

**House of Lords Select Committee on the European Union  
Inquiry into the European Commission's proposed directive on the application of  
patients' rights in cross-border healthcare**

**RCN Submission**

**1.0 Introduction**

**1.1** The RCN welcomes the proposed introduction of a clear legal framework for the application of patients' rights in cross-border healthcare in the European Union. The right to access care in another EU country already exists under EC regulation 1408/71<sup>1</sup> on the application of social security schemes and under Article 49 of the EC treaty on free movement and access to services and the subsequent interpretations of these provisions by the European Court of Justice (ECJ)<sup>2</sup>.

**1.2** However, given that the application of these rights has been largely determined by individual court rulings, this has created a piecemeal approach, a lack of clarity for patients and professionals, and an absence of agreed EU systems to ensure safe cross border care.

**1.3** For this reason the RCN believes that the objective of the EU's proposed directive should be to:

**1.4** Clarify existing rights and ensure these are easily understood, equitable, and enhance patient care,

**1.5** Ensure they do not undermine domestic provision and financing of health services,

**1.6** Ensure that patients have access to appropriate information in deciding whether to seek treatment in another EU country,

**1.7** Provide clarity on which country is responsible for the quality and safety of care and redress if anything goes wrong.

**2.0 Introduction**

**2.1** With a membership of over 390,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional

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<sup>1</sup> Council Regulation (EEC) No 1408/71, 14 June 1971 on the application of social security schemes

<sup>2</sup> In particular cases C-158/96 *Kohll* [1998], C-120/95 *Decker* [1998], C-368/98 *Vanbraekel* [2001], C-157/99 *Smits and Peerbooms* [2001], C-372/04 *Watts* [2006]

union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. The RCN welcomes the opportunity to contribute to the House of Lords Select Committee on the European Union Inquiry in the European Commission's proposed directive on the application of patients' rights in cross-border healthcare.

### **3.0 Patient Mobility**

- 3.1** There is very limited data on cross border care in the EU, but the European Commission's impact assessment estimates it accounts for about 1% of public health expenditure in the EU (including emergency treatment whilst temporarily in another EU country).<sup>3</sup> The level of cross border care also varies across Europe with much taking place in border regions.
- 3.2** About four per cent of those surveyed in the European Commission's Eurobarometer survey of 2007 had received care in another country in the last twelve months and 54% of those questioned would be open to travel to another EU country for treatment, particularly if a treatment were unavailable at home.<sup>4</sup>
- 3.3** Nevertheless, UK surveys have shown that patients would prefer to receive high quality care close to home and choice over treatment options rather than location of care. Whilst hospital infection rates and waiting times were important, communication with staff, ease of access and transport concerns were a priority for a majority of patients in a recent NHS Choices survey<sup>5</sup>. That same survey also suggests that people were broadly happy with the hospital they went to, whether they'd had a choice over a different location of care or not. So it is important that any EU legal framework does not undermine member states ability to provide these services locally to their population.
- 3.4** A recent report on *Assuring the Quality of Healthcare in the European Union*<sup>6</sup> identified a range of reasons why patients seek treatment in another EU country. In some cases they may already be abroad (eg on holiday, retired) in others they travel to another EU country explicitly to seek treatment (eg for convenience when living in a border region, being sent for specialist treatment by their home system, on a patient's own initiative). The report also provides some evidence from surveys of patients who have experienced cross-border care and how they

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<sup>3</sup> Impact Assessment: Directive on the application of patients' rights in cross border health care SEC(2008)2163, 2 July 2008

<sup>4</sup> Flash Eurobarometer Survey #210, 2007, Cross border health services in the EU; Analytical Report

<sup>5</sup> Dept Health (2008) 'Report of the National Patient Choice Survey, England'

<sup>6</sup> Assuring the Quality of Health Care in the European Union. A Case for Action, Helena Legido-Quigley et al, World Health Organisation 2008 pp42-50

rated the quality of that experience. These include patients from the London Patient Choice Project who were sent to five hospitals in Belgium (2003-2004).<sup>7</sup> Most were very satisfied with their care but there were a number of challenges – including linguistic/socio-cultural barriers, and issues relating to distance, travel, and continuity of care. It should be noted that most of the cross border care studied was planned and in some cases there were detailed contracts between providers.

