Member State data on cross-border patient healthcare following Directive 2011/24/EU

Reference year 2022

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Glossary

Coordination Regulations: Regulation (EC) NO 883/2004 on the coordination of social security systems, and Regulation (EC) No 987/2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems

Country: In this report the term ‘countries’ is used to refer to the EU Member States, and the EFTA Member States Iceland (IS), Liechtenstein (LI), and Norway (NO)

Directive: Directive 2011/24/EU on the application of patients’ rights in cross-border healthcare

EFTA Member States: Iceland (IS), Liechtenstein (LI), Norway (NO), and Switzerland (CH)

EU Member States: Belgium (BE), Bulgaria (BG), Czechia (CZ), Denmark (DK), Germany (DE), Estonia (EE), Ireland (IE), Greece (EL), Spain (ES), France (FR), Croatia (HR), Italy (IT), Cyprus (CY), Latvia (LV), Lithuania (LT), Luxembourg (LU), Hungary (HU), Malta (MT), the Netherlands (NL), Austria (AT), Poland (PL), Portugal (PT), Romania (RO), Slovenia (SI), Slovakia (SK), Finland (FI), and Sweden (SE)

European Economic Area (EEA): EU Member States and EFTA Member States Iceland (IS), Liechtenstein (LI), and Norway (NO)

Member State of affiliation/Member State of treatment: The terms ‘Member State of affiliation’ and ‘Member State of treatment’, defined by the Directive, are used as general terms throughout this report. They encompass the EU Member States and the EFTA Member States Iceland (IS), Liechtenstein (LI), and Norway (NO)

NCP: National Contact Point

PA: Prior authorisation

1. Summary of Main Findings

Most of the countries completed the questionnaire. 28 questionnaires out of the 30 expected were collected and analysed. The countries that were not able to provide a completed questionnaire are Iceland and Liechtenstein.

Data quality

Several data quality issues were encountered, as few countries still struggle to differentiate between requests received under the Social Security Regulations, and requests received under the Directive.

Some countries provided questionnaires with significant sections missing, because most of the requests do not fall under the Directive (i.e., France, Austria), or because they were not able to retrieve the data with the tools that they have currently available in their country (i.e., Germany, the Netherlands).

Germany, however, was able to report data for the first time, uncovering a great amount of information on patient mobility previously gone unnoticed.

Limitation of patient inflow

Only two countries out of 28 reported having adopted measures to limit patient inflow. These are Denmark and Romania. These countries already had a mechanism in place in the year 2021.

Overall, the number of patients whose access to treatment has been limited is extremely low, and very few cases are reported each year. For the year 2022, only one case from Denmark has been reported, while Romania reported zero cases.

In Estonia, there is a legal possibility to restrict a patient's inflow with specific Ministers' Regulation if the Supervisory Board of the Health Insurance Fund would propose it. However, the Minister has never declared this Regulation. More information can be found in the 'Limitation of patient inflow' section of this report.

Prior notification

10 countries out of 28 declared having a system for prior notification in place. The countries are Denmark, Estonia, Ireland, Greece, Italy, Hungary, Malta, Poland, Sweden, and Norway.

Hungary has implemented a new system for prior notification, raising the total number of countries with a system in place from nine in 2021 to 10 in 2022.

Healthcare subject to prior authorisation

19 countries out of 28 have a system for prior authorisation in place. The countries that do not have a system of prior authorisation as of 2022 are Czechia, Cyprus, Latvia, Lithuania, the Netherlands, Finland, Sweden, and Norway.

In 2022, 17 countries reported receiving 4 552 requests for healthcare subject to prior authorisation, Germany (2 781) Luxembourg (942), and Slovakia (579), reported receiving much greater numbers than the other countries. Together, these three countries constitute the 94.5% of the total amount.

Germany, Greece, Spain, Italy, Luxembourg, Malta, Portugal, and Slovakia (eight countries out of 17) reported authorising at least half of the requests received, while Belgium, Bulgaria, Denmark, Croatia, Hungary, Poland, Romania, and Slovenia (eight countries out of 17)

reported authorising less than half of the requests received. Ireland reported zero requests received in the year 2022. Overall, 80.2% of the requests received were authorised.

The main type of healthcare for which a prior authorisation request was authorised consisted of care involving an overnight stay (93%). The main reason for refusing requests was that the same type of healthcare could be provided in the country of affiliation within a justifiable time limit (82%).

Patient mobility seems to involve mostly neighbouring countries, as the ‘busiest’ flows of patients were from Slovakia to Czechia, from Luxembourg to Germany, and from Italy to Austria and Germany.

In 2022, a total amount of EUR 7 708 041 was reimbursed, considering the available data provided by 10 countries.

Healthcare not subject to prior authorisation

In 2022, 23 countries reported receiving 547 890 requests for reimbursement for healthcare not subject to prior authorisation. France (300 254) and Germany (160 647) reported receiving much greater numbers than the other countries, as together these two countries constitute 84% of the total amount.

A total of 12 countries reported receiving less than 1 000 requests in 2022 (Bulgaria 8, Czechia 440, Estonia 90, Greece 56, Spain 9, Croatia 192, Italy 149, Cyprus 44, Latvia 19, Lithuania 131, Malta 10, Portugal 27, and Romania 889).

All countries, except for Portugal, granted the vast majority of the requests received. 83.5% of the total requests received in the EU were granted.

Again, patient mobility seems to involve mostly neighbouring countries, as the ‘busiest’ flows of patients were from France to Spain, Italy, and Belgium, from Denmark to Germany, and from Poland to Czechia.

In 2022, a total amount of EUR 86 462 491 was reimbursed by the 23 countries that provided data.

2. Background

Cross-border healthcare refers to healthcare received by an individual outside of their Member State of affiliation. EU citizens have the right to receive healthcare in any EU country and to be reimbursed for cross-border care by their home country. To guarantee this fundamental right, the EU utilises different legislative instruments, one of which is Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.

This Directive also promotes cross-border cooperation, recognition of prescriptions and ensures the functioning of the European Reference Networks (ERNs).

The Commission adopted a report ([1]) to the Council and the European Parliament on the operation of the Cross-Border Healthcare Directive on May 2022. The report includes, among others, information on patient flows, the financial implications of patient mobility, on the functioning of the European Reference Networks (ERNs) and the National Contact Points.

This report highlights that the Directive is still fit for purpose and relevant, however barriers to access healthcare across borders persist, largely due to its application by the Member States. The 24 European Reference Networks for rare, low prevalence and complex diseases are a major achievement for cross-border healthcare cooperation. However, their integration into national systems is necessary to safeguard their sustainability and to fully benefit rare disease patients.

The Commission continues to monitor and support the implementation of the Directive with specific actions funded under the EU4Health programme.

A trend report on data flow will be published next year. The last trend report ([2]) for the period 2018-2020 is available at the website of the European Commission

Article 20 of the Directive requires the Commission to report on the operation of the Directive directly to the European Parliament and to the Council. This reporting exercise is carried out every three years starting from the 25 October 2015. The data used to analyse the operations of the Directive is collected yearly through an annual questionnaire to be compiled by the National Contact Points (NCPs) of each country involved with the Directive. The following report presents the data collected for the reference year 2022 and is the eighth annual report since the entry into force of the Directive (the first reported data refers to the year 2014).

Structure wise, this report starts with a brief overview of the EU policy context around cross-border healthcare, introducing the relevant Regulations and describing more in depth the Directive, explaining complementarity and differences, and outlining the countries that are affected by each legislative tool. The following chapter (Chapter 3) focuses on the approach followed to retrieve and analyse the data (Section 3.1), introduces the structure of the yearly questionnaire sent to the NCPs (Section 3.2), and outlines the several difficulties in collecting

([1]) https://health.ec.europa.eu/publications/commission-report-operation-directive-201124eu-application-patients-rights-cross-border-healthcare-1_en

([2]) https://health.ec.europa.eu/publications/data-patient-mobility-under-directive-201124eu-trend-report-reference-years-2018-2020_en

and reporting data encountered by the NCPs when compiling the questionnaire (Section 3.4). All the data collected is then presented in chapters 4 to 7, following the same structure of the questionnaire.

