeed there is a long-standing tradition of some cross-border patient mobility. Belgium is a small country with many borders. Health care services are always close to one border or another one. Languages cross borders and there has long been a cross-border workforce flow. Several initiatives were taken in the last decade to relax cross-border access to care. Often initiated by local health care providers and sickness funds and several of these projects became possible with the support of the EU, INTERREG, EUREGIO projects.

Although the patient flows to and from Belgium for pre-planned care were just so much higher than for most of the other member states, it remains a relatively marginal phenomenon even in Belgium. Cross-border care was traditionally mainly funded through European Regulation 1408/71 on the coordination of social security schemes, and thus Belgian prices and legislation applied to the care provided. In recent years however, patient flows into Belgium are increasing exponentially. In particular the number of Dutch patients treated in hospitals in the northern Flanders region was increasing. These developments suggested that it was not only patients who came to Belgium at their own initiative, but that the flows were the result of direct contracts concluded between foreign purchasers and Belgian hospitals.

This care is not necessarily funded through Regulation 1408/71, the Belgian authorities were (at least initially) not involved in these contracts and were worried about the potential impact these developments could have on, first of all, upward pressure on Belgian tariffs: if foreign purchasers offer higher prices to the Belgian providers, this could put upward pressure on Belgian tariffs. Secondly they were worried about priority setting: if Belgian providers could be inclined to treat foreign patients first if treatment of these patients is more lucrative and consequently waiting times for Belgian patients could rise in certain regions or for specific treatments.

A research team of the Observatoire Social Européen carried out a case study in the framework of the Europe for Patients Project to find out: What are the drivers for this enhanced cross-border mobility for all the players involved and in particular for the cross-border contracting by Dutch health insurers and by the UK National Health Service? And secondly: what are the potential consequences, challenges and opportunities?

The preliminary results suggest that this cross border contracting is a result of a multitude of factors including:

- First of all, the rulings of the European Court of Justice on the assumption of cost for health care received abroad and the way these rulings are interpreted by the public authorities of the countries involved.
- Secondly, because of the features and complementarities between the health care systems involved, which have led to over-supply on one side of the border and supply restrictions on the other side.
- Thirdly, through the search for policy answerers to the problems of waiting lists.
- Fourthly, by the strategies of Dutch health insurers looking for faster, cheaper and better care in a context of increased competition between Dutch sickness funds.
- Fifthly, through strategies of Belgian hospitals to increase their income to cover fixed costs and to allow them further specialisation in a competitive Belgian hospital environment.
- Sixth, through strategies of Belgian hospital doctors to increase their income.
- Seventh, strategies of Belgian sickness funds aiming to establish international alliances between health insurers and attempting to have preferred contracts with Belgian providers.
- Ninth, strategies of foreign health care purchasers aiming to breach monopolies of their home providers by enlarging the pool of providers beyond the borders.

- And last but not least, patients who vote with their feet. Mostly Dutch patients living close to the borders seem to be increasingly eager to come and to return to Belgian providers and are satisfied with the care they receive in Belgium.

Furthermore it seems that on the whole Belgian tariffs and quality standards are applied to the contracted care and that there are as far no indications for increased waiting times for Belgian patients. The application of the Belgian tariffs in the contracts is guaranteed through, first, with the UK...bilateral agreements with the Belgian authorities and the UK public authorities has been established on conditions for cross-border contracting. For the contracts of the Dutch health insurers there is the involvement of the Belgian sickness funds as a third contracting party in several of these contracts between the Dutch health insurers and the Belgian hospitals watching the tariffs that are applied. And thirdly, because the foreign purchasers have also an interest in keeping prices down.

Nevertheless, there are also indications that foreign purchasers are very eager to conclude a contract and if there is no guard of the Belgian tariffs (this is the Belgian authority - public authority - or the Belgian sickness funds), Belgian providers will try to charge higher tariffs. Furthermore, in the Dutch health care system, cost containment policies are mainly based on supply-control measures, whereas in the Belgian system demand-control through out-of-pocket payments and quantity-control measures such as budget sealings, play a more important role for cost containment. The interaction between the two systems could breach the Dutch supply-control strategies without being replaced by the demand-control measures.

There are also indications that the Dutch GP headkeeper system is loosening its grip on the patients going abroad. Finally, there is a clear demand from all stakeholders involved for more clarity and legal certainty on the practices they are involved in.

