AK EUROPA

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AK Position Paper

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

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About us

The Federal Chamber of Labour is by law representing the interests of about 3.2 million employees and consumers in Austria. It acts for the interests of its members in fields of social-, educational-, economical-, and consumer issues both on the national and on the EU-level in Brussels. Furthermore the Austrian Federal Chamber of Labour is a part of the Austrian social partnership.

The AK EUROPA office in Brussels was established in 1991 to bring forward the interests of all its members directly vis-à-vis the European Institutions.

Organisation and Tasks of the Austrian Federal Chamber of Labour

The Austrian Federal Chamber of Labour is the umbrella organisation of the nine regional Chambers of Labour in Austria, which have together the statutory mandate to represent the interests of their members.

The Chambers of Labour provide their members a broad range of services, including for instance advice on matters of labour law, consumer rights, social insurance and educational matters.

More than three quarters of the 2 million member-consultations carried out each year concern labour-, social insurance- and insolvency law. Furthermore the Austrian Federal Chamber of Labour makes use of its vested right to state its opinion in the legislation process of the European Union and in Austria in order to shape the interests of the employees and consumers towards the legislator.

All Austrian employees are subject to compulsory membership. The member fee is determined by law and is amounting to 0.5% of the members' gross wages or salaries (up to the social security payroll tax cap maximum). 560.000 - amongst others unemployed, persons on maternity (paternity) leave, community- and military service - of the 3.2 million members are exempt from subscription payment, but are entitled to all services provided by the Austrian Federal Chambers of Labor.

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President

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Director

Executive Summary

The Federal Chamber of Labour (AK) would like to state its position on the draft for a Directive on cross-border healthcare within the EU:

The planned Directive pursues the aim of codifying ECJ case-law on cross-border healthcare. If the EU Member States were to adopt this Directive, they would not only be obliged as is the case at present to take into account ECJ case-law, they would also have to implement the Directive in the form of codified national law. Transparency of the legal situation effected by such national legislation in all EU Member States could lead to a sharp increase in the cross-border utilisation of healthcare, which is currently more of a minor phenomenon. However, a strong increase in patient flows could lead to unwelcome condemnation of health policies between Member States. The AK in no way declares itself against the right of patients to seek healthcare throughout the EU; however, if this freedom to receive such services is crucial, we must ensure:

- That it leads neither to one-sided cost burdens for Member States
- Nor that national healthcare or the national services offered on which this healthcare is based suffer from the fact that patients request healthcare abroad in droves.

To avoid such developments, the AK believes that the Member States should therefore not only be authorised, as provided for in the draft, to provide for prior authorisation as a prerequisite for the refunding of costs if the financial balance of the health system or healthcare is seriously undermined due to the consequent outflow of patients – they should also be authorised to charge the full costs of the respective healthcare service to visiting patients (or to their social security systems) in order to prevent unjustified shifts in costs.

The rules on cross-border healthcare in the narrow sense constitute the main area of the planned Directive. However, the importance of the points in the draft summarised under "Cooperation on healthcare" should also not be underestimated. The AK supports the establishment of European reference networks and a European network on health technology assessment (HTA). It considers these provisions as well as rules on quality assurance to be important and forward-looking.

The AK position in detail

The AK welcomes the greater transparency for patients, but underlines that national and institutional interests have to be considered.

This Directive plans to codify ECJ case-law on cross-border healthcare. We therefore need to examine whether the draft has considered all key aspects of previous case-law and has assumed the legal position created by the ECJ.

Irrespective of the Directive, Art 22 Para 2 of Regulation (EC) No 1408/71 stipulates that a Member State must grant authorisation for treatment abroad where treatment cannot be given within the time normally necessary for obtaining the treatment in question. In this case, the insured person receives full reimbursement of costs. The Directive will not change anything here.

In its case-law on cross-border healthcare, which is now extensive, the ECJ relies on the freedom to provide services as laid down in the EC Treaty. Accordingly, patients can also receive health services within the EU without the need for authorisation from their health insurance. They need to prefinance these services and will receive a refund of the costs that these healthcare providers would have reimbursed at home from their health insurance fund, provided these services are contained in the list of services. The Directive will adopt this case-law in full.

In the case Geraets-Smits/Peerbooms (ECR 2001, I-05473), the ECJ uses Art 59 and 60 EC Treaty as the basis for enabling patients without authorisation from the relevant health insurance fund to also receive health services abroad that are not (yet) offered at home, yet are of an "international medical standard". In this case, the costs do not need to be refunded in full, only to the extent that they are also provided for in the concrete draft.

If the regulations provided for in the Directive on cross-border healthcare are summarised and compared with the prevailing legal situation (Regulation No 1408/71 and ECJ case-law since 2000), it is hard to discern a deterioration or an improvement for insured persons. However, for reasons of clarification it would be reasonable to also include the right to treatment/reimbursement resulting from the case Geraets-Smits/Peerbooms in the Directive.

