



EUROPEAN COMMISSION

**HIGH LEVEL PROCESS OF REFLECTION ON PATIENT MOBILITY AND HEALTHCARE
DEVELOPMENTS IN THE EUROPEAN UNION**

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HIGH LEVEL PROCESS OF REFLECTION ON PATIENT MOBILITY AND HEALTHCARE DEVELOPMENTS IN THE EUROPEAN UNION

Subject: Meeting of the high level process of reflection on patient mobility and healthcare developments in the EU, 3 February 2003 – minutes of the meeting

1. WELCOME AND INTRODUCTIONS

Commissioner Byrne welcomed participants to the first meeting of the high-level process of reflection on patient mobility and healthcare developments in the EU, including ministers and representatives of patients, healthcare providers, insurers and health professionals. A list of participants is attached.

2. APPROVAL OF THE DRAFT AGENDA

The draft agenda was agreed, with no additional items.

3. INTRODUCTION BY THE COMMISSION

Commissioner Byrne introduced the background to the high level reflection process, and his own focus on health issues. The Commissioner thanked all the Presidencies who had helped to move this subject forward. It was clear that health systems and health policies across the EU were more interconnected than in the past. This was due to a wide range of factors, including the impact of recent judgements of the European Court of Justice, but also shared culture and information technology allowing dissemination of medical technologies and information across borders. The lack of a common understanding at European level made it difficult to respond proactively to these pressures. Greater European collaboration could however be helpful. This did not mean changing the primary responsibility of Member States for their healthcare systems, but rather developing a shared vision to help to actively tackle these issues.

Commissioner Diamantopoulou focused on social security and social protection issues. There had been discussion within the Convention on these issues, with a consensus that though no new European competences were needed on social security, the means available needed to be strengthened. This included the open method of coordination, where there had been work on social exclusion and pensions, and there was now an ongoing exercise concerning health and long-term care for the elderly. The practical mechanism for coordinating social security systems, Regulation 1408/71, was also being simplified and modernised. On the health insurance card, the Commission was presenting a Communication; the card was not intended to create any new rights, but to simplify the use of existing rights and thus to facilitate mobility. It would be important to ensure appropriate links to these areas of work, and in general to the work of the Social Protection Committee, and to share information.

Commissioner Bolkestein said that European citizens did not understand why they could not take advantage of the internal market when it came to health services. This seemed unfortunate when some Member States had long waiting lists whilst others had spare capacity, and there was clearly growing public interest in this issue. The European Court of Justice had made clear that patients have the right to buy health goods or services in another Member State and be reimbursed. This had raised some concerns, but the Court had taken the specific circumstances of this area into account. In particular, the impact on the financial stability of systems should not be over-estimated, as Member States only had to reimburse where a patient would be reimbursed under their own national system, and at their own rate. The condition that ‘undue delay’ be determined exclusively on medical grounds had also caused concern, but Commissioner Bolkestein felt that the Court could not have reasonably come to any other conclusion. Member States were responsible for organising their health systems, so it was up to them to ensure compliance with the Court’s judgements, which should be done in a concerted and coherent manner. The Internal Market Directorate-General had launched a consultative process in July 2002, and would summarise all the contributions once they were received – the Commissioner called on those who had not yet replied to do so. These responses could form a valuable input to discussions in the reflection process.

In discussion of Commissioner Bolkestein’s introduction in particular, differing views were expressed. Some participants argued that the free movement of doctors and patients should constitute a fundamental right. Others felt that there was tension between individual rights and collective rights, and that patient mobility needed to be managed within a policy framework in order to also respect values of solidarity, equity and universal coverage, and to address practical issues such as the movement and distribution of medical professionals across Europe. These issues were also linked to wider discussion in the European Convention of the role of Europe in different aspects of health.

4. ISSUES TO ADDRESS

European cooperation to enable better use of resources

Introductions were made to this topic on the basis of the attached papers from the Danish, Swedish, French and Austrian ministers. These identified issues relating to the following topics: sharing spare capacity and cross-border care, including how far there would be European added value over bilateral arrangements, information issues and related legal questions; centres of excellence, evaluation of health technology; cross-border cooperation; and fundamental rights. The Italian Minister underlined the importance of quality aspects to cooperation; in considering centres of excellence, it would be important to understand clearly what excellence constituted. The Irish Minister emphasised that the possible agenda for work was broad, and priority should be given to what could practically be achieved during the coming year. Other points made in discussion included:

- economic aspects also needed to be taken into consideration, in terms of the financial impact for individual patients and on systems overall;
- rare diseases could be another area for work under this topic, as could cross-border threats to health;

- cooperation on specialist activities should be distinguished from movement linked to scarcity of provision or allocation of resources;
- 'centres of reference' might be a more appropriate term than 'centres of excellence', to ensure that the focus was on health needs and possibilities, rather than competition for the status of 'excellence';
- it was important to recognise that the vast majority of patients were and would continue to be cared for in their own countries, and indeed near their own homes; European collaborative measures should therefore not be disproportionate.