In conclusion, the study suggests that up until now, the mobile patients, foreign purchasers and Belgian providers are benefiting from the increasing possibilities for cross-border care. Nevertheless, prudence is called for. Patient flow still seems to be increasing. There is a willingness to charge and pay higher tariffs when a guard of the Belgian tariffs is not involved in the contracts. An EU level framework for cross-border contracts between providers and purchasers could be another instrument to increase legal certainty for all the players involved and to guarantee in the long run that all the patients concerned, those in search of care over the border and those being treated in their national system, continue to take advantage of this increased patient mobility. Thank you.

(Applause)

John Bowis:

Thank you Rita. And that of course reminds us that a lot is happening already without new proposals coming forwards. And it's coming in a number of different ways and obviously Belgium is central to this because of its closeness to a number of other countries but there's more importantly a lot of good experience building up from that practice. We do of course have to remember that the European Court of Justice judgement confirmed that authorisation is still necessary by the member state or whatever the service may be in order to ensure the reimbursement of costs. That's part of that judgement. There's another test case coming...the Watts reference from the UK, just to establish partly that and partly whether the patient has the right to go beyond contracts that are in place between governments and health services. But again, there's a lot of debate to come, a lot of test cases I suspect. But thank you for that background.

Now finally, we come to Spain and this is partly at the behest of my colleague Cristina Gutiérrez who kept reminding me that one of the big issues in patient mobility is all these people who go and retire to Spain and cause Spanish tax payers some problems or three. Well, Isabel de la Mata is a doctor...a public health doctor herself and she was Deputy Director General of health planning in the Spanish Health Ministry, but now she's closer to home here because she is the Spanish

attaché or whatever the correct term is in the Spanish Permanent representation...and looking after health matters, and is going to look at those long term residents and health tourism. Isabel.

- **Long term residents and health tourism**

- Isabel de la Mata, Health Attaché, Spanish Permanent Representation***

Isabel de la Mata:

Thank you, and thank you for allowing me to present the Spanish case. As other speakers, I will use my mother tongue and in that way you can understand some of the problems that tourists and long-term residents are encountering when travelling to other countries.

Isabel de la Mata: (Interpreter):

Well in Spain we have all sorts of cases to deal with. Cross-border health care is one of them, though I'm going to talk about long-term residents principally of course and health tourism. Now of course they do take up a lot of our service capacity and we do have problems coping with long-term residents from abroad.

Now we have to distinguish between two different things here first of all as regards to problems. First of all, money and patients. When you started talking in terms of patient mobility, our ministry were very concerned indeed because of these long-term residents we have in Spain from abroad. Now there are four basic situations I think we have to consider. First of all retired people who come to Spain to retire. They like the quality of life, they like the weather, they like the sun, high standard of living, etc. Then we have long-term residents who live part of time in Spain, part of the year in Spain and another part of the year in their own country. Then we have tourists per se and then health tourists.

Now as regards to the retired people, from the point of view of money there's no problem: they transfer their pension rights to Spain and then they are dealt with as a Spanish citizen. They have a health card just the same as everybody else in Spain and they then fall within the accounting system of the Spanish health system. They fall in turn under the regional health system wherever they're living in Spain. So there they slot into the existing system. There's no economic problem.

But there are other problems such as the problem of language: they don't know Spanish. And then there are other problems when some of the people fall ill, really ill, or they get very old, they sometimes find themselves on their own and want to go home to their home country. But then they can't because then they have to ask for authorisation to go for health treatments back home and people don't always understand this situation - neither our health system, nor the people concerned...the patients concerned, nor the health system back home. So, you don't just have the language problem, you also have a clash of systems when these people seek to move between them.

Of course we have a national health system in Spain. We have a GP system, they are the "guardians" of the system if you like. You have to go into the system via your GP, you can't go to a specialist direct in Spain. And also in Spain we don't have a highly structured system of nursing homes. We don't have visiting nurses to the same extent as in other countries and some people, old people, if they find themselves on their own, widows and so on, they do have considerable problems because of all these factors: language, no nursing homes, no visiting nurses, and so on and so forth, difficulty in going home for treatment, wanting to establish themselves in Spain. So those are problems such patients have to face if they're long term residents and of a certain age.

