"Patients' Rights have no Borders…. as well as risks!"

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To what risks do patients expose themselves? Who should they contact?

Ireland has a population of 4.3million and has a mixed public and private healthcare system.

In recent years Ireland, like many European countries has seen greater efficiencies in its use of in-patient and day case beds.

Over the past decade Ireland has had a reduction of 13% in the number of acute in-patient beds but has actually increased the number of in-patient discharges by 12% which was achieved by reducing patient length of stay by 14%.

There has also been an increase of 44% in the number of day cases over the decade.

Despite these increasing efficiencies, there are over 16,000 adults waiting in excess of 8 months for in-patient or day case elective procedures in Ireland as at November 2015. In excess of 3,500 children are waiting longer than 20 weeks for similar care.

The situation is even more stark for out-patient waiting lists. There are in excess of 380,000 adults on the waiting list for out-patient consultations, with 45,000 patients waiting in excess of 52 weeks.

There are generally no waiting lists for private care in Ireland and over 2 million of the 4.6 million population have private health insurance, a reduction of over 250,000 from a high of 2.3 million in 2008.

On the basis of the above, the significance of the provisions of the Cross Border Healthcare Directive for Irish patients is clear.

On the 25th October 2013 the Health Commissioner Tonio Borg made a statement here in Brussels on the entry into force of the Directive on Patients Rights in Cross Border Healthcare. He stated "Today is an important day for patients across the European Union, as of today, EU law in force enshrines citizens' rights to go to another EU country for treatment and get reimbursed for it".

Mr. Borg went on to say that for patients this Directive means empowerment and greater choice of healthcare. These words captured the letter and spirit of the EU Directive on Cross Border Healthcare.

The Directive does not give patients additional rights or entitlements but rather it gives them **choice** and **opportunity**: the choice to access necessary healthcare in

another EU country, and the opportunity to access that necessary healthcare in a timely manner.

Healthcare is a human right!

The transposition of the Directive was a significant milestone in the provision of healthcare for all EU citizens. The Directive has the potential to be even more significant to the public patient in Ireland who is subject to long waiting times for routine access to elective healthcare.

Risks

However, the experience of the patients and the National Contact Point in the implementing of the Cross Border Directive have not always been the "plain sailing" that would have been expected.

When I was invited to participate here today I spoke with the staff operating the National Contact Point in Ireland, who have daily direct contact with patients. I asked them what are the risks patients expose themselves to when accessing care under the provisions of the Cross Border Directive? They described those risks in broad categories of financial risk, language barriers and quality of care issues.

Financial risk

The financial risks can be broken down as follows:

- The first financial risk for the CBD patient is being invoiced and paying more for the same treatment than the patient from the country abroad would have been charged.
- The second financial risk for the CBD patient is hidden costs not being explained to the patient at the time of his/her decision. Patients have informed us that they have not been told of certain costs and only at the point of payment are these additional charges being advised. This type of lack of transparency in costs is a significant risk for patients and no patient should be making a decision with regard to cross border healthcare without full disclosure of costs and indeed reimbursement rates.
- The third financial risk for the CBD patient and the reimbursing institution is the provider abroad identifying the incorrect procedure in order to maximise the costs the provider may invoice.

Language

Language can also pose a risk:

- Language can pose a problem. But "healthcare" language may pose a significant risk. There is language used in the provision of healthcare that requires good communication skills. When you couple this risk with the use of a language which is not the first language of either the patient or the provider then this can certainly pose a significant risk.

Quality

Quality can also pose a risk:

- There is an old saying we are all familiar with “paper never refused ink”. Likewise the internet never refused glossy pictures and uncensored text.

We have experience of patients accessing care under the Cross Border Directive, which would give cause for concern in relation to quality.

I can think of one patient who accessed inpatient care from a provider but was not satisfied with that service. The patient complained to the NCP. When we enquired on behalf of the patient we learned that provider did not even provide the service for which the patient was admitted. This is but one extreme example of the type of issues that arise for patients.

The ability of a National Contact Point to intercede in these situations is limited. The National Contact Points have very limited powers – in fact National Contact Points have a non-executive function, and are a conduit of information and processes only. National Contact Points do not have powers beyond the borders of their own countries – and rightly so.

The Cross Border Directive has included the provision of healthcare by private providers. The logic of this is evident as without access to the private healthcare sector where there is spare capacity, the Directive might not offer any meaningful opportunity for patients to access necessary healthcare.

Private Healthcare

However, it is incumbent on all stakeholders to implement the Directive in the spirit and letter it was transposed.

For individual governments this means allowing access to healthcare by its patients without additional unnecessary administrative burdens and in a fully respectful manner of the patients’ entitlements to healthcare.

For the patient it means using the Directive to access healthcare in accordance with the rules and entitlements the patient has in his/her own country. To respect the national spend on healthcare as if it were being spent in his/her home country.

For the provider this means providing care in a quality, transparent and appropriate manner to meet the patient’s needs. It means invoicing the patient at the same costs as a patient from the country where the treatment is being provided – not altering costs to maximise against the available reimbursement rate in the CBD patient’s home country.