EU Public Health responsibilities are specifically addressed in Article 168 of the Treaty on the Functioning of the European Union (TFEU) ([3]), which sets an objective of "a high level of human health protection". Article 168 aims at fostering cooperation between the Member States to improve the complementarity of their health services in cross-border areas. Starting from this article, ensuring equal access to cross-border care, and providing a legislative framework to harmonize national laws on the subject, have become important objectives for the EU to ensure a high standard of life for its own citizens. EU citizens have today the right to access healthcare in any EU country and to be reimbursed for care abroad by their home country. The most important legislative tools in this context are:

- **Regulation (EC) No 883/2004** ([4]) on the coordination of social security systems.
- **Regulation (EC) No 987/2009** ([5]) laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems.
- **Directive 2011/24/EU** ([6]) on the application of patients' rights in cross-border healthcare.

Regulation (EC) No 883/2004 on the coordination of social security systems sets the rules aimed at protecting social security rights of EU citizens when moving between Member States. The regulation covers multiple dimensions of social security, including sickness benefits, maternity and paternity benefits, and benefits in respect of occupational diseases, among others. It applies to citizens of all Member States, Switzerland, Norway, Liechtenstein, and Iceland, UK patients falling under the Transitional Agreement post Brexit, as well as to refugees and stateless individuals residing and being subject to the legislation of EU Member States. It extends also to the members of their families and their survivors. Additionally, it applies to third-country nationals, to members of their families and to their survivors who legally reside in the territory of a Member State. This ulterior extension is set out in Article 1 of Regulation (EU) No 1231/2010 ([7]) ([8]) of the European Parliament and of the Council of 24 November 2010 extending Regulation (EC) No 883/2004 and Regulation (EC) No 987/2009 to nationals of third countries who are not already covered by these regulations solely on the grounds of their nationality. Among the several general principles of social security set out by Regulation (EC) No 883/2004, three are highly relevant and applicable to the context of cross-border healthcare. The first one is Article 4 of the Regulation, or the principle of equality of treatment (principle of non-discrimination), that prohibits direct and indirect discrimination on grounds of nationality. The second one is Article 5 of the Regulation, or the principle of equality of benefits, income, facts, or events; according to which the receipt of benefits and other income and facts or events occurring in one Member State have legal effects, meaning that they must be legally recognized by other Member States as if they had happened on their territory. The last one is

([3]) EUR-Lex - 4301854 - EN - EUR-Lex (europa.eu)
([4]) EUR-Lex - 32004R0883 - EN - EUR-Lex (europa.eu)
([5]) EUR-Lex - 32009R0987 - EN - EUR-Lex (europa.eu)
([6]) EUR-Lex - 32011L0024 - EN - EUR-Lex (europa.eu)
([7]) L_2010344EN.01000101.xml (europa.eu)
([8]) Regulation (EC) No. 1231/2010 extending social security coordination rules to third country nationals does not apply in Denmark.

Article 7 of the Regulation, or the principle of exportability, according to which EU citizens are allowed to export and receive their benefits in any other Member State.

Regulation (EC) 987/2009 lays down the procedure for implementing Regulation (EC) No 883/2004. It introduces regulation measures to guarantee the free movement of citizens in the EU and contains provisions concerning the cooperation and the exchange of data between the Member States' institutions and the persons concerned. In addition, it contains rules for determining the legislation applicable according to Regulation 883/2004.

Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (hereafter 'the Directive') complements the separate EU Regulations on social security coordination. Its main goal is to facilitate access to safe and high-quality healthcare in another Member State by setting out the rights for patients seeking healthcare abroad and to ensure patient mobility in accordance with the case law of the Court of Justice of the European Union. It also promotes cooperation on healthcare between Member States regarding prescriptions, rare diseases, eHealth, and health technology assessment, whilst fully respecting their responsibilities for the definition of social security benefits relating to health, and for the organisation and delivery of healthcare. The Directive was adopted in March 2011 and came into force on 24 April 2011. Member States had time until 25 October 2013 to transpose the Directive into national legislation, however, several Member States missed the deadline, complete transposition was achieved only in late 2015.

The combination of these three legislative tools allows EU citizens to have more freedom of choice when it comes to healthcare. They can now decide to seek medical treatment at home in their residing Member State, or they can seek medical treatment in another EU country, depending on their needs and preferences. The Directive and Regulations guarantee to EU citizens the right to claim reimbursement from their national health system or insurance provider for medical expenses paid in another Member State. However, there are some key differences between the tools in terms of scope, Prior Authorisation (PA), and reimbursement. These differences are summarised in Table 1 below. Based on these differences EU citizens can apply for reimbursement of care received in another Member State or EFTA country under either the Directive or the Regulation.

Topic	The Coordination Regulations	The Directive
Geographical coverage	The EEA and Switzerland, in other words the EU Member States and the EFTA Member States Iceland, Liechtenstein, Norway, and Switzerland.	The EEA, in other words the EU Member States and the EFTA Member States Iceland, Liechtenstein, and Norway.
Providers	Providers within the statutory system, i.e., public providers.	Providers within and outside the statutory system, i.e., public and private providers.
Prior authorisation	Prior authorisation is a requirement for receiving	Prior authorisation is an exception from the main rule. A system of prior authorisation can be applied for certain treatments, generally

Topic	The Coordination Regulations	The Directive
	planned healthcare in another Member State.	inpatient care and care requiring highly specialised or cost intensive medical equipment or infrastructure, as long as it is necessary and proportionate to the objective to be achieved and does not constitute a means of arbitrary discrimination or an unjustified obstacle to the free movement of patients.
Reimbursement	Costs for planned (with PD S2) and unplanned (with EHIC) cross-border healthcare are, in principle, reimbursed under the conditions and reimbursement rates of the Member State of treatment.	Costs of planned and unplanned cross-border healthcare are reimbursed according to the conditions and reimbursement rates that would have been assumed by the Member State of affiliation. The patient has to advance the costs and apply for reimbursement upon return to the Member State of affiliation.

Table 1 - Differences between the Coordination Regulations and the Directive. Source**:** *Data on cross-border patient healthcare following Directive 2011/24/EU - Reference year 2020 ([9])*

Two articles from the Directive are highly relevant in the context of this project. According to Article 6 of the Directive, Member States should provide information on cross-border healthcare to patients through the establishment of one or more National Contact Point (NCPs) for cross-border healthcare. NCPs are therefore one of the most important sources of data regarding cross-border healthcare and patients' mobility. Article 20 of the Directive, as anticipated earlier, imposes to Member States to report annually their data. This data collection exercise is related to the operation of the National Contact Points and on patients' mobility. It has been carried out annually starting from 2015 and it covers data from the reference years 2014 to 2022 (covered in this year report). Data is collected using an agreed questionnaire sent out to the Member States. Article 20 also imposes that the European Commission shall draw up a report on the operation of the Directive to be submitted to the European Parliament and to the Council every three years.

([9]) 2020_msdata_en.pdf (europa.eu)

3. Data Collection and Quality

This chapter of the report provides an overview on the data collection and includes several key information to be considered when reading the data presented in the other chapters that will follow. Section 3.1 gives a very brief overview of the data collection process undertook, highlighting the number of responses received. Section 3.2 outlines the general structure of the questionnaire, including the specific information collected. The full questionnaire can be found in Annex I. Section 3.3 presents the exchange rates adopted in this report. Several countries reported financial information in their national currency, in the report all the data is presented in Euro, according to the exchange rates reported in this section. Finally, Section 3.4 presents an overview on data quality. Several countries still faced difficulties in providing accurate data or providing data at all. In this section all the information on difficulties and inconsistencies are reported as they were shared directly from the NCPs.