And then you have the same problems to a lesser extent of people who say, spend two months in then two months at home, backwards and forwards, and backwards and forwards. Also, you have a lot of people who aren't legally resident in Spain. They might have a house in Spain and might even spend eight or nine months a year in Spain without having become official residents. To give you an example of the problems here, in the Valencia region you have a great number of British and German citizens living, lots of people in fact from the European Union, from the "old 15". And here I'm looking at figures from 2003 and in the Valencia region, the number of official residents

was 73,000 people in the Valencia region. But we were aware that there were 158,000 people constantly resident in the region. Not all of them therefore had an official residence card. You see, 73,000 had a card out of 158,000 we knew were there. So when people who weren't registered as residents needed health care, they would have to use their E111 form as if they were tourists even though they were de-facto in Spain for quite a long time, up to eight or nine months a year, let's just say.

So there, you do have administrative problems when people turn up for long-term treatment with an E111 form. And also there's a problem with them because their medical records are all kept in their country of origin, and they are using an E111 form and not a Spanish health system membership card.

Then you have tourists and if they have an acute health problem they use the E111 form, get immediate necessary treatment, and go away again if all goes well. There again, there's a problem of language, with any of these categories. If they go to casualty for example, it's not... they don't speak Spanish. The chances of the medical staff speaking their language are rather small. You can hope that everybody speaks English but don't count on it, certainly not amongst Spanish nationals living in Spain. And this applies at all levels: nurses, doctors, administrators – they don't necessarily speak English.

As I was saying before, we have a free public health system in Spain at the point of service. You don't have to pay anything on the spot. So Spanish citizens are used not to paying on the spot and the same applies to the medical staff. They're not used to charging people money on the spot. They do ask for a health card – yes. But if people turn up without a health card or an E111 form, well, everybody still has the right to treatment and they receive their treatment. But then, as our staff aren't used to charging money, well nothing gets paid and we do get, to some extent, some financial problems because of this. People aren't turned away. So that means that hospitals and health services don't recover that money in these cases. With an E111 form of course the money is paid back one way or another administratively. But, in the case of people without a form or without a health card, the money is lost.

Now, on health tourism. Two categories here: First of all you have legal health tourism people spending a fortnight on holiday in Spain and combining the visit for some health treatment. Normally this is done privately and we know this happens a lot. And this has been going on for a very long time. A special category of course is in-vitro fertilisation. There we have a lot of specialised centres offering the service in holiday centres. And that is another phenomenon worth noting.

Now there's another form of health tourism - "illegal" health tourism, I think we can call it. In many cases, in casualty in hospitals, we see doctors identifying people who aren't normal tourists. They turn up in casualty but they're obviously not tourists. And often, they're doing what Spanish people do...they're people who can't and are on waiting lists in their own country, and they do what Spanish people do in Spain to get quick treatment, they don't want to be on a waiting list for whatever it is, so what they do is they just go into casualty and have a go there. And sometimes we do get people with quite serious problems, turning up with their E111 form and they've done it quite deliberately because they're having difficulty getting the treatment they require back home because of waiting lists.

Now the new E111 system also makes it possible not just to receive specific treatment for a specific problem when they're abroad, but also to carry on receiving long-term treatment when they are on holiday abroad. And that is something else we have to cope with. This applies in particular to pensioners on holiday in Spain, and there, under Spanish law, they don't have to pay anything at all. When coming into Spain and continuing some kind of long-term treatment or receiving medical products or medicines from the Spanish system during their short stay in Spain. But there is a problem there again, which I've mentioned before, when you have people turning up in Spain for treatment and we don't have their health history because their health history is kept at home, sometimes there are problems. Sometimes the nature of the health problem is such that we feel

we should send them home immediately to somewhere where their health records are kept. That's a practical administrative problem.

And sometimes you get patients turning up asking for a particular type of medicine which they require during their stay abroad and there again is the problem which we've heard about this morning already: denominations are different from country to country, names of medical products are different from country to country and the doses vary also. Not only do names vary from country to country, but dosages within individual pills for example, vary. So there, there are problems of continuity if you like. And we see this in many categories of products. And this is a problem in pure medical terms because the patients are not going to get the continuity of treatment they seem to expect. This can be a problem for some patients. If they have some sort of chronic complaints and they go travelling around Europe, they really are going to have problems getting continuity of treatment.