The AK welcomes in principle the greater transparency that should arise for patients through implementation of the concrete draft directive. However, if we also look at cross-border healthcare from the viewpoint of the healthcare and social security systems of the Member States, national and institutional interests in transferring patients to other Member States cannot be ignored at the outset. It would then be possible for healthcare providers to try to save high hospital costs by reduc-

ing their own treatment capacities and "sending" patients abroad.

In the light of this, the AK endorses the following approach in the draft for a directive: as long as the financial equilibrium of the social security system and adequate care with hospital services at home is ensured, the Member States should be bound by the above-mentioned cost reimbursement rules. On the other hand, if the financial balance of the health system and/or healthcare of a Member State with hospital services is in danger of being "seriously undermined" due to the consequent outflow of patients, the Member States concerned have the possibility to introduce prior authorisation for cost reimbursement. However, Member States experiencing a sharp increase in patient numbers must also be given the right to be able to insert a proviso on the refusal of treatment. For all that, the Member States must above all be able to charge the actual full costs of services to the systems where the patients come from. From an Austrian perspective in particular, this is important because hospital treatments here are financed in part by social security contributions and tax revenue. If only the social security rates were charged to a large number of visiting patients, the strain on Member States whose insufficient healthcare service might pressurise patients into requesting Austrian services would be unduly eased by Austrian tax payers.

As yet, there has been no "health tourism" worth mentioning. One reason for this is that we do not anticipate larger patient movements from the new EU Member States for economic reasons (pre-financing of services, low cost refund). We cannot predict whether this will also apply to Member States with comparatively high costs in future. In the process, it is also not least to do with the question of whether the social security providers or health authorities can order patients virtually to go abroad for treatment. This Directive will in any case not alter the prevailing legal situation.

Against this purely financial calculation as a motive for individual Member States, it should be objected in principle that insured persons will hardly accept a health system that cannot guarantee hospital care as close to their place of residence as possible and in their own country (language barriers). It is therefore rather unlikely that individual Member States – against the loyalty obligation of EU countries in accordance with Art 10 EC Treaty – will deliberately ("improperly") curtail their healthcare capacities in order to present the insured persons with a fait accompli. However, it is hard to predict for certain what developments will arise as a result of widespread transparency in the legal situation regarding cross-border healthcare.

Member States with excellent healthcare in principle like Austria must at any rate – as called for above – be able to protect themselves against patient flows arising from healthcare shortages in other countries leading to healthcare bottlenecks for its own

The AK asks for regulations to protect its own population against patient flows from other countries leading to healthcare bottlenecks.

population. One consequence of such a scenario might be that paradoxically a Member State affected in such a way tries to create healthcare possibilities in neighbouring Member States for its own population. Another possibility in order to compensate for undercapacity affecting natives could be a push towards privatisation in the hospital sector, which has seen fears of a "brain drain" of hospital staff from public to private hospitals. On the other hand, voluntary cooperations between Member States, in particular in areas near the border, are conceivable in order to achieve synergies through optimum distribution of work.

However, in order to use such synergies – also in terms of a genuine transparency gain for patients (and not only a small, privileged, well-informed section of the population), corresponding information systems on the respective treatment costs and respective cost reimbursement systems need to be created in the social security systems and national health systems.

The AK notes the following on the individual formulations:

In **Art 3 of the draft**, it should be made clear that besides the Directive there should also always be the possibility to apply for authorisations in accordance with Art 22 of Regulation No 1408/71. Para 2 should be deleted – in its place, a lit g should be included in Para 1 in which reference is made explicitly to Regulation No 1408/71 in order to make it clear that the Regulation still fully applies.

Article 4 lit a of the draft defines the term "healthcare" as services provided by a health professional in exercise of his profession. According to the second sentence of recital (9) of the proposed Directive, as regards long-term care the Directive does not apply to assistance and support for families and individuals who are, over an extended period of time, in a particular state of need. According to the third sentence of recital (9), the Directive does not apply, for example, to residential homes or housing, or assistance provided to elderly people or children by social workers or volunteer carers or professionals other than health professionals. The Directive therefore differentiates between health services (within the meaning of Directive 2005/36/EC) and social services. In connection with this, we should take into consideration the fact that Regulation No 1408/71 also covers services from nursing services in the ECJ's opinion (see case Molenaar, ECR 1998, I-843). As the draft also adopts the substantive scope of Regulation No 1408/71 in Art 4 lit g, there is a discrepancy between Art 4 lit d (definition: health professionals) and Art 4 lit g and i, which defines the term "insured person". However, this discrepancy loses in importance because the Regulation states that for a longer stay in a Member State the right of this country is applied anyway.

It is unclear what the passage "under the supervision" in Art 4 lit a is supposed to mean.