3.1. Data collection process

Data collection started with the revised version of the questionnaire being sent to all interested countries NCPs via mail by DG SANTE. The questionnaire was sent alongside a guidance manual, translated into the language of the NCP, as an assistant to the completion of the data collection and reporting exercise. NCPs were instructed to forward the completed questionnaires to a functional mailbox created for the occasion and managed by the study team. The deadline set for the completed questionnaires was the 15 September 2023. Almost all countries managed to meet the deadline.

Liechtenstein does not participate in the cross-border healthcare expert group and has not been included in this exercise. Iceland has not provided annual data for 2022, latest data received from Iceland are for years 2016 and 2019.

The data collection process was finally completed on the 8 November 2023, with a total of 28 questionnaires received out of the 30. The map below represents graphically the country of origin of all the questionnaires collected for year 2022.

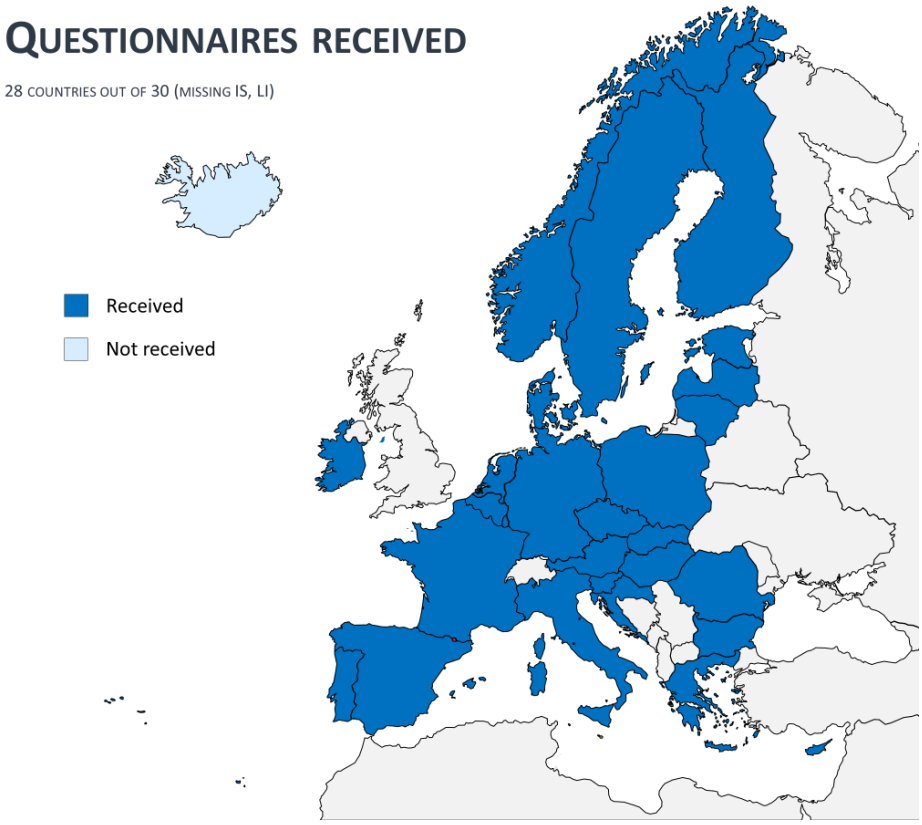


Figure 1 – Questionnaires received by country.

After receiving all the questionnaires, the study team contacted via mail all the NCPs that provided questionnaires with missing/inconsistent data and no further explanation. Once adequate clarifications and/or the final version of each questionnaire were received, the data was extracted, and the analysis process started. Results of this analysis are presented in this report in Chapters 4 to 7.

3.2. Questionnaire structure

The questionnaire allowed NCPs to report the data into five different sections, three of which cover specific indicators, one collects general information on the NCPs, and the last one consists of free text on any issue on which the respondent may want to provide further details. The questionnaire also contains an Introduction section explaining the structure and the nature of the reporting exercise, and a section with the most important definitions to be considered while reporting. The five data-oriented sections and their focus are described below:

1. **National Contact Points:** In this section, the NCPs are asked about recent changes to the NCP structure in the country and have to list the contact information of each NCP.
2. **Limitations, Patient inflow:** This section contains only two questions, asking NCPs to report whether the country has adopted measures to limit patient inflow, and, if yes, the number of patients to whom access to treatment has been limited. The two questions are followed by a textbox where NCPs can provide information on the relevant legislation.

3. **Healthcare subject to Prior Authorisation:** In this section, NCPs are asked to report all data concerning healthcare not subject to prior authorisation. The first question asks whether a system of prior authorisation exists in the country. If there is not such a system in their country, the NCP is instructed to skip directly to the next section of the questionnaire. The data collected in this section is the following:
    - The form in which a request for prior authorisation can be made (in person, post, mail, online, etc).
    - The form in which a request for reimbursement can be made (in person, post, mail, online, etc).
    - The number of requests for prior authorisation (received/authorised/refused).
    - Authorised requests for prior authorisation by type of healthcare.
    - Authorised requests for prior authorisation by country of treatment.
    - Refused requests for prior authorisation by reason for refusal.
    - Processing times for a request for prior authorisation (average time/time limit).
    - Processing times for a request for reimbursement (average time/time limit).
    - Amount reimbursed.
4. **Healthcare not subject to Prior Authorisation:** In this section, NCPs are asked to report all data concerning healthcare not subject to prior authorisation. Before starting, however, a quick question asks whether a system if prior notification exists in the country. The data collected in this section is the following:
    - The form in which a request for reimbursement can be made (in person, post, mail, online, etc).
    - The number of requests for reimbursement (received/granted/refused).
    - Granted requests for reimbursement by country of treatment.
    - Processing times for a request for reimbursement (average time/time limit).
    - Amount reimbursed.
5. **Additional information:** In this section NCPs can, on a voluntary basis, provide any additional information they consider useful, explain reasons behind missing or inconsistent data, and highlight general difficulties faced.

3.3. Exchange rates

All financial information included in this report is presented as euro. Exchange rates were retrieved from InforEuro ([10]), the Commission's static converter providing official monthly accounting rates for the euro, the corresponding conversion rates for other currencies, and historic conversion rates. All rates reflect the values referring to the November 2023. For Croatia, which reported all financial information in Croatian Kruna (HRK), the last available

([10]) InforEuro, the exchange rate of the Euro currency (europa.eu)

conversion rate (January 2023) was used. The table below presents the conversion rates used throughout the report.

Country	Currency	Exchange rate (=€1)
Bulgaria	**BGN**	1.9558
Czechia	**CZK**	24.557
Denmark	**DKK**	7.4639
Croatia	**HRK**	7.5345
Poland	**PLN**	4.4451
Romania	**RON**	4.9665
Sweden	**SEK**	11.839
Norway	**NOK**	11.843

Table 2 – Exchange rates taken from InforEuro (November 2023; January 2023 for HRK)

3.4. Data quality

As previously reported, a total of 28 responses to the questionnaire were received at the time of this report. As in previous years, some countries have been able to provide partial information to some of the questionnaire sections. This section provides a detailed explanation of specific issues reported by each of the responding countries and further details on the data provided.

In **Austria**, no specific records are kept providing data on treatments under Directive 2011/24/EU. This is because the reimbursement of costs of private medical treatments already existed in the national regulations before Directive 2011/24/EU and therefore the Patient Mobility Directive did not bring any significant innovation. In the information provided by Austria, there is no distinction made between cases covered by Directive 2011/24/EU and national cases due to a private medical visit, as the reimbursement system is the same.

In **Belgium**, not all health insurance funds provided data on the average time for dealing with requests for healthcare subject to prior authorisation. Therefore, it is not possible to identify a national average time for authorisation or reimbursement of these requests. However, based on the data received it's concluded that all decisions on authorisation requests were taken within the maximum time limit set for dealing with such requests. Regarding the number of refused requests for prior authorisation, four of them were refused due to insufficient motivation or documentation and 10 were refused due to other unspecified reasons. Belgium decided to apply the principles of Directive 2011/24/EU also in relation to Switzerland. In 2022 Belgium issued one prior authorisation on the basis of the principles of Directive 2011/24/EU for healthcare in Switzerland and reimbursed the amount of EUR 1 684.46. Data concerning Switzerland is not included in the figures provided for this report.