I'll leave on that for now. Thank you very much.

John Bowis:

Thank you very much Isabel. You've highlighted some of the headaches that there are or can be from health tourism. We've also had a large number of British people living in the sun in southern Spain. We used to categorise them in three: there were either those who have gone there for their health, to retire in the sun and so on; there were those who were there for tax reasons; and there were those who were there because otherwise they would be serving time in a British prison. *(Audience laughter)* I think Spanish membership of the European Union has helped to solve the last point, but you've highlighted why there are still problems in a number of ways. You mentioned the language, the travel home issues, and the recovery of costs and so on, which need to be looked at as part of this whole review of patient mobility.

So thank you for that. Now, let me give the floor to Cristina.

Cristina Gutiérrez MEP: Interpreter:

Well thank you. I think we've heard a very good description of the case in Spain but it's much the same in Italy and Greece as well. I know this. Now, there are two issues I'd like to tell you about here. First of all, I think we have to enlarge what we mean by hospital assistance to patients...treatment offered by hospitals to patients. I think we have to be very clear about what we mean here because you can have day-surgery, which is very, very sophisticated and very, very expensive. You can't regard that as simple out-patient treatment. In fact, day-surgery can be even more expensive than accommodating a patient for a number of nights in a bed and I think we have to distinguish between the different categories of treatment here. Especially ambulatory treatment – day-surgery. In some countries day surgery is far more available, far higher quality and there is a temptation there for health tourism. And also it is well known that the general level of hygiene is much higher than in others. And this also causes people to avoid treatment in their own countries in certain cases. Another issue...first of all, just to finish the last point. I'd like us to consider this very seriously, somehow dealing with this particular situation more efficiently.

Now, my second issue. I think here when it comes to refunds you have to look at how refunds are administered as well. I think in Spain you have a very chaotic system. What happens is, payments made by patients (if they're made)...payments for the health system are made to the central ministry in Madrid, whereas you have an awful lot of local, regional administration as well, and the accounting system between regions and the centre is very confused. And it's very important, I think, whatever happens, whoever is entitled to a refund, either the patient or a health system who's given health care receives the money they have spent back. So there there's a need for improving the system. This applies not only within Spain but of course internationally as well, in the case of getting the accounting right and getting the who pays properly refunded. So this applies to patients and administrations.

Recently I had a health administrator come to me, emphasising these problems to me and he also talked about another problem we have and that is the disposal of bodies. You also have problems

of people literally seeking to avoid burying their relatives in Spain and in several countries, I know, because funerals are so expensive. The burial costs at least £600, I know, I've just heard, in the UK, and we *do* hear some rather strange stories of people seeking to avoid burial and leaving their bodies, or whatever, their relatives abroad in hospitals. Thank you.

John Bowis:

Well I suppose that's the ultimate in health care!

(Audience laughter)

But, thank you Cristina for reminding us of our mortality.

Now, we are in the final discussion period. Isabel may wish to respond on that specific point...*(audience laughter)*...not necessarily the last one!

But we strictly of course, have our four speakers: Robert Kieffer, Philippe Harant, and Rita Baeten as well as Isabel from this section. But we also of course have our speakers from the earlier section and we have Magda and *in loco parentis* for the Director General is Nick Fahy there from the Commission.

So, would you like to?

Isabel de la Mata:

No.

John Bowis:

No. Perhaps you wouldn't. No. Okay, let's...does anybody want to respond? Yes. Philippe.

Philippe Harant: (Interpreter):

On this question of day care, ambulatory care, we're in an area which is not very clear. The Court of Justice says there is day surgery, there is in-patient care, there is out-patient care, but in the Services Directive there is a proposal for a definition of what is hospital care. The first definition was to say that you had to have an overnight stay, so day surgery would not be covered as hospital care. So we're in an area which is very vague and should be clarified.

John Bowis:

Absolutely true. Which is why a lot of us were unhappy about the way that directive was tackling it because the court judgements, as I understand it, did not restrict it to overnight stays in hospital but to treatment.

Robert.

Robert Kieffer: (Interpreter):

Thank you. I'd like to add to that. If you look at the Peerbooms ruling, it's not about a stay in a hospital – it's about planned treatment. Now, a hospital theatre is an infrastructure which has to be planned for when it's going to be used, so that's day surgery for you. It's different to ambulatory care.

