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European Federation for Diaconia
Europäischer Verband für Diakonie
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Conference of European Churches
Conférence des Églises Européennes
Konferenz Europäischer Kirchen

Joint response to the Consultation from the Commission

regarding Community action on health services

Eurodiaconia and the Church and Society Commission of The Conference of European Churches (CSC of CEC) welcome the Commission's consultation on Health services and its attempt to clarify the application of Community law in this field. We particularly welcome the focus on the responsibility of the Member States to protect the General Interest and the emphasis on the interrelatedness of social and health-care services. We believe that any future legislative or non-legislative initiative should build upon and expand on the principles as described in the Council Conclusions on Common values and principles in EU Health Systems of 1-2 June 2006.

European churches and diaconal organisations provide a wide range of health (and integrated social and health) services all over Europe for young and old, physically and mentally disabled and engage half a million professionals and volunteers in their hospitals, institutions and projects. We therefore welcome the opportunity as stakeholders in the debate on Health services in the EU to be able to contribute to the current consultation.

We kindly ask the Commission to consider our response with the answer we recently gave with Caritas-Europa and COMECE to the related consultation on Social services of general interest, which you will also find attached. We would also like to draw your attention to the separate response of Caritas-Europa and COMECE to this Consultation regarding Community action on Health Services, as we share common concerns.

Question 1: what is the current impact (local, regional, national) of cross-border healthcare on accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

We appreciate the possibilities cross-border health services offer, for example, reducing waiting lists and in developing better health services through cooperation across borders. However, we

have concerns that the expansion of cross-border services may lead to a marketisation of these services to the detriment of their specificities, the general interest they serve and the principle of solidarity they are governed by.

Health Services – like social services – have specificities that call for special protection in order for them to fulfil their mission of "General Interest". Characteristics of Social and Health Services include an "asymmetric relationship between providers and beneficiaries that cannot be assimilated with a 'normal' supplier/consumer relationship" and "they are comprehensive and personalised integrating the response to differing needs in order to guarantee fundamental human rights and protect the most vulnerable" (Communication on Social services of general interest in the European Union.(COM (2006) 177 final, p.5).

Statistics show that often those with the least financial means have the most medical needs[1] and that the elderly and the chronically ill cost the most to health services[2]. Therefore we are concerned that the Commission is increasingly treating Health Services as goods sought on demand instead of services provided according to need, as these most vulnerable categories of patients would risk losing out in a health system based on a market strategy. Enabling the provision of quality and accessible health services is a public responsibility and treating Health Services on market terms could jeopardise the General Interest and the principles of solidarity and accessibility; which the Commission Communication also recognises in chapter 2.3 as pillars of the public healthcare systems in our European Social Model.

Question 2: what specific legal clarification and what practical information is required by whom (eg; authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?

Clarification is needed as regards what constitutes "undue delay" within the Member States.

We would encourage the development of a system that would enable easy exchange of essential information between medical professionals to effectively treat patients, whilst ensuring the necessary confidentiality.

Sufficient information about methods of treatments and diagnosis in other Member States should be made available to those coordinating health care. A good exchange of data would enable evidence-based treatment and also prevent unnecessary treatment or repetition of investigations.

Question 3: which issues (eg: clinical oversight, financial responsibility) should be the responsibility of the authorities of which country? Are these different for the different kinds of cross-border healthcare described in section 2.2 above?

The responsibility of paying for treatment should lie with the authorities/insurers in the patient's country of origin ("home state") where the treatment criteria of undue delay or prior authorisation are met in the case of hospital treatment, as it is up to the Member States to choose how to finance the treatment.

[1] 2001 study by the Institut scientifique de la santé publique Bruxelles

[2] 2006 study by the Institut National d'Assurance Maladie-Invalidité Belge

Medical/clinical oversight should be the responsibility of the country in which the care is provided ("receiving country") while the treatment is taking place. There needs to be a discussion on who is responsible for medical oversight in the case of long-term and post-operative care.

Question 4: who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm, how should redress for patients be ensured?

The Commission should investigate the idea of helping set up a standardised EU-wide complaints procedure in every Member State to ensure ease of use and evaluation with an Ombudsman to oversee the system.

Question 5: what action is needed to ensure that treating patients from other Member States is compatible with the provision of a balanced medical and hospital services accessible to all (for example, by means of financial compensation for their treatment in 'receiving' countries)?