#### **4.0 The Proposed Directive**

**4.1** Under the proposed directive, member states will need to define clear quality and safety standards and monitoring systems to ensure that health care providers monitor and meet these standards. The RCN strongly supports the introduction of this framework and the clarification in the proposed legislation that requirements in relation to quality, safety and liability applied to cross border care should be those of the country where the treatment occurs, not the home country. This gives clarity to patients and means that any treatment received in the UK follows UK regulatory requirements.

**4.2** The RCN also welcomes the proposals in the directive to introduce supporting measures through “national contact points” to ensure that patients have access to information on how to navigate the system, on care provided, cost and outcomes. It is important that this information, as with any health information, is reliable, comparable and adapted to the users, particularly as there may be commercial interests from some health care providers in attracting patients.

**4.4** The proposals do not refer explicitly to the information needs of health professionals. These need to be considered given health professionals’ roles in advising patients, and assisting in interpreting information.

#### **5.5 Authorisation and Payment**

**5.1** The draft directive confirms previous Court of Justice rulings that patients should be able to access outpatient care in another member state and seek reimbursement for these costs. It also proposes that generally patients should be able to seek hospital care without prior authorization. The proposals do not affect a health system’s right to apply conditions for access to health care such as needing to be referred through General Practice for specialist treatment. This is an important principle for the UK, which the RCN would wish to see maintained.

**5.2** The RCN supports the requirement for countries to have transparent systems and time limits for responding where prior authorisation is sought - this is particularly important if the motivation for seeking treatment abroad is “undue delay” when the patient may be experiencing significant pain and discomfort.

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<sup>7</sup> See above pp 70-72

- 5.3** As long as there are clear and transparent decision making processes and reasonable justification, the directive should allow for some variations in what is funded amongst different localities and countries of the UK, to reflect local priority setting.
- 5.4** It is unclear whether the current proposals allow countries to introduce a general requirement for prior authorization for non-urgent hospital care, or whether it needs to be on a case by case basis, if funders have concerns about the outflow of patients causing a serious risk to financing and planning of services.
- 5.5** The RCN is concerned about a system where patients pay up front for hospital care and then seek reimbursement which is likely to involve significant initial costs for the patient. This could discriminate against patients with limited resources. The RCN would argue that in cases where prior authorisation is sought for treatment there should be a direct transfer of payments between funders and this should be made explicit in the proposal.
- 5.6** The RCN agrees that in the majority of cases reimbursement should be provided up to the level of the costs of that care under the home health system. We believe that patients seeking treatment outside the UK by choice should not expect to place an added financial burden on the NHS. In any case the current system (under EC regulation 1408/71) remains in place whereby a home health system can decide to pay the full costs, where it has decided that it is better to treat a patient in another country.

## **6.0 Other Practical Implications in the UK**

### **7.1 Top up Funding**

- 7.2** Since patients from the UK choosing to seek treatment in another EU country would only be reimbursed up to the cost of the treatment at home, the UK will need to be clear about whether a patient receiving funding from the NHS can make top-up payments, without forfeiting their NHS funding:
- 7.3** to cover the added cost of similar treatment in another country,
- 7.4** to cover additional treatment/aftercare,
- 7.5** or to cover drugs for which the patient has a prescription, authorised by a clinician in another member state, but which would not normally be covered by the local funder in the UK
- 7.6** Currently the position is that a UK citizen cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS

organisation<sup>8</sup>. In other words, if a patient chooses to top up NHS care with private payments for treatment then they would also have to pay for all NHS treatment related to that diagnosis – this can inflate costs from around £2000 for a course of treatment to around £20,000 for full package of care<sup>9</sup>. There are several specialist drugs that are widely used in other parts of the EU, particularly in cancer care but which are not approved by NICE for use in the NHS. This has caused the public considerable concern and in response a review was led by Prof Richards on the use and impact of top up payments in NHS cancer care<sup>10</sup>.