Charles Tannock MEP:

Yes. Thank you Chairman. Yes, listening to Mrs. de la Mata, there was a sense of *déjà vu* when she was talking about the Spanish health care system being free at the point of delivery and practicing local non-discrimination between Spanish and EU citizens. Because coming from a background myself of having been an NHS consultant in central London for many years, certainly we saw a lot of what we called "health tourism" in the NHS which also practiced this business of non-discrimination between UK citizens and other EU citizens. And I always thought that it would have been much fairer if we had a system of reciprocity for EU citizens whereby we would extend

to the EU visitors the same treatment regime package, in terms of costs and charges, as we ourselves enjoy in their countries. I was once admitted to a French hospital where I had to pay up front and I was only able to get 80% reimbursement, in fact there was a 20% net cost, which wouldn't have happened to a French person visiting Britain. It struck me as being rather bizarre.

And certainly in London I remember controversially (this is more than 10 years ago now), I had a small paper published with a colleague, doing an audit on my beds, and in which I found out that 20% of our beds were being occupied by overseas visitors admitted often through casualty and recovering charges (not just from the EU course) was always felt to be extremely difficult. No incentive, of course, for our local managers to pursue it through all the paperwork that it entailed and often we even had to pick up the tab...our taxpayers had to pick up the tab for very expensive repatriations with nurse escorts, even hiring private planes, and goodness knows what.

And it's very ironic that I do remember a conversation more than 10 years ago with the Spanish Consul in London on the issue of a Spanish patient that we wanted to send back to Spain. And he was very frank and admitted to me that the British NHS had a reputation for being a "soft touch" for free treatment for overseas visitors.

John Bowis:

That's a comment made, I think. Now of course, people may be fleeing the NHS because of the rapid rise in MRSA in hospitals. But that's another matter.

Christofer Fjellner.

Christofer Fjellner MEP:

Thank you very much. My name is Christofer, I'm a Swedish Member of Parliament. I have a very general comment – it's probably more connected to the early round of speakers. It was a couple of things that actually got me thinking, and I've been thinking about them for quite a while right now. And that is, to start with, the fact that patients crossing borders should be some kind of result of natural shortcomings in the health system. And the more I've been thinking about it, I actually don't...I don't think I agree upon that. Because I think globalisation as such has reached very far into the service sector - we can see it in outsourcing and other things – and now we can see that it touches upon the core of the welfare state more or less. So I think it's more or less...you know what I mean... process. And honestly a very, very positive process. Mobility is, for me, per definition, good. It's a fundamental aspect of competition and competition is the fundamental aspect of getting progress, so to me that is a very good process.

What I'm worried about at the moment is more or less that this process is, rather than being looked upon as something of a possibility, as a problem of many politicians, not at least within this house...because politicians tend to be scared when people take command and vote with their feet, because they lose control and it becomes very hard to regulate. But for me, every day that we don't increase the possibility of having more mobility over borders in this aspect is actually a loss today because it means less patients will have the possibility to have all the advantages of crossing borders. And I think Europe as such will have problems losing in competition on the global health market, because there is such a thing at the moment. Therefore, even though we search for perfection not...at least when it comes to the Services Directive, and that is an area where there could be and should be improvements, I think just lifting health out of the Services Directive, as is a very debated issue in this building at the moment, is for me to lose important momentum. We have to of course strive for perfection but we... I don't think that work should actually risk the fact that we lose momentum in this aspect. Thank you.

John Bowis:

Thanks Christofer. Angela.

Angela Coulter:

I think that's a very important point. I actually think that empowering patients is a very potentially powerful vehicle for raising quality standards. Empowering them means informing them and

offering choices. I didn't agree with Willy when he said that patients don't want choice. I think that's nonsense actually. I think people *do* want choice but we must recognize that actually the decision to stay where you are is a choice. And for many people, that will be the choice they'll take because they do want to have well-coordinated care close to where they live. But if they have concerns about quality they *will* want to move to somewhere which provides better quality. And I think that will happen increasingly.

So hopefully, offering those opportunities and facilitating them will drive up quality standards, so ultimately what everybody wants, which is very good quality care at home, will become more possible. I think there are some exceptions to that and that is people who need very specialist services for rare conditions and so on where that may be an unrealisable goal and so people will need to travel for that. But you're right: actually facilitating mobility could benefit everybody.