Regarding the number of requests for reimbursement of healthcare not subject to prior authorisation in Belgium, not all health insurance funds provided data on the number of requests received or the resolution of such requests. Therefore, Belgium cannot provide detailed information on the number of requests granted, refused, withdrawn, or considered inadmissible. On the processing time of these requests, not all health insurance funds provided

data on the average time for dealing with requests for reimbursement and therefore it's not possible to identify a national average time for dealing with such requests. Similarly, not all health insurance funds provided data on the number of granted requests for reimbursement, therefore, it's not possible to report the full picture of the current situation. Belgium also reports having a special arrangement called "Ostbelgien-Regelung" that provides special rules on access to specialist healthcare in Germany for the German-speaking population in the Eastern part of Belgium. This arrangement also involves special rules on reimbursement of such cases based on Directive 2011/24/EU. Furthermore, similarly to requests for healthcare subject to prior authorisation, Belgium decided unilaterally to apply the principles of Directive 2011/24/EU also in relation to Switzerland. In 2022, Belgium reimbursed a total amount of EUR 29 104.33 for health care provided in Switzerland not requiring a prior authorisation. The information concerning Switzerland is not included in the figures of the report.

In the case of **Germany**, it is reported that the data provided in the questionnaire also contains cases that are not explicitly covered by Directive 2011/24/EU. The German legislator established in the GKV Health Modernisation Act of 14 November 2003 to apply the rules of the European Court of Justice case law, enshrined in Directive 2011/24/EU, to two further case constellations. According to German Law, the rules of Directive 2011/24/EU are to be applied not only to applications for reimbursement of benefits during a temporary stay in another EU/EEA country, but also to claims for reimbursement of benefits for entitlement to benefits a) during a temporary stay in Switzerland; and b) in the foreign country of residence of insured persons located in the EU/EEA/Switzerland, with the exception of foreign countries of residence listed in Annex 3 of Regulation (EC) No 987/2009 or with which a waiver of reimbursement has been agreed (avoidance of double payments) but at the time of the report there was no reimbursement waiver with any state. This applies both to applications for prior authorisation (Article 8 of Directive 2011/24/EU) and to reimbursement applications relating to health services not subject to prior authorisation (Article 7 of Directive 2011/24/EU). Therefore, it is not possible to differentiate the cases relating only to Directive 2011/24/EU form the two additional case constellations described above.

In **Denmark**, when a Danish-insured person applies for reimbursement for the costs of unplanned treatment received in another EU/EEA country, the person has the option to have their application assessed under the terms of both Regulation (EC) No. 883/220 and Directive 2011/24/EU, unless the treatment is provided by a private healthcare provider. In this way, a potential refund will be paid according to the set of rules which is most favourable for the applicant. Applications for reimbursement according to the Regulation are processed by the Danish Patient Safety Authority, while reimbursement under the Directive is granted by the regional authorities, the municipalities or the Danish Medicines Agency depending on the type of treatment received.

Finland reported that they compile statistics on solutions, not on persons or applications. A solution means operation and treatment given; thus, a person can have several operations and solutions per visit. It is further explained that the average time in working days for dealing with requests for reimbursement for healthcare not subject to prior authorisation includes claims for reimbursement according to national Finnish law which concerns situations where a person has fallen ill while travelling outside the EU. However, this does not seem to have a considerable effect on the average days reported. Finland, according to national law, reimburses planned treatment given in Switzerland even though Switzerland has not implemented the Directive. Moreover, two requests were received from the UK during 2022. In this regard, Finland has reported 18 requests from Switzerland and two from the UK.

In **France**, there is a system of prior authorisation which only applies to a list of care which falls under the Social Security Coordination Regulations (Regulation (EC) No 883/2004 and Regulation (EC) No 987/2009). France reported that for the data of 2022 it's not possible to differentiate the cases related to Directive 2011/24/EU and those related to Social Security Coordination Regulations. The figures reported for the requests received refer to all the files received in 2022 for care in one of the 30 EEA countries (Switzerland and UK excluded) no matter when such request is processed. Healthcare that does not fall under the Directive were excluded. The figures for the granted and refused requests refer to every file reimbursed or refused in 2022 for care in one of the 30 EEA countries (Switzerland and UK excluded), where cases that do not fall under the Directive were also excluded. The average processing time is calculated from the date of signature by the insured on the claim form (or the date of online deposition) to the date of treatment. In April 2022, the online service was launched, allowing the insured to submit his claim directly online which will save time in processing the file, once the files accumulated during the health crisis are all processed.

In **Greece**, the data provided for 2022 refer only to individual claims under Directive 2011/24/EU. The figures provided for healthcare subject to prior authorisation, refer only to authorisations that led to actual treatments that were reimbursed under Directive 2011/24/EU. The figures provided for healthcare not subject to prior authorisation relate to both planned and unplanned care.

Croatia reports that the average time for dealing with requests for reimbursement (19 working days) is longer than the maximum time limit according to Croatian legislation (which is 60 days). The reason is that they have to check whether healthcare was provided by a private healthcare provider or a provider which has a contract with compulsory health insurance in some EU Member State. The reason for such a procedure is the insistence of the insured persons for their requests to be solved according to EU Regulations (883/04 and 987/09). In some cases, correspondence with other EU Member States takes longer than 60 days.

In **Hungary,** the planned treatments of Hungarian-insured persons in other Member States (over 500 cases each year) are based on the Regulation and reported using form S2 ([11]).

In **Ireland** they operate a system of Prior Notification although prior authorisation is only required for Enzyme Replacement Therapy. Enzyme Replacement Therapy is the only procedure that the Republic of Ireland has notified the European Commission of requiring Prior Authorisation. Ireland has not had any applications for this therapy in 2022. Ireland also informs that they had one Prior Notification application approved for the UK in 2022. Ireland also made 332 reimbursements approved for the UK during 2022. These patients fell under the Transitional Arrangements post-Brexit and are included in the figures of this report. Some of the approved reimbursements may relate to reimbursement claims received in 2021 but which were not processed until 2022. At the end of 2022 there were 879 claims for reimbursement awaiting processing.

Latvia informed that the cases of unplanned care (9 out of the 19 received in 2022) are initially processed according to the Social Security Coordination Regulations, requesting reimbursement rates from the Member State of treatment. After receiving the reply that the treatment was provided by a private provider the case is processed according to the Directive. For calculating the average time of processing, only the time period when the cases are

([11]) See Forms that certify your benefits situation when moving within the EU at https://europa.eu/youreurope/citizens/work/unemployment-and-benefits/social-security-forms/index_en.htm

processed according to the Directive is considered. Overall, all 19 cases are considered when calculating the average time, but for 10 cases (clear Directive cases) processing time starts with the application, while for nine cases processing time under the Directive starts after the competent institution of the place of treatment has replied.

Malta reported that three cases of reimbursement not requiring prior authorisation were reimbursed for a treatment that was started in 2019 in the UK. Therefore, the list could not be reconciled with the country of treatment list.

The Netherlands informed that health insurers all have their own procedures which makes it impossible to get generic country-wide data.

Norway reported that the figures provided for 2022 for granted and refused requests for healthcare not subject to prior authorisation were not necessarily received in 2022 as the date considered was the granting or refusal date. It is specified that the numbers for Denmark might include reimbursement for healthcare received in Faroe Island and Greenland.

In **Poland**, if a request for prior authorisation under the provisions of the Directive fulfils the conditions specified in the provisions on the coordination of social security systems, the National Health Fund grants authorisation under the provisions of coordination. However, when submitting a request under the provisions of the Directive, the beneficiary can object to being granted authorisation under the provisions set out in the EU Regulations on the coordination of social security systems. The above means that national regulations provide for the possibility to convert a request submitted under the provisions of the Directive into a request under the provisions of coordination. In 2022, there was one request for a prior authorisation under the provisions of the Directive, that was converted into a request under the provisions of the coordination of social security systems.