**7.7** In its response the RCN has argued that top up payments per se create gross inequalities in care provision and may even divert resources from a state funded patient to a private payer. However we have great sympathy for the sense of inequity that some UK patients express where they could easily get life prolonging therapy in other parts of the EU but not in England. We believe that attention should be on the authorisation processes for NHS funded care and not on the development of another layer of complexity for patients to navigate.

## **8.0 Costing treatments and measuring outcomes**

**8.1** The proposed directive will require member states to have a mechanism for calculating costs to be reimbursed that should be based on objective, non-discriminatory criteria known in advance. Given that some aspects of the treatment may be provided in another country, and aftercare provided on the patient's return to the UK, funders will need to be able to clearly identify the costs of different elements of care.

**8.2** Currently, NHS England uses Healthcare Resource Groups to quantify and allocate resources to episodes of care, but there are different funding approaches in Wales, Scotland and Northern Ireland. The NHS England activity based payment system, Payment by Results (PbR), uses a fixed price tariff weighted for case mix but only in the main with hospital based activity although there are plans for a tariff for community and mental health care.

**8.3** Whilst we recognise that internationally many health systems use 'casemix adjusted' payment methods to fund hospital activity, they are all distinctly different and each operates within different allocation and commissioning systems. Great care will be needed to ensure that costs comparisons are being made on a like for like basis.

**8.4** Recently, Government has announced plans to tie payments more closely to quality outcomes<sup>11</sup>. It would be important to consider the impact of mobility on

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<sup>8</sup> Dept of Health (2004) 'A code of conduct for private practice: recommended standards of practice for NHS consultants'

<sup>9</sup> RCN (2008) 'Response to the Review of Private Prescriptions in NHS Cancer Care'

<sup>10</sup> Ibid

<sup>11</sup> Dept of Health (2008) 'High Quality Care For All: NHS Next Stage Review - Final Report', p41

this initiative and ensure that commissioners have access to comparable information on quality and outcome measures, particularly patient satisfaction measures.

## **9.0 EU Cooperation on Healthcare**

**9.1** The RCN supports moves to strengthen cooperation in the EU on health technology assessment and the continuing development of centres of reference/excellence.

**9.2** The RCN also welcomes proposals for a system of mutual recognition of prescriptions which recognises the prescribing roles of a range of health professionals. In a number of member states<sup>12</sup> nurses now have prescribing powers and any new e-prescription system needs to recognize this.

**9.3** E-health interoperability, particularly in relation to patient records, will have a significant impact on ensuring safety and continuity of care from referral, to treatment, after care and recovery. This means focusing on safe communication to support safe care, rather than prioritizing data standards, as outlined in the RCN's recent policy statement on electronic patient records.<sup>13</sup>

**9.4** Work to improve e-health interoperability will also need to address any language barriers to clinicians and patients accessing and communicating information relating to patient data as these will not be resolved solely through technical standards.

**9.5** Finally the proposed directive enshrines in EU law for the first time the overarching values (eg solidarity, universality, equity) and operating principles (quality, safety, patient involvement) for health services agreed by health ministers in 2006<sup>14</sup>. It is unclear what this will mean for the long term in relation to future EU initiatives on health service provision or the potential challenges to national regulatory and standard setting systems at EU level, particularly within the European Court of Justice, which has played such a key role to date in clarifying patients' rights in cross border care.

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<sup>12</sup> Includes UK, Ireland, Sweden, Spain, Netherlands

<sup>13</sup> RCN e-Health Programme, Policy Statement: Nursing content of electronic patient/client records, June 2008 [http://www.rcn.org.uk/\\_\\_data/assets/pdf\\_file/0010/176860/ndc\\_Briefing\\_June\\_08.pdf](http://www.rcn.org.uk/__data/assets/pdf_file/0010/176860/ndc_Briefing_June_08.pdf)

<sup>14</sup> Council of European Union, Council conclusions on common values and principles in EU health systems, 1-2 June 2006