It must be ensured that cross-border mobility does not generate problems of accessibility to quality health services for patients in the "receiving country" i.e. allows reverse discrimination. It would be important for the Commission to collect data about such mobility in order to monitor this potential problem. Foreign patients must not receive preferential access to treatment as compared to residents of that Member State. This may be of particular relevance when out-patients provide the receiving country with a higher level of reimbursement than the receiving country would be provided with from its national health system or insurers for a resident patient. The European Commission might wish to envisage pilot projects with accompanying studies in internal EU border regions.

Question 6: are there further issues to be addressed in the specific context of health services regarding movement of health professionals or establishment of healthcare providers not already addressed by Community legislation?

The growing demand for care and healthcare personnel also opens for the issue of a growing "grey market" of unqualified and/or unregistered caretakers; many of whom are migrants in an irregular situation. A concrete example is the high number of people registered as doing a caretaker's job when in fact they are providing health services. Some are qualified medical professionals, but employed below their qualification. Others are not qualified but still providing health services.

Precarious working situations, the effect on the healthcare system and the impact on patients should be seriously considered.

The recognition of certificates is an important factor which needs to be improved in the healthcare sector, but also the status of migrant health professionals deserves attention. A secure status reduces separation from families and possible exploitation.

A specific issue with regard to healthcare professionals is raised by the European Network of Health Care Chaplaincies, which has expressed concern over the fact that in some Member States the right to provide spiritual care has been challenged. The fact that chaplains are not recognised as health care providers impinges on their ability to provide their health care services so they call for recognition**.**

Question 7: are there other issues where legal certainty should also be improved in the context of each specific health or social protection system? In particular, what improvements do stakeholders directly involved in receiving patients from other Member States – such as healthcare providers and social security institutions – suggest in order to facilitate cross-border healthcare?

We ask the European Commission and the Member States to pay special attention to the health situation of migrants and ethnic minorities. In some Member States programmes are in place to address the specific needs of migrants and ethnic minorities including intercultural training of personnel, which could be models for further activities in this area.
We also ask the European Commission to pay special attention to the need for healthcare of people with uncertain legal status. We are aware of the difficulties to find appropriate practical solutions in this area, but no-one should be excluded from access to necessary medical treatment because of his or her nationality or legal status. Health care providers who are offering humanitarian assistance to persons in irregular situations must not be penalised nor should this be regarded as facilitation of illegal residence.

Also in relation to cross border provision of services, special awareness ought to be paid to ethical questions. Given the divergent legal and ethical framework in each of the now 27 EU Member States e.g. on assisted procreation, medicide and euthanasia, genetic diagnostics and therapies, EU legislation should carefully take into account the Subsidiarity principle. No member state should be urged to support or refund medical treatments or therapeutical applications or health care services, which do not conform to its national ethical and legal norms. In this context, criminal law also has to be taken into account; however, the harmonisation of law in this area is currently at a very early stage at European level. We would ask any activities in this area to be coordinated with the relevant Council of Europe instruments. A number of detailed statements depicting the ethical implications of these issues can be found at www.cec-kek-org/content/bioethics.html.

Question 8: in what ways should European action help support the health systems of the Member States and the different actors within them? Are there areas not identified above?

We support the Commission in encouraging cooperation in health-related research within the EU and assist specialist centres in Member States through EU financing. These centres would then share information and their research results EU-wide.

We would strongly support the EU promoting campaigns for the prevention of health problems, for example prevention of alcohol, tobacco and drug abuse, promoting healthy eating and lifestyle and the improvement of working conditions. Research shows that the work and social environment has a massive impact on the health situation.

Question 9: what tools would be appropriate to tackle the different issues related to health

services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

Bi-lateral or tri-lateral agreements between specific Member States on cross-border health-care may also be a way of ensuring access to healthcare for citizens of the EU who live in peripheral border areas where the nearest hospital is in a neighbouring country. Such agreements could help ensure accessibility of quality healthcare for all. Such cross-border cooperation between two or three countries would help clarify the problems of payment procedures and safe cross-border service provision.

Taking into account the close link between social and healthcare services (as expressed in the White paper on services of general interest and the Communication of the Commission on Social services of general interest (COM (2006) 516 final)) as well as in this Communication on health services (see chapter 2.1), we call for the Commission to take an integrated approach to social and health care in any future action. It must be ensured that the sectors are not governed by different regulatory environments as for example services provided in the context of long-term care and drug rehabilitation include integrated social and health service provision.