Portugal reported that in 2022 there were several cases of requests not subject to prior authorisation that were wrongly reported on the platform of the Directive, but which are covered by EU Regulations because they were made in a situation of temporary stay. These cases have been counted as requests refused for the current report although the citizen was informed of the correct procedure to apply for this reimbursement.

Sweden informed that the total requests received for reimbursement not subject to prior authorisation includes all cases under either the Directive or the Regulations as it’s not possible to determine immediately upon receival which legislation will be applied. For the average processing time and the total amount reimbursed the figures only reflect those cases resolved under the Directive, cases resolved under the Regulation aren’t included.

Slovenia informed that during the process for prior authorisation, they do not request information about the country of treatment. They cannot provide information on the authorised requests for prior authorisation by country of treatment as this data is submitted by the insured person when applying for the reimbursement of costs of the treatment provided. For the average processing time, they can only provide information on the time passed from a receipt of the application for reimbursement until the decision is issued. Slovenia did not calculate the working days.

4. Limitation of Patient Inflow

Countries subject to the Directive can decide autonomously whether to introduce or not measures aimed at limiting access to treatment, according to Article 4(3) of the Directive. Countries may limit access to treatment for patients not affiliated with them on the ground of overriding reasons of general interest, such as healthcare planning requirements. All 28 countries that submitted the yearly questionnaire replied to this question. Answers are represented graphically in the map below.

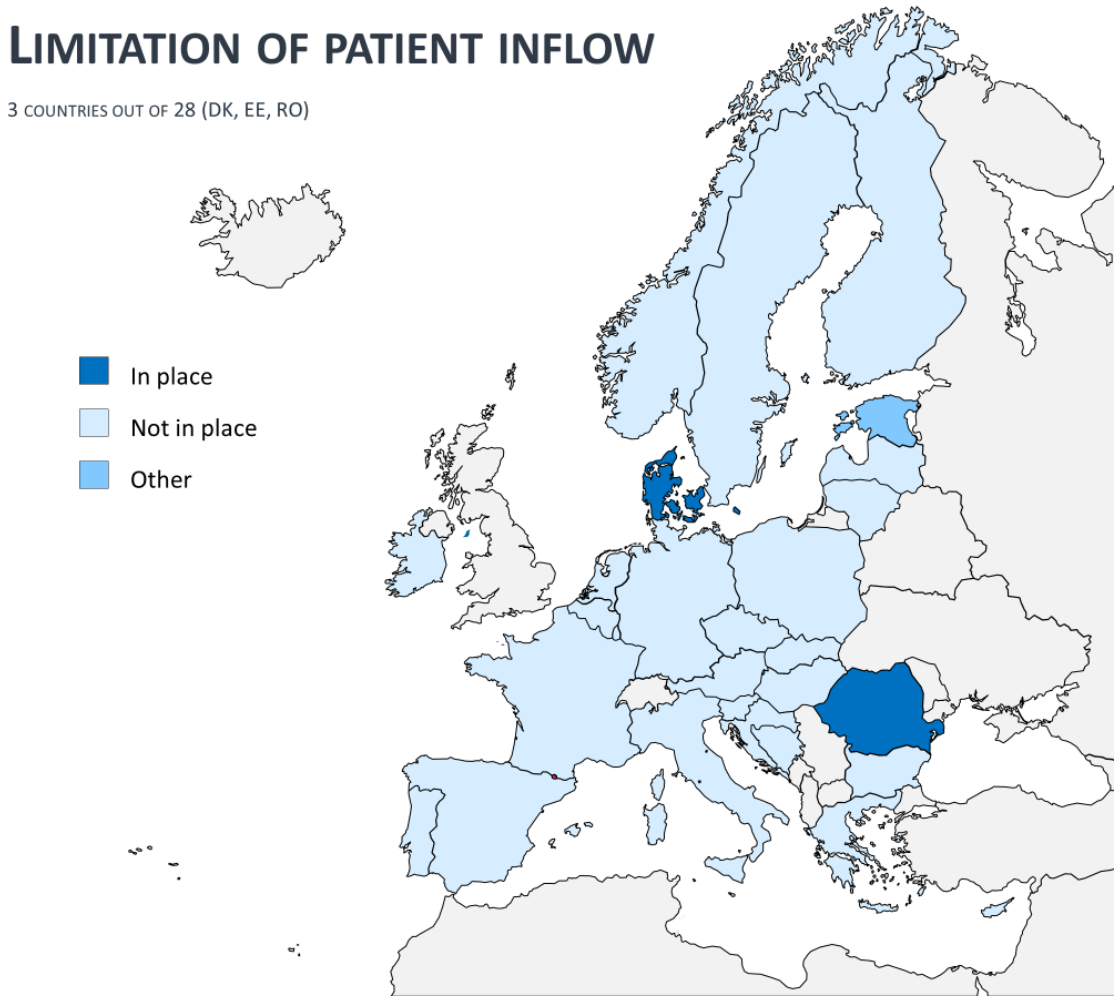


Figure 2 – Countries that adopted measures to limit patient inflow

Only two countries out of 28 reported having adopted measures to limit patient inflow. These are Denmark and Romania. No other country reported having adopted new measures to limit patient inflow. In Estonia it is a legal possibility to restrict a patient's inflow with specific Minister's regulation. However, the Estonian Minister of Health has not established a regulation for the restriction of patients' inflow to Estonia as of 2022.

Overall, the amount of patient whose access to treatment has been limited is extremely low, and very few cases are reported each year. For year 2022, only one case coming from Denmark has been reported and Romania reported zero cases. The numbers have always been very low since the entry into force of the Directive, as only 15 patients had their access to treatment limited from 2016 onwards.

5. Prior Notification

As explained previously, the yearly questionnaire collected data concerning both healthcare subject to prior authorisation and healthcare not subject to prior authorisation. For the latter, the Directive, under Article 9(5), gives to Member States and interested countries the right to offer patients a '*voluntary system of prior notification whereby, in return for such notification, the patient receives a written confirmation of the amount to be reimbursed on the basis of an estimate. This estimate shall take into account the patient's clinical case, specifying the medical procedures likely to apply*'. This system of prior notification may apply to any type of care or treatment, contrarily to prior authorisation, which is required only for certain specific cares or treatments. The prior notification system remains purely optional, and it is at each country's discretion to choose whether to implement it or not.

In the questionnaire, respondents were simply asked to specify whether in their country a system for prior notification is still in place or has been recently introduced. All 28 countries that submitted the yearly questionnaire replied to this question. Answers are represented graphically in the map below.