In **Art 4 lit b of the draft**, the term "insured" is used. This term occurs in sev-

The AK supports the quality assurance measures and obligations of Art 5 of the draft and stands up for the introduction of minimum standards.

eral passages of the draft (for example in Art 4 lit h or in Art 6 Para 1), although it gives the impression that only countries with social security systems are covered by the Directive. This applies above all to Art 6 Para 1, where the system of cost reimbursement should apparently hold exclusively for "social security systems", even though the majority of Member States in the meantime ensure medical treatment not via social security systems, but via public health systems. If we interpret this literally, it could be insinuated that the cost reimbursement rule in the Directive does not apply to public health systems. Whilst Art 4 lit g of the draft provides some clarification by referring to Art 1 of Regulation No 1408/71 (personal scope) for the legal definition of the term "insured person", whereby persons are regarded as "insured" that are "compulsorily insured" against social risks in the social security system, a more abstract formulation (like in Art 4 lit h) should be chosen for reasons of legal certainty and comprehensibility. The Regulation cited is known to not differentiate between social insurance systems, national health services or the new "insurance obligation" (in the Netherlands).

The definition of "health professionals" in **Art 4 lit d of the draft** should be reconsidered. In an appendix, it should be made possible for countries, besides the regulated professionals cited in Directive 2005/36/EC, to also recognise other qualified health professions which the Directive may be applied to.

Problematic is the fact that Regulation No 1408/71 referred to in Art 4 lit g only includes in its scope citizens and not also third-country nationals "insured" in the Member States in the Directive.

The AK supports the objectives of **Art 5 of the draft**: it involves quality assurance measures and obligations whenever harm is caused to patients by healthcare providers. The Member States therefore need to adopt "clear quality and safety standards" on their territory and ensure that these are also monitored, that professional liability insurance is introduced and that patients have the means of making complaints if there are mistakes in treatment. Commission guidelines should make it easier for Member States to implement these measures, and the AK believes that these guidelines should set minimum standards. The AK also advocates incorporating "patient insurance irrespective of the party at fault" in Art 5 Para 1 lit e. On the issue of quality assurance, the AK invites the Commission to present its ideas on this subject. These could provide new impetus for a European discourse on quality assurance in healthcare among providers.

According to Art 5 and recital 34 of the draft, patients should be provided with key medical and above all financial information relevant to the healthcare. As regards hospital care, the question arises of what price patients from Member States should be charged for treatment. If they are insured persons within the meaning of Art 4 lit g

receiving services in the Member State of treatment, only prices that also hold for those insured at home can be prescribed. Accordingly, in Austria the full costs ("Oil sheikh rate") cannot be charged, only the standard costs of service-oriented hospital financing in Austria – converted into absolute amounts – which consist in any case of resources from the respective health fund and deficit coverage. However, we should take into consideration the fact that Austrian insured persons also pay taxes besides their health insurance contributions, which are also used among other things to cover the investment costs of hospitals. Making foreign patients only pay for the operating costs and not the investment costs would therefore contravene the principle of cost transparency and fairness.

It is also unclear the amount that an Austrian insurance institution should pay patients for hospital services in another Member State. Is it the standard full costs mentioned, an amount equivalent to the nursing fee allowance in accordance with § 150 ASVG (Act on General Social Insurance) or other reference values?

Article 6 Para 3 of the draft authorises Member States to impose on a patient seeking healthcare in another Member State the same conditions for receiving these services as in its territory provided these are not discriminatory or hinder cross-border healthcare. Conversely, according to Art 11 Para 1 of the draft healthcare should always be provided according to the legislation of the Member State of treatment. These two provisions seem to indicate that the national restrictions of both Member States affect a patient seeking cross-border healthcare.

Article 8 of the draft regulates hospital and specialised care in hospitals. According to the draft for a directive, an individual Member State can only introduce a system of prior authorisation for reimbursement by its social security system of the cost of hospital care provided in another Member State in an extremely restricted way. It is only permissible to introduce such a system of prior authorisation if the health system affected is seriously undermined due to this "outflow". The fact that far greater protection of the healthcare services offered and protection against the unjustified shift in costs to the detriment of well equipped health systems is needed has already been outlined in detailed above. To clarify again: it would be completely unacceptable from a social policy perspective for example if a Member State chronically underendows parts of its healthcare, keeping social security contributions or other financing elements low in order to lure investors (low taxes, low ancillary wage costs) to its country, and "gets rid of" the nascent treatment bottlenecks by moving patients to well equipped, expensive health systems. Even more controversial is the problem with sophisticated treatments, where there are already waiting lists for domestic patients. These healthcare bottlenecks should not be exacerbated by providing visiting patients with unlimited access.

The AK proposes only to oblige social security institutions to reimburse costs for prescriptions from another Member State if these costs also need to be borne by the social security system in the Member State of affiliation.

The draft for a directive regulates in Art 14 the recognition of prescriptions for medicinal products authorised in the Member States concerned. Accordingly, any prescription issued in another Member State, provided Art 71 Para 2 of Directive 2001/83/EC on the creation of a Community code does not state the opposite, can be used in the Member State of affiliation. With such prescriptions, no consideration should be shown for the national code of reimbursement in accordance with recital 39 (although not according to the draft text!). As this leads to discrimination in any case of insured persons that only have a domestic prescription for medicinal products, the AK proposes changing the draft so that the social security institutions are only obliged to reimburse costs for prescriptions from another Member State if these costs also need to be borne by the social security system in the Member State of affiliation (e.g. as part of a reimbursement code or a positive list). What is more, a contrary practice would also contravene Art 11 of the draft.

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