Bernhard Grewin:

I would, in a sort of way, try to underline some of these thoughts that have just come up, because I think the driving force...the major driving force is actually the patient – the individual patient, the citizen, what they do. Although I think that cooperation on a governmental level and so on is very important to improve the efficient and the quality and safety of health care in a European perspective. But I think... I have this thought that I think it's important to take into consideration that citizens in the European Union countries today and the entire Union – more and more see differently at governments and at governmental work. I mean, health care was so very much welfare. It should be an important part of welfare. But I still think that a lot of us are...(being in the decision position), we perhaps look at health care as a way of governing people. I think that people less and less see it like that. They see it from the individual perspective, as a service they have a right to have. And I think this is extremely important, otherwise we'll miss the train. And we'll miss a lot of trains if we don't see this: that a modern citizen of the European Union sees the health care system as a service institution – not a way of governing people. I think we have to take this into consideration.

And secondly, I would just like to underline that, (Willy Palm was talking about this), I mean, we are not opening up borders, but I'm absolutely convinced that we will not have all that much of mobility. We will not have all that much of patient mobility nor professional mobility, but just enough to drive a change in the various systems, and also drive a change for cooperation (as Nick Fahy was pointing out) – and that is the challenge. That is the challenge.

And finally, if I may say so, why we think it's important to regulate...to regulate in one way or the other, the rulings of the Court of Justice concerning reimbursement. That is because it is not fair that...because if certain patients do go abroad for some reason to get health care and they don't get it reimbursed by their government, we've seen the court cases in the European Court and we have also seen the court cases in the various countries that the governments start because they object to them going abroad. So therefore we have to have a regulation and rules so every patient who does this knows that they have a right for reimbursement otherwise they go and they take a chance and they do not want, every single time and every single patient, don't want to get themselves involved at home in a court case that goes on for years and years. In that case because they absolutely put off trying this possibility and I would say a lot of these patients who try these possibilities, they do it and they get things done and they improve health care (that I said early on) for everybody. So don't think that this is just something that's done by certain people with education and all that, and all those arguments, although it might be so that they are strong and forceful people. They do it and if it rains on them it will definitely rain on all the others as well because it will develop health care and that is a major thing. And it will also develop the access and the equality of health care in the Union. Thank you.

(Applause)

John Bowis:

Very good. Good. Well, there you are, applause speaks for itself, but I think that's absolutely right that to encourage us to go further, faster and you've all talked about the patient being central to

this and it's what the patient is looking for that we should listen to. And so Christofer would like us to go much faster and that's fine. You keep on that pressure! As legislators we have to make sure that we are doing it at a pace and at a scope which doesn't damage those who can't cope with the system, can't cope with choice, and need that basic care and protection. And if we get that balance right, then as you say, then everyone will benefit from the pioneering.

Now I've got a number of speakers. Avril

Avril Doyle MEP:

Thank you and congratulations to all the contributors from the top table, I think it's been a fascinating and most useful morning.

There's no definition of public health – it means different things in different countries in the EU. And I think we need to resolve that. To some people it's a speciality, you know the speciality of public health medicine; to others it's the health of the public we're talking about, in small letters, you know when you talk about the public health. And it's an area I think we've got to resolve because it is causing problems in legislation. Others will say that the real ministers for health are the ministers for finance. And that is a fact folks.

At the back of all our wishful thinking, if I may say that, and there's nothing that any of us disagree on - we agree on the end, it's just how to get there we might have different ways. But at the end of the day, the political reality is that the rollout of health services in each of our member states is a member state competence paid for by the taxpayers of that individual member state. So while we want a horizontal issue here in terms of patient mobility and our right to get treatment, either elective or emergency treatment in different countries, we've got to remember that the individual member states' Minister for Finance has the final say in all this. And that should sober us in terms of our ambitions in relation to this area.

I don't think we gave enough in questioning of Willy Palm who has a fascinating area: the whole insurance area. It differs enormously in every member state. We don't have generalised public insurance in Ireland at all. You have access to hospital care and for emergency but over 40% of Irish people have private medical care as well, which they have to. And that doesn't even guarantee you access unless you're an emergency.