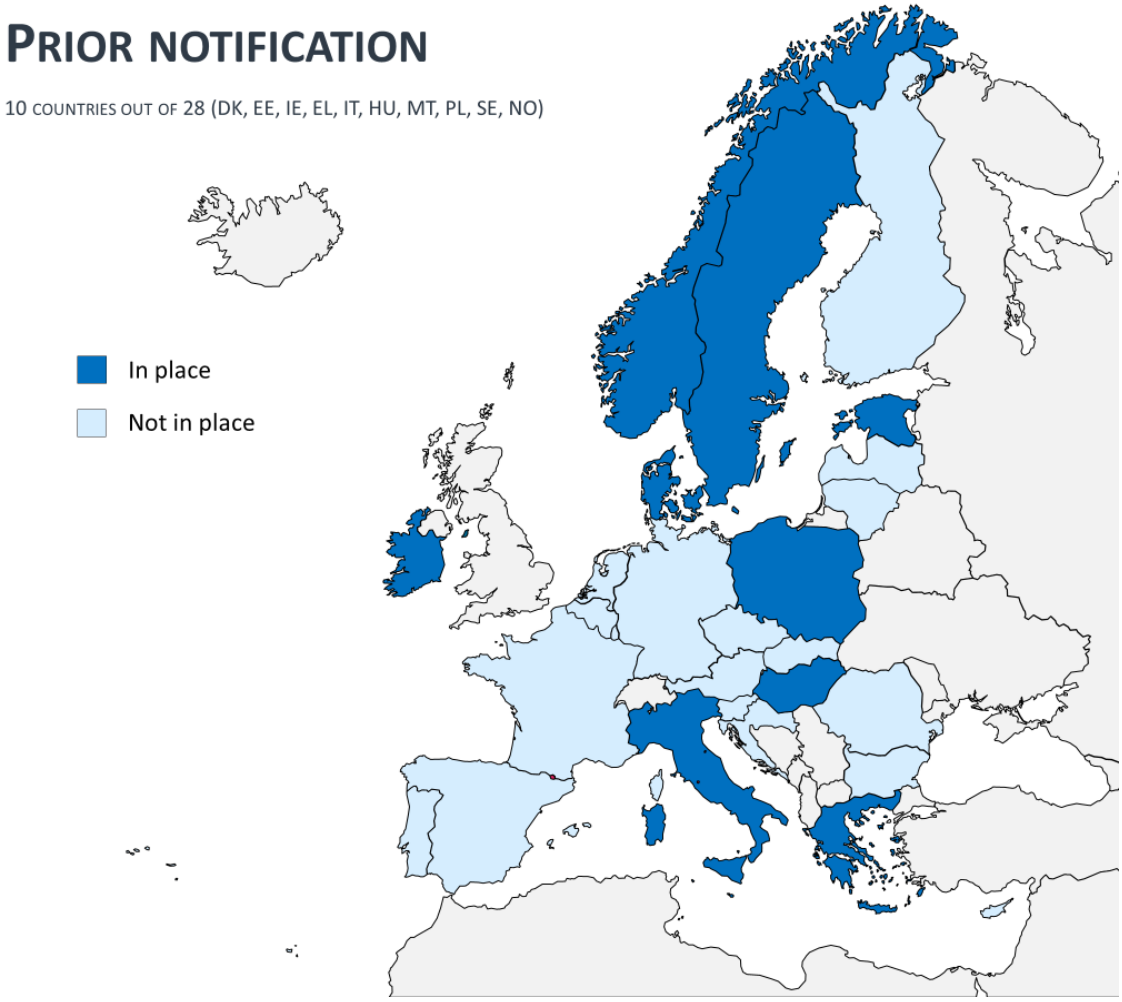


Figure 3 – Countries with a system for prior notification in place

Overall, 10 countries out of 28 declared having a system for prior notification in place. The countries are Denmark, Estonia, Ireland, Greece, Italy, Hungary, Malta, Poland, Sweden, and Norway. Compared to the previous year, Hungary implemented a new system for prior notification, raising the total number from 9 to 10. In all the other nine countries the prior notification system has been in place since the transposition of the Directive.

6. Healthcare Subject to Prior Authorisation

Prior authorisation is a formal permission from the country of affiliation for the assumption of planned cross-border care costs. Generally, it is used for treatment that requires hospital accommodation for at least one night, or treatment that requires the use of highly specialised or cost-intensive medical infrastructure or equipment (more information about the types of healthcare that require prior authorisation can be found in Section 6.3). Under the Directive, each Member State and interested country evaluates internally whether there is a need for a prior authorisation system, and if so, identifies which treatments and cares require prior authorisation when performed abroad.

This section of the questionnaire opened with a question on whether the country implemented a system for prior authorisation. Consequently, the data presented in this chapter of the report concerns only the countries that confirmed having a system for prior authorisation in place. Answers to this initial question are reported graphically in the map below.

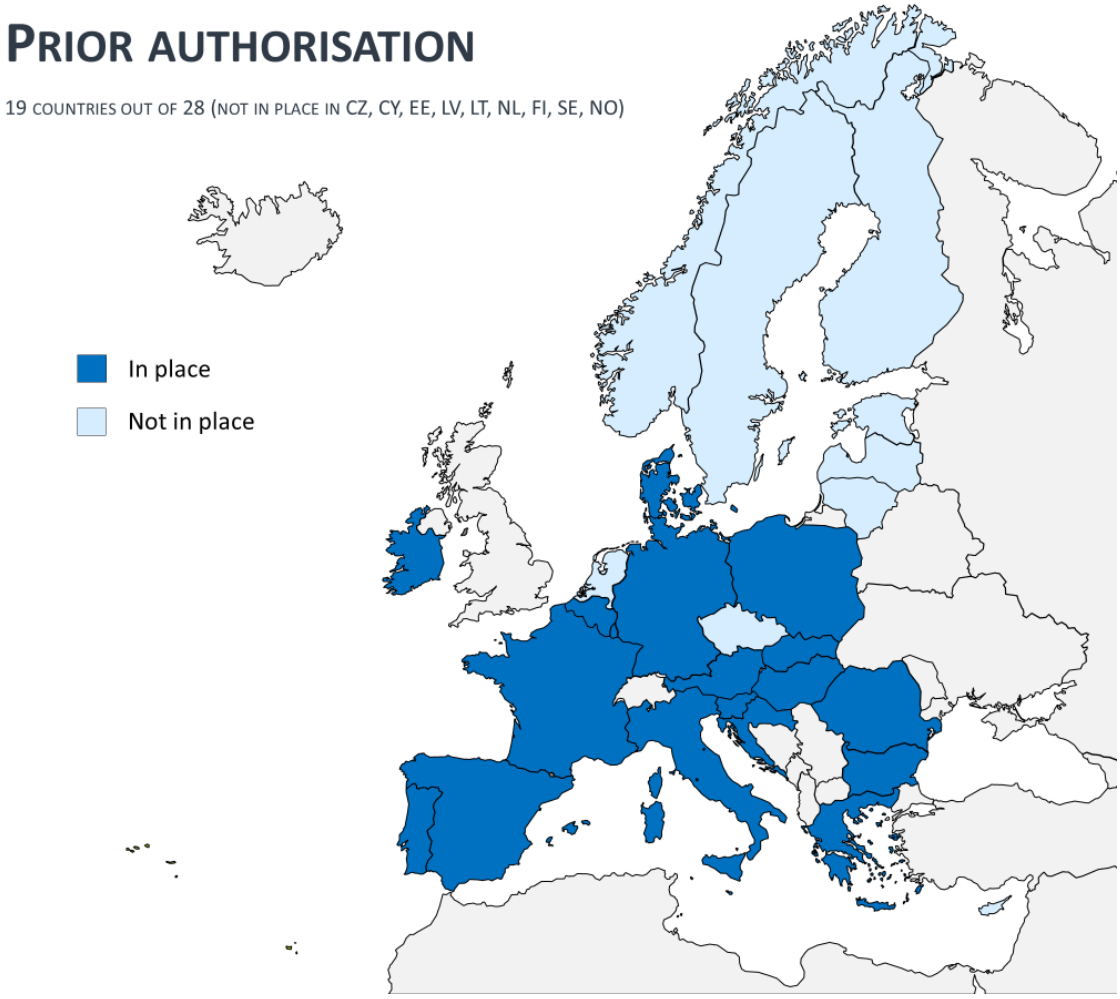


Figure 4 – Countries with a system for prior authorisation in place

Overall, 19 countries out of 28 have a system for prior authorisation in place. The countries that do not have a system of prior authorisation as of 2022 are Czechia, Cyprus, Estonia, Latvia, Lithuania, the Netherlands, Finland, Sweden, and Norway. This is similar to previous year, with no new countries introducing a new system of prior authorisation, and no country

removing a system already in place. In this regard, the last changes were performed in 2019, when Cyprus decided to remove their prior authorisation system, and year 2018, when Latvia decided to remove their prior authorisation system. Both occurred due to new national legislations being adopted in the respective countries.

6.1. How to request Prior Authorisation?

Since 2021, the questionnaire includes a question on the ways a request for prior authorisation can be made (in person, online, via mail, etc). All countries with a prior authorisation system in place replied to this question, except for Romania. The table below reports the answers collected.