Information requirements for patients, professionals and policy-makers

This topic was introduced on the basis of the attached note from the Finnish Minister, outlining issues related to information including possibilities of cross-border treatment, treatment comparisons, comparable nomenclature, and e-health that could be taken forward by the working group. In discussion, the following points were made:

- it would be important to consider what information was necessary to ensure continuity of care in the context of patient mobility, for both short-term and long-term stays in other Member States. It was also important to consider the orientations and objectivity of information from different sources, and how information could be compared;
- issues concerning medical confidentiality should also be addressed to facilitate appropriate information exchange for European cooperation;
- information also needed to be shared on different policies in different Member States, as there were some important differences (including on start- and end-of-life issues, raised by the French Minister in particular);
- economic aspects were also important on this issue, as was the question of patient rights;
- free movement of doctors was also an important issue, both for professionals wishing to move between Member States and for planning of overall provision.

Access to and quality of care

This topic was introduced on the basis of a paper from the UK Minister and agreed with the rest of the working group. This paper focused particularly on quality aspects, describing a quality framework and identifying possible European issues, while stressing the need to be proportionate when considering what was needed at European level. It proposed information-gathering on cross-border patient flows and quality assurance in Member States. Through his personal representative, the Greek Minister emphasised the importance of these topics, which would be addressed more extensively at a Greek Presidency conference in Patras at the start of May. In discussion, the following points were made:

- it was important to consider both what patients sought and what was cost-effective;
- on access issues, a European medical card could be a long-term project to enable access to healthcare throughout the Union.

Reconciling national health policy with European obligations

This topic was introduced by the Belgian Minister on the basis of the attached paper. This identified issues in four areas: protecting common goals of equity, universality and solidarity, a horizontal approach of taking health into account in relevant processes, guaranteeing legal certainty, and institutional needs, though focusing in particular on ensuring legal certainty and clarification of competence. In discussion, the following points were made:

- this topic was linked to the European Convention, where there had been discussion in working group XI "Social Europe" on including health as an objective of the Community and of extending article 152 (though not to healthcare). Members of the reflection process could draw on any emerging consensus in making their contributions to the European Convention through the normal channels.
- There was also a link to the Court's jurisprudence. It could be useful to establish some principles and to define key concepts and terms to help guide the Court on this area in the future;
- it was important to address these issues, despite the sensitivities in doing so. Some participants considered that there was a case for extending the abilities of the Union to tackle major public health issues that transcended borders, such as tobacco control and communicable diseases.
- Member States must however be free to determine how healthcare systems work for their citizens, notwithstanding the principles of the single market. It was essential to ensure the sustainability cohesion and integrity of national systems on the basis of the shared values of solidarity, universality and equity, and to facilitate cooperation between states where useful to support this.
- the work undertaken by the Social Protection Committee in the context of the open co-ordination method had proved a valuable way of tackling issues where there was a need to find a balance between free movement and these shared values, and this approach could be extended to further areas in the health field.
- After discussion, it was agreed that this theme should be taken forward by establishing a working group, which would focus in particular on the issues covered in the "guaranteeing legal certainty" section of the Belgian paper. The group should represent the different kinds of health system, and it was agreed that it should consist of representatives from Belgium, the Netherlands, Finland, the UK and France, plus representatives of purchasers, patients and providers. It was emphasised, however, that it was essential that the other representatives should be able to make an input directly to this group through written contributions, as well as (as with all groups) in 'plenary' discussions of all participants in the reflection process. As a first step it was agreed to distribute a questionnaire developed by Belgium which set out key issues to be considered.

5. WORKING METHODS AND PROCESS

Commissioner Byrne outlined working methods for the reflection process. These were agreed as follows:

- the reflection process should conclude by the end of 2003, with a meeting before the summer (June/July) and at the end of the year (November/December).
- on other participants, representatives of candidate countries would also be invited to take part , as well as a Member of the European Parliament (Mr Byrne would follow this up);
- information would be made available to those not participating, including regular updates to the Council.
- The work of the process should be transparent and therefore information about it should be publicly available, including the subjects discussed and the participants. However, the views expressed by individuals should remain confidential.
- On future events, the Italian Minister informed participants of a ministerial meeting under the Italian Presidency on 5-6 September, part of this meeting could address the area of access and quality. Other participants were also invited to consider what events or other inputs could contribute to the reflection process.

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