We have a treatment purchase fund, which is how we've responded to mobility in Ireland, where the government spent in 2002 something like 6.5 million Euros sending 2000 patients abroad. The government! The system at home organised them to go abroad because they were too long on waiting lists for elective surgery in Ireland, for hips, and hearts, and eyes and everything else. So we sent 2000 abroad. If you like on these documents, you have the number of patients who elected to come to Ireland for treatment in the same period: 1.

And that's not because our medicine our medicine is bad. If you get into a bed in Ireland, you get superb medical treatment, but you could be waiting forever to get in unless you come in literally horizontal into a casualty or A&E and they have to put you in the bed and treat you. And that is clogging up A&E, people go to the GP's – we have the GP system...[...].

...I mean you can't get in the normal way, they land in at accident and emergency, clog that up – we have almost 400 people today on trolleys in our accident and emergencies in the Republic of Ireland as we speak, waiting to get into beds! People that the doctors in accident and emergency say aren't well enough to be sent home yet there aren't beds to follow through in. We've a huge crisis at A&E and bed crisis there. Just to see that choice, we would like choice in our own member state, but under our system your choice is you go to your local hospital and your local consultant unless you've got private and then you can go. But rather than encourage two-tier medicine to allow choice for everybody, not just the private patients, there isn't really choice – you take what you're offered or maybe will be able to go abroad to other countries. Enough mobility will drive change. That last contribution from Dr. Grewin from the CPME was very important: we only need a certain amount of mobility to drive change in the national member states' rollout of their health

services. And that is what is critical. We will embarrass them into delivering locally if there's sufficient demand for rooting elective surgery to go abroad.

And my final point, Mr. Chairman, there's a health tourism issue that I'm not sure we mentioned and that has been mentioned to me: that in some low cost economies where they actually have good medicine in certain and certain specialities, under what we are proposing now, there have been incentives for some countries to encourage patients from Ireland and the UK and France to come to them for treatment if it's going to be refunded at the levels of the country of origin. Because in some countries, at the moment, they provide surgery for one-third or one-quarter of the cost to their own nationals that you would get, let's say in Ireland. Now if they're going to be paid Irish prices for surgery in certain countries, say in Eastern Europe that I'm not going to mention, who have excellent medicine, there will be an incentive to encourage patients in from the UK and Ireland to operate on them, to get triple the cost from the UK and Irish government than they'd get for treating one of their own patients. Now that has not proved a problem in Belgium so far, that was touched on here by professor Baeten I know, but I can see that growing enormously. There will be a huge incentive for it.

Final point, if I may. We've a crisis in the provision of health professionals in Ireland and all over Europe, (this is coming down the track so fast) in doctors and nurses. In Ireland we've excellent medical schools and ten years ago, we had plenty of doctors – we exported them all over - the doctors. Now, because third level medicine is actually free if you're an Irish student coming out of school you can get into medical school free providing you attain a very high academic qualification. What the medical schools are doing, they're reserving half their places for non-nationals and non-Europeans charging them exorbitant fees to subvent the Irish student. As a result, we've cut down enormously the places for Irish students to get in. And hence we have a crisis in providing doctors and nurses from our own country. For economic reasons, which have nothing to do with good medicine or mobility of patients, we've got to look at the whole...provisions of health professionals which we haven't touched on today is a huge crisis coming down the tracks of the EU. Thank you.

John Bowis:

Thank you Avril. You've highlighted an extension of patient choice I haven't thought of: in Ireland obviously you can choose whether to share a bed with another patient. But that's um....

Philippe.

Philippe Harant: (Interpreter):

There is one point you've raised which is extremely important, that is patient mobility has been fairly low in numbers and flows so far. But we should remember that patient mobility must allow us to improve our systems. It will be a driving force, as you say, for improving our health systems and health care, but they should as you rightly said, it shouldn't remove the competence from the member state, it's a member state competence and investment must be made by the member states for their citizens. Patient mobility shouldn't lead to a long-term solution whereby we are exporting problems. We have to find solutions but we don't want to start exporting problems. Patient mobility should remain low enough not to start creating problems for some member states.

John Bowis:

This is going to have to be our last round of answers because we have to stick to times for our translators. Willy.