Country	In person	Online	Mail/post/fax
Belgium	X		X
Bulgaria	X		
Denmark			X
Germany	X		X
Ireland	X		X
Greece	X		X
Spain	X	X	X
Croatia	X		X
Italy	X	X	X
Luxembourg			X
Hungary			X
Malta	X		X
Austria	X	X	X
Poland	X	X	X
Portugal		X	
Slovenia	X		X
Slovakia	X		X

Table 3 – Ways in which a request for prior authorisation can be made

In 13 out of the 17 countries that replied to this question, a request for prior authorisation can be made in person. In Bulgaria, this is the only mean for patients to request prior authorisation. A request can be made online in five countries of the 17 that replied to this question. Portugal is the sole country in which requests can be made only online. All countries except for Bulgaria and Portugal (15 out of 17) allow their patients to make requests via mail, post, or fax. Out of these, Denmark, Luxembourg, and Hungary allow only this mean as a way for patients to present a request for prior authorisation. Austria, Spain, Italy, and Poland are the only four countries that allow their patients to make requests by all three means (in person, online, via

mail/post/fax). Eight countries out of 17 accept requests made both in person and via mail, post, or fax.

6.2. Requests received for prior authorisation

The questionnaire asked countries that confirmed having a system of prior authorisation in place to share the total number of requests received, authorised, and refused in year 2022. As in 2021's questionnaire, countries were not asked to report the number of withdrawn/inadmissible requests, as these numbers have been low through the years and proved to be difficult to distinguish and report for most countries.

Of the 19 countries that have a system for prior authorisation in place, 17 of them managed to provide data regarding requests received, authorised, and refused. France and Austria confirmed having a system for prior authorisation in place but were unable to report data concerning the requests received. For France, this is because the prior authorisation is only for a list of care which fall under the Social Security Coordination Regulations, and there are no criteria of acceptance under the Directive. In the previous year, the section was filled with the number of prior authorisations delivered under the Regulations, but this year the NCP decided not to report any data. For Austria, no specific records are kept providing data on treatments under the Directive. This is because the reimbursement of costs of private medical treatments already existed in the national regulations before the entry into force of the Directive and therefore its adoption did not bring any significant innovation. There is no distinction made between cases covered by the Directive and national cases due to a private medical visit, as the reimbursement system is the same.

Before presenting the collected data, it is important to notice that in some cases the number of requests authorised and refused does not equal the number of requests received (e.g., Bulgaria, Denmark). This is a consequence of the fact that some requests are received later in the year and are not processed until the following year, and the number of authorised and refused requests can also include requests received in the previous year but processed only in 2022. The table below reports the collected data, specifying in brackets the percentage of requests authorised and refused over the total number of requests received.

Country	Received	Authorised (%)	Refused (%)
Belgium	47	6 (12.7%)	41 (87.3%)
Bulgaria	4	0	3 (75%)
Denmark	41	7 (17%)	29 (70.7%)
Germany	2,781	2,377 (85.5%)	404 (14.5%)
Ireland	0	0	0
Greece	4	2 (50%)	2 (50%)
Spain	7	6 (85.7%)	1 (14.3%)
Croatia	3	1 (33.3%)	2 (66.6%)
Italy	76	55 (72.4%)	21 (27.6%)
Luxembourg	942	638 (67.73%)	304 (32.27%)
Hungary	3	0	3 (100%)

Country	Received	Authorised (%)	Refused (%)
Malta	6	6 (100%)	0
Poland	1	0	1 (100%)
Portugal	7	7 (100%)	0
Romania	4	1 (25%)	0
Slovenia	47	11 (23.40%)	18 (38.29%)
Slovakia	579	536 (92.57%)	20 (3.45%)
TOTAL	**4 552**	**3 653 (80.25%)**	**840 (18.45%)**

Table 4 – Number of requests for prior authorisation (received/authorised/refused)

Out of the 17 countries that reported data concerning requests received for healthcare subject to prior authorisation, Germany (2 781), Luxembourg (942), and Slovakia (579), reported receiving much greater numbers than the other countries, as together these three countries constitute the 94.5% of the total amount of requests received in the EU in 2022. All the other 14 countries reported low numbers of requests received, with only one country receiving more than 50 requests (Italy, 76), and three countries receiving more than 10 requests (Belgium, 47; Denmark, 41; Slovenia, 47). Bulgaria, Ireland, Greece, Spain, Croatia, Hungary, Malta, Poland, Portugal, and Romania reported receiving less than 10 requests for healthcare subject to prior authorization in 2022.

The data from Germany is significantly higher than most other countries since the data collected also contains cases that are not explicitly covered by the Directive. According to the German Law, the rules of the Directive are to be applied not only to applications for reimbursement of benefits during a temporary stay in another EU/EEA country, but also to claims for reimbursement of entitled benefits. These include a temporary stay in Switzerland as well as the stay in the foreign country of residence of insured persons located in the EU/EEA/Switzerland [12]. This means that it is not possible to evaluate cases relating only to the Directive.

Germany, Greece, Spain, Italy, Luxembourg, Malta, Portugal, and Slovakia (eight countries out of 17) reported authorising at least half of the requests received, while Belgium, Bulgaria, Denmark, Croatia, Hungary, Poland, Romania, and Slovenia eight countries out of 17) reported authorising less than half of the requests received. Ireland, despite having a system for prior authorisation in place, reported zero requests received in year 2022.

Compared to 2021, numbers remain very stable. In 2021 a total of 4 929 requests were received, only 400 more than in 2022. Of these, 3 804 were authorised, again a similar number to the 3 604 that were authorised in 2022. Consequently, also the number of refused requests is similar, with 1 121 refused requests in 2021, and 840 refused requests in 2022. The greatest difference between the two years lies in which country was able to submit data for the year. Overall, in 2022 more countries were able to provide data, raising the total number of respondents to 17 from 14 in 2021. Bulgaria, Germany, Hungary, and Portugal were able to provide data for 2022 report, while not being able to do so in the previous year. In 2021 France

(12) With the exception of foreign countries of residence listed in Annex 3 to Regulation (EC) No 987/2009 -EUR-Lex - 32009R0987 - EN - EUR-Lex (europa.eu)- or with which a waiver of reimbursement has been agreed (there is currently no reimbursement waiver with any state)

was the country that received most requests (3 373) but could not provide any data for this year. Since in the country. prior authorisation falls completely under the scope of the Regulations rather than the Directive, the NCP decided to not report any data this year to avoid overinflating the numbers. It must be noted that the 3 373 requests reported in year 2021 do not reflect the number of requests received under the Directive. This noticeable absence was covered in the total number of requests received by Germany, that was able to report this kind of data in 2022 for the first time, and by reporting numbers similar to the numbers reported by France in 2021, ensured that the total amount of received, authorised, and refused requests in the EU remained similar between the two years. Analysing the variation in numbers reported by the countries that were able to provide data for both years, it can be observed very little variation. The only two differences worth mentioning are the decrease in the total number seen in Belgium (from 72 requests received to 47), and the increase in the total number seen in Slovakia (from 361 requests received to 579).

6.3. Types of healthcare for authorised requests

In the questionnaire, countries were asked to specify, when possible, the type of healthcare concerning the requests for prior authorisation that have been received. Five different types of healthcare were included in the questionnaire to choose from:

Type 1: Healthcare which is made subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources and involves overnight hospital accommodation of the patient in question for at least one night (Article 8(2)(a)(i) of Directive 2011/24/EU).

Type 2: Healthcare which is made subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources and requires use of highly specialised and cost-intensive medical infrastructure or medical equipment (Article 8(2)(a)(ii) of Directive 2011/24/EU).

Type 3: Healthcare which involves treatments presenting a particular risk for the patient (Article 8(2)(b) of Directive 2011/24/EU).

Type 4: Healthcare which involves treatments presenting a particular risk for the population (Article 8(2)(b) of Directive 2011/24/EU).

Type 5: Healthcare which is provided by a healthcare provider that, on a case-by-case basis, could give rise to serious and specific concerns relating to the quality or safety of the care, with the exception of healthcare which is subject to Union legislation ensuring a minimum level of safety and quality throughout the Union (Article 8(2)(c) of Directive 2011/24/EU).

The table below shows the number of authorised requests by country and type of healthcare.

