Patients' rights in cross-border healthcare

2008/0142(COD) - 04/09/2015 - Follow-up document

The Commission presented a Report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.

Directive 2011/24/EU came into force on 24 April 2011. It was due to be transposed by Member States by 25 October 2013. It clarifies the rights of patients to seek reimbursement for healthcare received in another Member State.

This report sets out the current state of play of transposition, and covers the most important and relevant provisions, such as the use of prior authorisation, the level of patient mobility, reimbursement practices, information to patients and cooperation under the Directive. It also report on the use of delegated powers.

The main conclusions of the report are as follows:

Transposition: infringement proceedings were launched against 26 Member States on the grounds of late or incomplete notification of such measures. As of 1 July 2015, four infringement proceedings remained open, and all four Member States concerned had made firm commitments to address the outstanding issues.

Patient mobility: the report noted that **patient mobility for planned healthcare remains low**, whilst patient mobility in terms of unplanned healthcare seems to be considerably higher. France, Luxembourg, and possibly Finland and Denmark appear to be exceptions to this general observation.

As regards **reimbursements made for treatment not subject to prior authorisation**, Finland, France and Luxembourg provided aggregate data for the Directive and the Social Security Regulations. Finland reported 17 142 reimbursement claims, France 422 680 and Luxembourg 117 962.

In the other 20 Member States, a total of 39 826 reimbursements were made specifically under the Directive: of this total Denmark alone accounted for 31 032.

The level of use of planned healthcare elsewhere is far below the potential levels suggested by the number of people indicating in the Eurobarometer survey that they would consider using cross-border healthcare. The Commission considered that there are a number of reasons why this may be the case.

1) **a number of Member States were late implementing the Directive**, which will impact on the numbers able to use it during 2014;

2) as also indicated by the Eurobarometer, **the number of citizens who are aware of their general rights to reimbursement is extremely low**. Even where citizens are aware of their rights, there are a number of Member States where it is difficult for patients to find out more about how to use these rights in practice;

3) whilst some Member States have implemented the Directive fully and are making considerable efforts to facilitate patients' rights to cross-border healthcare, **there are a considerable number of Member States where the obstacles placed in the way of patients by health systems are significant**, and which, in some cases at least, appear to be the result of intentional political choices:

- some of the current systems of prior authorisation are more extensive than the current numbers of requests would appear to justify;

- in many cases it is not clear exactly which treatments require prior authorisation;
- lower reimbursement tariffs than those used in the home Member State are a clear disincentive;
- there are a number of burdensome administrative requirements which may well deter patients.

It may be that that the natural demand for cross-border healthcare is relatively low for a number of reasons:

- unwillingness of patients to travel (e.g. because of proximity to family or familiarity with home system);
- language barriers;
- price differentials between Member States;
- acceptable waiting times for treatment in the Member State of affiliation.

The report notes that some of the demand that does exist may be catered for under local bilateral arrangements, which exist in some Member States. However, **it is not possible to conclude now that use of cross-border healthcare accurately reflects potential demand**.

However, the impact of the Directive should be considered more widely than simply cross-border healthcare. It has contributed to a number of important discussions going on in many Member States regarding healthcare reform.

National Contact Points and Information to patients: the Directive contains a significant number of provisions relating to transparency for patients on their rights, and on the quality and safety of healthcare services. This subject of **which information patients need**, and how it should be provided, is likely to be on the agenda for some time to come. The Directive provides a ready-made space (and forum, in the shape of the network of NCPs, which meets regularly) for the Commission and Member States to share ideas on how this challenge might be met.

So far, it is clear that there are significant differences between NCPs in the way they operate and the quality of the information they provide. There may well be merit in **exploring common approaches or guidelines** for the work of NCPs in future discussion.

Cross-border collaboration: the pressures faced by health services are leading to increased interest in making better use of resources via cross-border collaboration. Whilst the initial work undertaken by the Commission so far has thrown up some suggestions for action at EU level (e.g. sharing of best practice from successful projects; development of checklists for those considering cross-border collaboration), it is clear that these would only work in support of national or local activities.

Cooperation between health systems has created a new framework for Member States' cooperation. This could deliver **tangible benefits** to health systems across the EU. To take just one example, the **European Reference Networks** (ERNs) **could seriously improve access to care for rare / low-prevalence and complex diseases where expertise is rare**. To realise this potential, ongoing support and commitment from all sides will be needed.

Initial work by the Commission shows that there is a limited number of **existing cross-border projects** which may provide valuable 'lessons learned' for future parties. It has also identified specific areas where greater cross-border collaboration could make a significant difference to patient outcomes, for example in **access to critical care for myocardial infarctions**.

Successful cross-border collaboration requires significant buy-in from local-level actors, with the support of national authorities. The next step is to **identify those EU activities and best practices which will help implement real cross-border collaboration** which delivers added value. Geographical areas which might benefit from such collaboration also need to be identified.

Telemedicine: the advance of technology means that 'telemedicine' services (including online pharmacies) are likely to become **more common and more significant** in the immediate future. It may therefore prove useful to consider whether and how the applicable rules (e.g. on applicable legislation; access to, and reimbursement for, treatment) need to be developed and clarified.

Delegated acts: the Commission is of the view that the delegated powers conferred by Directive 2011/24 /EU should remain in force.

The field of **medicinal products and medical devices** is one where change may occur rapidly. Although exclusions from the principle of mutual recognition of prescriptions are not currently needed, such a need may arise in the future, and would need to be dealt with swiftly via a delegated act in order to safeguard public health.

Regarding **ERNs**, the first Networks will be established in 2016, and will then need to be evaluated. This evaluation is likely to mean that it is desirable to adjust the content of the current Delegated Act in the future.