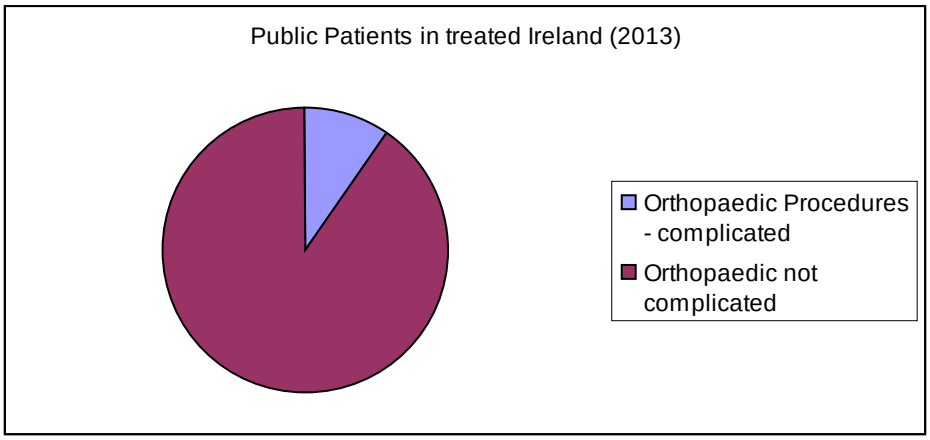
Let’s look at some of these examples a little closer and take just two examples of the issues that are arising from our experience in Ireland:

Hip replacement

The first example is an examination of orthopaedic procedures, specifically hip replacements accessed under the provisions of the Cross Border Directive.

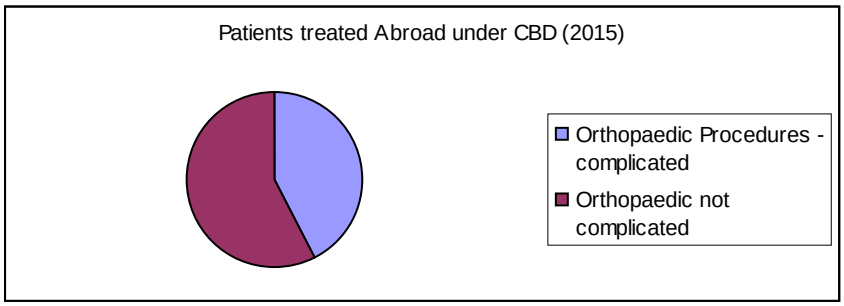
Pie chart 2013

When we examine the types of hip replacement cases in relation to complexity carried out in Ireland prior to the CBD the ratio of complexity is 10% complicated to 90% non-complicated.



Pie chart 2015

When we examine the complexity of cases in 2015 preformed under the provisions of the CBD the following is what we notice: The level of complex cases being returned now rises to 43% with 57% for non-complicated cases. This is an increase of over 30% in the rate of complex cases under the provisions of the CBD.



The question arises why is this? Why would these cases which were on the waiting list in Ireland as non-urgent and non-complicated cases suddenly increase by in excess of 30%?

The reason quite clearly is the reimbursement rate. In Ireland we have published our reimbursement rates. A complicated case has double the reimbursement rate of that of a non-complicated case, therefore if the hospital abroad indicated that the case was complicated it can charge more. When this trend became evident we implemented a system of seeking evidence of the complications. Immediately upon

this action this trend has reversed to reflect the percentages which we would have expected.

Fraud

Another stark example of where the private sector has sought to use the Directive for its own gain has been in another area of healthcare. A healthcare provider has provided patients with documentation purporting to be providing treatment in another jurisdiction. Irregularities in the documentation alerted the NCP to a potential attempt at fraudulent reimbursement under the provisions of the Cross Border Directive. Of all of the patients presenting documentation from this single provider not one can demonstrate having actually travelled abroad for the treatment and in fact the NCP has confirmation that the treatment did not take place abroad.

Sharp practice in the private sector is without doubt the biggest risk to the Directive for both the patient and the funding institutions.

Purse strings

The private sector is pushing an agenda whereby the funding institutions should pay the healthcare provider directly without recourse to the patient. I caution the patient most specifically against this.

Any and all payments in the form of reimbursement or otherwise should go to the patient. Why you might ask? The reason is the patient is the "customer". The customer's greatest leverage in any transaction is the ability to withhold full or partial payment until or unless he/she is satisfied with the service.

I urge the patient do not be drawn in by anyone purporting to take your power, your control and your leverage from you. Hold onto your rights, do not allow any commercial enterprise to seek to circumvent your leverage. In doing so you are protecting your rights as the patient and by extension the public purse of the country which is reimbursing you.

CBHD – a jigsaw piece

The Cross Border Directive is the most far reaching development in the provision of healthcare across Europe. It is the final piece in the puzzle – Regulation 883/2004 or S2 as it is more commonly known, the EHIC and now the Cross Border Directive provide the complete circle of care a patient may wish to access in Europe. By working together to ensure rights are upheld and respected this Directive can be all the European Commission envisaged it to be for European citizens.