Willy Palm:

Just very quickly. Of course my statement about choice was a provocative statement, of course patients want choice, but it was more as an illustration that while there are very cultural differences and that joins the point of the variety of health systems where you're coming from a country where choice has been over time limited. And where in Belgium and I would also say in France, we are going towards a system where we think that perhaps patients have had too much choice and we are trying to put them in a more coordinated approach of health care. But I hear that in the UK, by

2008, 15% of the NHS care will be provided by private providers, so I don't see any reason why this 15% could also not be provided by foreign providers. So there, mobility is of course an issue.

The only thing, I think which is important to take into account is that while we have this variety of health system and today, if a patient goes abroad he puts himself through certain risks. He doesn't know the system where he's going to, he doesn't know the tariffs that will be applied, the reimbursement levels, he doesn't know the clinical practices, he doesn't speak the language. And even the competences that professionals have in countries are not harmonised so a nurse can do things that perhaps in Belgium a nurse cannot do. So this is a whole thing where there is no harmonisation at all and where we should take this into account. I also liked your point on the complementarity thing, because we are now speaking of coordination of statutory systems but we are nervous to speak about well, what comes next? The complementarity element, complementarity health insurances – they are not coordinated at all at the European level.

John Bowis:

Nick Fahy.

Nick Fahy:

Thank you Chairman. And on behalf of the Commission I just wanted to say thank you very much to you and to everyone else who we've heard today for the contributions on what has been an extremely helpful debate and an opportunity to listen to a wide range of opinions. We look forward to the Parliament's formal report on the communication, but this is already an enormous and wealth of experience and input which we will draw on and take into account in the follow-up to the communication and the work that we are going to be undertaking in the coming months and years. And I just wanted to recall very briefly the past and the future to this. Because even five years ago the concept of a Commission communication on patient mobility and a Parliament report on patient mobility, health care and all the other issues that we've raised today would have been impossible. And simply would not have been accepted. And so we should to that extent be very grateful to the court for having, in response to the request of citizens and to cases brought by citizens, have raised and forced the institutions at European level to address a set of issues relating to health care. And the fact that we are having these discussions now is in itself a huge step forward.

But we have another challenge coming in the next coming years and decades, we haven't mentioned it very much today, but it's the challenge of demographic ageing. And the imperative for European societies to find ways of maintaining growth and prosperity and maintaining their social values and social model over the coming 20, 30, 40 years when the dependency ratio of all the people on people of active age, will become a very serious challenge to all of us, and in particular the finance ministers that we heard mentioned earlier.

The issues that we've discussed today are part of the solution. The increase in choice, the driving up of quality, the improvements in raising best practices across the Union to the standards of the best – they offer the potential to bring improvements of the same kind of order of magnitude as the increases in dependency that demographic ageing will bring. And by maintaining people healthier and longer and enabling people to have better and higher quality health care, we keep more people active in society. So this is an important debate not just for justice (if that was a small thing) for patient mobility and for health care, but for our ability to maintain our social value and our social models in the coming decades. And I'm very grateful to you and to everyone else who has spoken for contributing to it. Thank you.

John Bowis:

Thanks very much Nick.

(Applause)

Well I think, we will close what I think has been an excellent morning. It's been an excellent morning firstly because of our speakers and contributors from the platform but secondly also because of the participation that you've brought today and it's an issue/debate which will continue.

We have our report which will go now through the Parliament, hopefully starting in committee next week, and then we look forward to the next stage which will come back from the high-level review group.

To refer to the point that Nick made about demographic ageing, that is something that we certainly have on board and it is our intention that we will have a hearing on that as a specific issue because that again is something too often we see as a problem, actually we should see it as an opportunity. But it needs careful consideration and management.

Thank you again. I've certainly taken away a number of issues which will need to be added to our report and our thinking in the Parliament not least on rare diseases, and tele-medicine and so on. There are many, many issues that have cropped up, many issues that will go on cropping up.

So, can I first and finally thank our interpreters from the twelve languages we've had around the room today. I'm very grateful to them for their contribution, hardly silent but sometimes unseen in the background through the glass. Also to our technician who managed to rescue us at an early stage when we could have had a major technical problem. To our staff from the Parliament and our own staff, my own staff, if I may thank them for helping to organise this. Magda in particular for working with us and putting it all together. And to her and to Robert Madelin, who is absent, to Dorjan, to Willy, to Bernhard, to Angela, to Robert, to Philippe, to Rita and to Isabel – it's a great team and thank you very much for coming.

(Applause)