Social cohesion has a positive influence on health; hence the EU should intensify cooperation within the framework of the OMC on Social Protection and Social Inclusion. Equally we would encourage the further development of the OMC in Health and Long-Term Care, increasing the sharing of best practice and benchmarking.

As "the benefits that different health and social security systems provide and their organisation remain the responsibility of the Member States" the Commission should take great care that any actions do not jeopardise the ability of Member States to protect the General Interest in their country.

Brussels, 31 January 2007

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The Church and Society Commission (CSC) *is one of the commissions of the Conference of European Churches (CEC). The CSC links CEC's 126 member churches from all over Europe and its associated organisations with the European Union's institutions, the Council of Europe, the OSCE, NATO and the UN (on European matters).*

Its task is to help the churches study church and society questions from a theological social-ethical perspective, especially those with a European dimension, and to represent common positions of CEC member churches in their relations with political institutions working in Europe.

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Our Mission: We link our members to serve for solidarity and justice. Our strategic aims are to ensure quality of life for all in a social Europe, to link institutions of diaconia, social initiatives and churches in Europe, to be and to enhance a network of competence.

Attachment:

Joint response of Caritas Europa, the Church and Society Commission of the Conference of European Churches, Comece and Eurodiaconia to the Social Services of General Interest Questionnaire (16 January 2007)

Attachment:

Caritas EUROPA

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Conference of European Churches
Conférence des Églises Européennes
Konferenz Europäischer Kirchen

COMECE
Secretariat of the
Commission of the
Bishops' Conferences of the
European Community

EURODIACONIA
European Federation for Diaconia
Europäischer Verband für Diakonie
Fédération Européenne de la Diaconie

Joint response to the Social Services of General Interest

Questionnaire

Churches, Caritas and Diaconal organisations in Europe welcome the European Commission's efforts to define the specific characteristics of social services of general interest offering the recognition of the specificities of these services and their importance in fostering social cohesion and inclusion in society. We also welcome the endeavor to safeguard and uphold the quality and accessibility of social services of general interest through a clarification of how Community law influences the provision of these services.
We welcome the Commission's involvement of church and civil society in this process as we, churches, Caritas and Diaconal organisations, find ourselves to be stakeholders in the joint effort to uphold the European social model as we engage over 1 million professionals and volunteers in the broad field of social services.

Field 1 – Description of social services

1. Please indicate whether the description of the social services as provided by the Communication (see above under "scope") is appropriate and adequate, also with a view to social security schemes responding to the criteria deriving from the *Poucet and Pistre* case law.

- *We welcome the Commission's work to define the scope and the special characteristics of social services as well as its reference to social cohesion, which we see as a key objective of social policy.*
  We particularly appreciate the description of social services as being both preventive and curative and the importance given to both social security schemes and person-oriented services.

- *We think a clearer formulation should be adopted in order to avoid any misunderstanding: "statutory and complementary social security schemes" are not in*

themselves "social services" (as described in the communication). But social services act in the implementation of social security schemes and as such contribute to the common good, which is one of the reasons they must be treated differently from other services in the market.

- *The recognition of social services as being rights-based and guaranteeing the fundamental rights of the individual is reflected in their person-oriented approach. Churches and diaconal organisations share this principle. In the Christian understanding, human dignity does not depend on productivity, economic contribution or life situation, but resides in people created in the image of God with equal worth.*

- *We regret the decision not to address health services in the Communication contrary to the announcement in the White Paper on services of general interest of* "a Communication on social services of general interest, **including health services**" *(our emphasis). Social and health services share the same characteristics and on a practical level it is difficult to make a distinction between the two. Therefore we ask the Commission to pay special attention to the close links between health and social services.*

2. If you consider that the description could be improved or other (type of) services should be added, please provide for concrete drafting suggestions.

- *In line with the above considerations, the Communication should refer to "*services ***implementing*** statutory and complementary social security schemes*" instead of the current wording which defines "statutory and complementary social security schemes" as a category of social services.*

Field 2 – Pertinence of the characteristics

3. Please indicate whether the characteristics identified by the Communication are pertinent to gauge the specific features of social services of general interest as compared to other services (of general interest)?

