

Interview with MEP Françoise Grossetête, rapporteur on cross-border health care

Directive will guarantee improvements in quality of care

By Sophie Petitjean | Tuesday 18 January 2011



On 19 January, MEPs must adopt their position at second reading on the Directive on cross-border health care based on the compromise reached at the end of 2010 with the Council. Widely supported by the various political groups, this agreement marks the end of lengthy negotiations concerning the rights of patients being treated in another member state, including the issue of the reimbursement of care. The day before the vote, EPP rapporteur Françoise Grossetête (France) welcomed the fact that, from 2013, a patient being treated in another member state will be able to be reimbursed up to the amount of the reimbursement anticipated by his own national health system for similar treatment, if he is entitled to this in his country of affiliation.

Could you illustrate the directive's contributions via a concrete example: let's take the case of a Belgian person with a hip problem. What steps must he take under the directive in order to be treated in another member state?

The patient must find out from his national point of contact whether it would be appropriate for him to be treated in another member state. Because, as of this directive, each member state is obliged to set up a point of contact – a kind of one-stop shop – making it possible to inform and direct the patient according to his medical requirements. This point will give him information on the conditions of access and the conditions of reimbursement in force. Depending on the case, the patient must obtain prior authorisation from the member state of affiliation. Current health care treatment will not require prior authorisation; it will be sufficient for the patient to contact his social protection system, whereupon he will be given a document enabling him to be treated elsewhere and to be reimbursed.

How will this work in the case of non-hospital treatment, which is often more costly?

When it concerns hospital treatment or specialised treatment, the member state will – at that moment – be required to give prior authorisation. This can only be refused on obvious grounds. The EP has obtained a closed list of criteria, such as a person with a heart condition who may be refused authorisation on the grounds that a transfer could be dangerous for him. The same goes for a patient who wants to be treated in an establishment with a poor reputation.

Waiting times are, on the contrary, a good reason for granting him prior authorisation. If the waiting time is too long in the member state of origin, this constitutes a good reason and prior authorisation must be granted.

Nevertheless, won't it be up to the patient to advance the money required for the treatment?

No, there can be cases where payment does not need to be made by the patient, insofar as there will be a bilateral agreement between member states. At that moment, payment will be made directly from one member state to another.

But there will not always be a bilateral agreement and, in such a case, the patient will effectively be obliged to advance the money. Generally speaking, if he undergoes non-hospital treatment, he will be reimbursed according to the compensatory measures pursuant to Regulation (EC) No 883/2004 on the coordination of social security systems already in force for students and tourists. For more costly health care treatment, for example hospital treatment or highly specialised treatment, the patient will be entitled to ask for an evaluation of the cost of treatment and whether he is required to pay in advance. The directive anticipates the reimbursement period to be as reasonable as possible.

What concessions did Parliament need to make in order to obtain the support of the Council?

We are somewhat disappointed by current measures in terms of online health: we would have liked to see European standards in order to have real interoperability of data and to ensure the continuity of care between the various administrations from one country to another, but Germany and the United Kingdom opposed this. We will therefore set up voluntary cooperation between member states.

The same goes for rare diseases, a point that had not even been retained by the Council in its common position. We reintroduced this notion and, finally, prior authorisation must be given to a patient suffering from a rare disease following positive examination by an expert. It is true that this is only a recommendation; we would have liked things to be simpler and more obligatory, but this is an important starting point.

Do you understand the fact that Portugal, Poland, Romania and Austria opposed the compromise, under the pretext of having to reform their health care systems in order to comply with the directive?

Perhaps, but this is a good thing; it will force some member states to develop their systems. I know that some are opposed to it for fear of seeing too many patients seeking health care treatment in other member states. It may also be because we did not want to distinguish between the public sector and the private sector and because some member states have an important private system. In all cases, this can only be a guarantee to improve the quality of care.