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Editorials

Cross border health care in Europe

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European Commission proposals provide legal clarity and more information for patients

This week the European Commission publishes its long delayed proposals for how citizens of the European Union should obtain health care in other member states. These proposals will be considered by the European Parliament and governments of the member states.¹ The proposals build on a process involving health ministries and other stakeholders that began in 2003.

Current arrangements for cross border health care were established in the 1970s, when it became clear that free movement within Europe would require that people could receive health care when abroad. It was also recognised that people might need to be sent abroad for treatment, but that this should be controlled by the organisations paying for the care.²

The number of people crossing European borders has increased exponentially.³ A new generation of Europeans sees national frontiers as increasingly irrelevant. Some of them have challenged what they see as unjustifiable restrictions on their right to obtain health care in another country and, in many cases, their arguments have been upheld by the European Court of Justice.⁴ This has resulted in a legislative framework regulating cross border care that is full of holes created by legal precedents, but with little clarity about what those precedents mean in practice. It was never going to be easy to resolve this confused situation, and a recent attempt to treat health services like any other service foundered when the many specificities of health care became clear.

The commission's proposals are incremental. They maintain provisions already in place and focus on areas where clarity is needed. They have three main strands.

Firstly, the values (universality, access to good quality care, equity, and solidarity) and principles (quality, safety, care based on evidence and ethics, patient involvement, redress, and privacy and confidentiality) underpinning European health systems are clearly stated. These were previously agreed by Europe's health ministries.⁵ Responsibility for ensuring that services comply with these values and principles should lie with the member state on whose territory the care is provided, although subject to

future agreement on mechanisms to ensure that core values and principles are adhered to everywhere.

Secondly, a specific framework will be introduced for the aspects of cross border care not already covered by existing legislation, such as that covering people who fall ill while temporarily abroad. Key elements relate to people who choose to go abroad to obtain care. If this is non-hospital care, they simply arrange it themselves. If it is hospital or other specialised care, which the commission will define, countries may introduce systems that require people to seek prior authorisation before obtaining care abroad, but only if they can show that this is necessary to prevent outflow of patients from making their hospitals non-viable. Refusals must be limited to those necessary to avoid such adverse effects on their existing hospital system. Where the home country has a system of primary care gate keeping, this will be respected. In both cases, patients will be entitled to reimbursement only up to the amount that would be paid at home and will not be allowed to make a profit. This framework also proposes a network of national contact points for patients seeking information and tidies up several unresolved matters. For example, it will make it clear that pharmacies should honour prescriptions issued by doctors in other member states, subject to necessary checks and with certain drugs excluded.

Thirdly, mechanisms will be established to foster European collaboration on health services, such as shared facilities in border areas, common methods of technology assessment, and centres of excellence for rare conditions.

The proposals provide much needed legal clarity in many areas and should provide patients with more information than they have at present. Yet the proposals also raise new problems that may need to be tested in the courts. The most controversial of these may be how member states apply the agreed values and principles. At the very least, the proposals will probably lead to a wide ranging debate on the considerable cultural differences seen in European health systems.

Patients will not be able to demand procedures abroad that are not authorised at home, although their home system can use existing mechanisms to access such procedures if thought to be appropriate. The phenomenon of “postcode prescribing”—where drugs are available to patients in one primary care trust but not another—has already been tested in the English courts.⁶ In future, such cases may have a European dimension as European citizens become more aware of national differences in entitlements.

The proposed legal instrument is a framework directive. This establishes the principles underlying subsequent legislation and sets the broad parameters within which it can operate. However, it leaves flexibility to respond to specific problems and changing circumstances. This will be necessary given the extensive agenda ahead. In particular, the proposals leave responsibility for quality and safety with individual member states, even though some do not yet have effective systems in place, but it does hint at future European action to facilitate improvements.⁷ The need to deal with the compatibility of mechanisms for maintaining professional competence is particularly pressing, given the more mobile workforce.^{8 9}

The commission’s proposals should be seen not as a route map for patients’ mobility in Europe, but rather as a set of general directions, which would leave governments and other stakeholders to fill in the details.

Notes

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Footnotes

- Competing interests: MM participated in the impact assessment of the EU's proposals and coauthored a working paper on quality of health care in Europe. This editorial draws on research conducted in the Europe for patients project, supported by the European Commission's sixth framework programme.
- Provenance and peer review: Commissioned based on an idea from the author; not externally peer reviewed.

References

1. European Commission. *Proposal for a directive of the European Parliament and of the council on the application of patients' rights in cross-border healthcare*. Brussels: European Commission, 2 July 2008.
2. Council of the European Union. *Regulation (EEC) no 1408/71 of the council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the community*. Brussels: Council of the European Union, 1971.
3. Rosenmöller M, McKee M, Baeten R. *Patient mobility in the European Union: learning from experience*. London: European Observatory on Health Care Systems, 2006.
www.euro.who.int/observatory/Publications/20060522_4.
4. Kanavos PG, McKee M. Cross-border issues in the provision of health services: Are we moving towards a European health policy? *J Health Serv Res Pol*2000;**5**:231-6.
5. Council of the European Union. *Council conclusions on common values and principles in EU health systems*. Luxembourg: Council of the European Union, 1-2 June 2006.
6. White C. Final guidance issued on Herceptin after appeal rejected. *BMJ*2006;**333**:409.
[10.1136/bmj.333.7565.409](http://dx.doi.org/10.1136/bmj.333.7565.409).
7. Legido-Quigley H, McKee M, Nolte E. *Assuring the quality of health care in the European Union*. London: European Observatory on Health Care Systems (in press).
8. Merkur S, Mossialos E, Long M, McKee M. Physician Revalidation in Europe. *Clin Med* (in press).
9. McKee M, Belcher P, Coulter A, Raje D. *Consultation regarding community action on health services*. London: Royal College of Physicians, 2007.