- *We believe the characteristics are generally sufficient to gauge the specific features of social services of general interest.*

- *However, the characteristics of social services as operating on the principles of solidarity and social justice is pertinent to gauge two specificities of social services **if** by this we consider that risks are not individual but structural. This view necessitates public*

responsibility in ensuring provision of and in regulating social services. As such they are key elements in the operation of social security schemes.

4. Please provide, if needed, for concrete drafting suggestions for the formulation of the characteristics as they are currently presented by the Communication.

5. Are there characteristics to be added? Please provide for concrete drafting suggestions and examples of services concerned by these characteristics.

   - *When we define person-oriented social services we must realise that they often address not only the physical and mental needs but also the spiritual aspect of care for each human being. Being person-oriented and addressing individual needs also means recognising that the religious dimension of life is of importance to the majority of people. We would therefore appreciate a definition which also allows this aspect to be included.*

     A drafting suggestion could therefore be: "person-oriented social services often address not only the physical and mental needs but also the spiritual aspect of care for each human being."

     We also suggest adding "religious traditions" along with the "local cultural traditions" so that the text reads: "They are strongly rooted in (local) cultural ***and religious traditions.****"*

   - *A central characteristic of many social services is that they work with the capacity of the user and assist him/her to become independent – in this respect they are fundamentally different from other services provided against consideration.*

   - *Social services of general interest often include an element of advocacy in order to defend the interests of the beneficiary and to work for social justice in society*

     A drafting suggestion would therefore be: "they often include an element of advocacy."

6. Please provide as a maximum 3 relevant examples of social services representing one or more of the (additional) characteristics which could be taken as good example for the special nature. Please indicate which concrete element of the characteristics is clearly deducible from the example chosen.

Debt counselling
This service is provided by churches and diaconal organisations to prevent indebtedness of families and single persons and to help them to consolidate their debts. This is a relatively new social service of growing importance meeting the challenges of private insolvencies, which is of primarily preventive character, needs a very high level of personal trust and continued companionship over several years and includes an important advocacy function on behalf of debitors.

Rehabilitation measures and integration measures for disabled people
These services help disabled people to (re-) integrate into society, for example with special vocational training. They are often long-term measures, which need high investments, for example in specialised "sheltered workshops". Such "sheltered workshops" can only be competitive on the market with additional financial support, because their workers are people with special needs. If they were primarily regarded as "economic activities", they would not be able to fulfil their special task to integrate handicapped people into work, becoming more independent and participating in public life.

Hospice services
These services offer assistance to dying people in hospitals and specialised hospices, as well as in families and private environments. The professionals in the services most often work alongside volunteers offering attendance, practical help and very often pastoral care. For many recipients, a common value-base and/or religious background of the service provider is very important in this situation, as they want to be sure to be allowed to die according to their own convictions. This is an area where an integrated provision of health services and social services is an important quality factor and where values and religious traditions play a vital role.

7. How could these characteristics relate to the exclusion of specific social services from the scope of the Services Directive (Art. 2(2)(j) read together with the relevant Recital 27) as politically agreed on 29 May 2006 (Doc. 100003/06)[3] ?

Because of the characteristics and special nature of social services we need a legal environment where we can make sure that these services are safeguarded. The services directive goes some way to recognise that these characteristics justify a specific approach to social services.

Field 3 – Use of characteristics by Member States

8. Please give a definition of what the "general interest" is in your country, and specify in which way (at national, regional or local level) it is defined or is intended to be defined in the future.

We believe that in the field of social services the definition of the General Interest must take into account the welfare state principle where it is based on constitutional rights.

9. How can the characteristics be used by the Member States, at national, regional or local level, when defining the particular general interest mission of a social service and determining the arrangement for its performance and organisation?

[3] Text available at the following website: http://ec.europa.eu/internal_market/services/services-dir/proposal_en.htm

10. Have there been problems in the past with giving a concrete mandate to fulfil the particular general interest mission of a social service?

Field 4 – Use of characteristics at EU level

11. Please indicate how (e.g. in a binding way or not), in your view, the organisational characteristics could/should be used at EU level (e.g. agreed checklist) in order to verify whether for a specific social service the applicable Community rules are respected?

As is recalled in the Communication it is the responsibility of the member states to define which services are of general interest.
We welcome the Commission's efforts to assist in clarifying the specificities of social services of general interest.
However, even if the characteristics given in the Communication are shared among member states the list cannot be legally binding or exclusive.

