Royal College of Nursing

RCN INTERNATIONAL DEPARTMENT

RCN Comments on the EU Proposals on Patients' Rights to Cross-Border Care[1]

Introduction

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 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 European Commission's initiative to provide a clear legal framework for the application of patients' rights in cross-border health care in the European Union. It is an important opportunity to clarify existing rights and ensure these are easily understood, equitable, and enhance patient care. This includes ensuring that patients have access to appropriate information in deciding whether to seek treatment in another EU country, and providing clarity on which country is responsible for the quality and safety of care and redress if anything goes wrong.

The RCN is concerned that a system for accessing cross-border care, particularly hospital care, based on payment up front and reimbursement will increase inequalities as many people will not have the means to pay for expensive hospital or specialist treatment first and then claim back later. There are also a number of challenges to be addressed in relation to continuity of care, including interoperability of e-health and communications between patients and professionals across borders.

Any cross-border arrangements, which make up a very small percentage of health care in Europe, should not undermine domestic provision and financing of health care. 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[2].

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[1] These comments also formed part of the RCN's submission to the 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, September 2008

[2] Dept Health (2008) 'Report of the National Patient Choice Survey, England'

That same survey also suggests that people were broadly happy with the hospital they went to, whether they 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.

Authorisation and Payment

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 authorisation. 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.

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.

As long as there are clear and transparent decision-making processes and reasonable justification, the directive should allow for variations in what is funded amongst different localities and countries of the UK, to reflect local priority setting.

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.

The directive needs to be clearer on when prior authorisation can and cannot be made a requirement by funding authorities for an individual seeking treatment in another country, based on the argument that the outflow of patients could cause a serious risk to financing and planning services. It is unclear whether the current proposals allow countries to introduce a general requirement for prior authorisation for hospital care, or whether it needs to be on a case by case basis.

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 parallel system (under EC regulation 1408/71) remains in place whereby a home health system can decide to pay the full costs of a treatment, where it has decided that it is better to treat a patient in another country.

Patient Safety and Patient Information

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.

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.

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.

Specific Implications for the UK

Top-Up Payments

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:

- to cover the added cost of similar treatment in another country,
- to cover additional treatment/aftercare,
- 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

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[3]. 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[4]. 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 Professor Richards on the use and impact of top-up payments in NHS cancer care[5].

In its response the RCN has argued that top-up payments 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

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[3] Dept of Health (2004) '*A code of conduct for private practice: recommended standards of practice for NHS consultants*'
[4] RCN (2008) '*Response to the Review of Private Prescriptions in NHS Cancer Care*'
[5] *Top Up Payments and NHS Funded Cancer Care - An RCN response to the review of the consequences of additional private drugs for NHS care*, August 2008

funded care and not on the development of another layer of complexity for patients to navigate.

Costing Treatments and Measuring Outcomes

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.

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. Whilst we recognise that internationally, many health systems use 'case mix 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.

Recently, Government has announced plans to tie payments more closely to quality outcomes[6]. It would be important to consider the impact of mobility on this initiative and ensure that commissioners have access to comparable information on quality and outcome measures, particularly patient satisfaction measures.

EU Cooperation in Health Care

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

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[7] nurses now have prescribing powers and any new e-prescription system needs to recognise this.

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 prioritising data standards, as outlined in the RCN's recent policy statement on electronic patient records .[8]

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[6] Dept of Health (2008) '*High Quality Care For All: NHS Next Stage Review - Final Report*', p41

[7] Includes UK, Ireland, Sweden, Spain, Netherlands

[8] RCN e-Health Programme, Policy Statement: Nursing content of electrnic patient/client records, June 2008
http://www.rcn.org.uk/__data/assets/pdf_file/0010/176860/ndc_Briefing_June_08.pdf

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.

Finally the proposed Directive enshrines in EU law for the first time the overarching values (for example solidarity, universality, equity) and operating principles (quality, safety, patient involvement) for health services agreed by health ministers in 2006[9], which member states are expected to apply. 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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[9] Council of European Union, Council conclusions on common values and principles in EU health systems, 1-2 June 2006