Field 5 – Experiences with the application of Community law

The Communication and its Annex provide for a further clarification on the conditions of application of Community rules and principles to social services in particular in the following fields:

- Public procurement
- Public-private partnerships
- Freedom to provide goods and services and freedom of establishment
- State Aid

12. Please indicate whether difficulties (may) still arise and if so in which legal areas and for which type of social services.

In some member states regulations are applied unnecessarily in order to comply with Community rules even when this is not required. This is particularly the case when member states use tendering procedures to contract social service providers when this, in fact, is not required. We would therefore like to call for a clearer communication on the application of Community rules.

A difficulty that may arise in the future is the unintentional effects of applying Community law to the field of social service in a way that will impede on the ability of services to fulfil their mission of general interest. If using tendering procedures it is essential to have criteria of selection which do not only focus on price but which take into account other criteria that will enable the service providers to offer services that live up to the characteristics as defined in the Commission's communication.

It also has to be taken into account that continuity is an important characteristic and quality element of social services of general interest. Continuity also underpins the confidence in the social protection system of the Member States. This point should be taken into account when considering public tendering procedures.

13. Please provide for concrete examples and experiences to illustrate these difficulties.

14. Please give an indication on the debate in your country/organisation on how these difficulties should be addressed (e.g. clarification of the non-applicability of state aid rules to different social services of general interest).

Field 6 – Social security schemes responding to the criteria deriving from the *Poucet and Pistre* case law

15. Please indicate whether the questions in the Fields 2, 3 and 4 could also have significance with regard to social security schemes responding to the criteria deriving from the *Poucet and Pistre* case law.
16. Please indicate whether there is a need for further and specific clarification on the application of Community rules as enumerated in Field 5 with regard to these social security schemes.

Field 7 – Future steps at Community level

17. Which expectations do you have concerning future steps at Community level?

We expect that the area of social policy will continue to be a competence of the Member states.

However, if steps were to be taken towards a legislative initiative at EU level, the specificities of different sectors of services of general interest need to be taken into account whilst a piecemeal approach must be prevented to avoid developing conflicting approaches across different sectors of services of general interest.

We also expect more impact assessments of where current and future EU legislation affects policy areas outside the remit of its competence (such as social policy).

18. In case further steps should be considered, what could be the content, but also the advantages or disadvantages of these, including in particular intensified exchange of information, open method of co-ordination, Commission's Communications but also a Framework Directive for social services?

As Europe is widening its cooperation in the economic field we are concerned that the social dimension will suffer. However, we believe that subsidiarity must be the guiding principle for constructing social protection also in the future. ***We do welcome a strengthening of the open method of coordination*** *in the field and welcome any ways that it could be made to have greater impact through bench-marking and ways it could involve more stakeholders.*
We would also welcome the Commission initiating a debate on minimum standards within the Member States.

We also encourage dialogue with civil society and churches (taking into account art. I-47 and art. I-52 of the Constitutional Treaty as well as declaration 11 of the treaty of Amsterdam) including the open method of coordination at the national level and the debate on the future of the social dimension of Europe at the EU level as these organisations have played and play a strong role in providing social services, in fostering social inclusion and in advocating for the weakest in society.

19. Please indicate the expectations with regard to the monitoring and dialogue procedure in the form of biennial reports announced by the Communication.

Brussels, January 16 2007

Caritas Europa

The Church and Society Commission of the Conference of European Churches (CEC)

The Secretariat of the Commission of Bishops' Conferences of the European Community (COMECE)

Eurodiaconia

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Caritas Europa
Created in 1971, Caritas Europa is one of the seven regions of Caritas Internationalis, the worldwide confederation of 162 Catholic relief, development and social service organisations working to build a better world, especially for the poor and oppressed, in over 200 countries and territories. Caritas Europa is the umbrella organisation of the European network of 48 Caritas member organisations, working in 44 European countries. Caritas Europa focuses its activities on policy issues related to poverty and social inequality, migration and asylum within all countries of Europe, and issues of emergency humanitarian assistance, international development and peace throughout the world. With regard to all these issues, the organisation develops policies for political advocacy and lobbying at European level as well as at national level. The organisation is strongly involved in supporting the activities of its member organisations and those in the wider Caritas Internationalis confederation.

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