Country	Type 1	Type 2	Type 3	Type 4	Type 5
Belgium	1	5	0	0	0
Denmark	7	0	0	0	0

Greece	2	0	0	0	0
Spain	3	3	0	0	0
Croatia	0	1	0	0	0
Italy	32	20	0	0	3
Malta	1	5	0	0	0
Portugal	2	5	0	0	0
Romania	1	0	0	0	0
Slovenia	6	5	0	0	0
Slovakia	536	0	0	0	0
TOTAL	**591**	**44**	**0**	**0**	**3**

Table 5 – Authorised requests by type of healthcare

All countries that authorised at least one request in 2022 were able to answer this question, except for Germany and Luxembourg (11 countries out of 13). Most of the requests authorised concerns healthcare Type 1, with 591 (93%) requests authorised. Most of those requests were authorised by Slovakia (56). Italy authorised 32, and all the other countries authorised less than 10 (Belgium one, Denmark seven, Greece two, Spain three, Malta one, Portugal two, Romania one, and Slovenia six). A total of 44 (6.9%) requests were authorised concerning healthcare Type 2. Of these, Italy authorised 20, while every other county authorised less than 10 (Spain three, Croatia one, Malta five, Portugal five, and Slovenia five). No requests concerning healthcare Types 3 and 4 have been authorised in 2022. Only three requests concerning healthcare type 5 have been authorised in 2022, all three of them being authorised by Italy.

Compared to the previous year, the proportions between types of healthcare remain similar, 86.9% of the authorised requests were concerning healthcare type 1 in 2021, compared to the 93% observed in 2022. Concerning healthcare type 2, the number of authorised requests in 2021 covers the 11.1% of the total requests authorised, compared to the 6.9% observed in 2022. In the 2021 report, types 3, 4, and 5 were grouped because of their very low number (nine). The trend is similar to this year, as all nine requests in 2021, and all three requests in 2022, were received and authorised in Italy.

6.4. Reasons for refusal

In the questionnaire, countries were asked to specify, when possible, the reason for refusal behind the requests for prior authorisation that have not been authorised. Five different reasons were included in the questionnaire to choose from:

Reason 1: This healthcare can be provided on its territory within a time limit which is medically justifiable, taking into account the current state of health and the probable course of the illness of each patient concerned (Article 8(6)(d) of Directive 2011/24/EU).

Reason 2: The healthcare is not included among the national healthcare benefits of the Member State of affiliation (Article 7(1) of Directive 2011/24/EU).

Reason 3: The patient will, according to a clinical evaluation, be exposed with reasonable certainty to a patient-safety risk that cannot be regarded as acceptable, taking into account the

potential benefit for the patient of the sought cross-border healthcare (Article 8(6)(a) of Directive 2011/24/EU).

Reason 4: The general public will be exposed with reasonable certainty to a substantial safety hazard as a result of the cross-border healthcare in question (Article 8(6)(b) of Directive 2011/24/EU).

Reason 5: This healthcare is to be provided by a healthcare provider that raises serious and specific concerns relating to the respect of standards and guidelines on quality of care and patient safety, including provisions on supervision, whether these standards and guidelines are laid down by laws and regulations or through accreditation systems established by the Member State of treatment (Article 8(6)(c) of Directive 2011/24/EU).

The table below shows the number of refused requests by country and reason for refusal.

Country	Reason 1	Reason 2	Reason 3	Reason 4	Reason 5
Belgium	26	1	0	0	0
Bulgaria	3	0	0	0	0
Denmark	18	11	0	0	0
Greece	2	0	0	0	0
Spain	0	1	0	0	0
Croatia	2	0	0	0	0
Italy	17	4	0	0	0
Poland	1	0	0	0	0
Slovenia	18	0	0	0	0
Slovakia	15	1	4	0	0
TOTAL	**102**	**18**	**4**	**0**	**0**

Table 6 – Refused requests by reason for refusal

Most of the non-authorised requests were refused for Reason 1, with 102 (82%) requests for prior authorisation refused in 2022. Here there are no outliers in terms of numbers refused by country, as all of them refused quite similar numbers. Specifically, Belgium refused 26 requests, Bulgaria refused three, Denmark refused 18, Greece refused two, Croatia refused two, Italy refused 17, Poland refused one, Slovenia refused 18, and Slovakia refused 15. Concerning Reason 2, a total of 18 (14.5%) requests for prior authorisation have been refused. The majority of those requests have been refused by Denmark (11). Belgium refused one, Spain refused one, Italy refused four, and Slovakia refused one. Only four requests have been refused for Reason 3, all of them by Slovakia. No requests have been refused for Reasons 4 or 5.

Compared to the previous year, the proportion of reasons behind refusals shifted significantly. Only the 57.9% of the requests refused in 2021 happened on the basis of Reason 1, compared to the 82% observed in 2022. Consequently, a similar difference can be observed for Reason 2, with a total of 38.3% of the total in 2021 decreasing to just the 14.5% of the total in 2022. The percentage of requests refused for reasons 3-5 remained similar between year, equalling to 3.2% of the total in both 2021 and 2022.

6.5. Processing times

The questionnaire collected data on the average processing times for a request for prior authorisation, as well as the average processing times for the reimbursement for prior authorisation. Additionally, countries were asked to report the time limit to process both a request for prior authorisation, and reimbursement for prior authorisation. The table below reports the average processing times and time limit, expressed in number of days.

Country	N of days (PA)	Time limit (PA)	N of days	Time limit
Belgium	n.a.	45	n.a.	n.a.
Bulgaria	20	30	n.a.	n.a.
Denmark	11	14	80	No Limit
Germany	n.a.	21	n.a.	No Limit
Ireland	0	20	0	20
Greece	40	40	40	40
Spain	23	45	40	90
France	n.a.	15	n.a.	n.a.
Croatia	30	60	60	60
Italy	21	30 (15 if urgent)	48	60
Luxembourg	5	21	40	No Limit
Hungary	8-60	60	8-60	60
Malta	7	45	365	540
Austria	n.a.	14	n.a.	14
Poland	30	30	n.a.	n.a.
Portugal	n.a.	35	n.a.	90
Romania	3	5	70	No limit
Slovenia	53	60	47	60
Slovakia	10	15	30	180
EU	**21.09**	**31.8**	**82**	**111**

Table 7 – Average processing times and time limit for processing requests for prior authorisation, and for processing requests for reimbursements

Overall, 14 countries provided information regarding average processing times for a request for prior authorisation. The average European processing time equals 21.09 days. Ireland was excluded from this calculation, as they reported 0 days of average time, having received zero requests in 2022. Hungary was excluded as well, as they reported a range instead of a natural number. The longest average processing time comes from Slovenia, with an average of 53 days. The shortest processing time comes from Romania, with an average of 3 days. Again,

Ireland has been excluded for the same reason presented above. Concerning the time limit for the processing of a request for prior authorisation, 19 countries provided information in the questionnaire. All 19 countries declared having a time limit, and the European average equals 31.8 days. The longest time limit comes from Croatia, Hungary, and Slovenia, with a total of 60 days. The shortest time limit comes again from Romania, with a maximum of 5 days.

Overall, 12 countries provided information regarding average processing times for reimbursement for prior authorisation. The average European processing time equals 82 days. Ireland was excluded from this calculation, as they reported 0 days of average time, having received zero requests in 2022. Hungary was excluded as well, as they reported a range instead of a natural number. The European average is however highly influenced by Malta, with the highest average processing time, equalling to one full year. All other countries reported no more than 80 days as the average processing time. The shortest average processing time come from Slovakia, 30 days. Concerning the time limit for the processing of a request for reimbursement for prior authorisation, 15 countries provided data. In four countries (Denmark, Germany, Luxembourg, and Romania) there is no time limit. The average European time limit equals 111 days. Again, this data is highly influenced by Malta, where the time limit equals to one year and a half (540 days). Other than Malta and Slovakia (180 days), all other countries have a time limit inferior to 100 days, with the shortest time limit coming from Austria (14 days).

6.6. Country breakdown

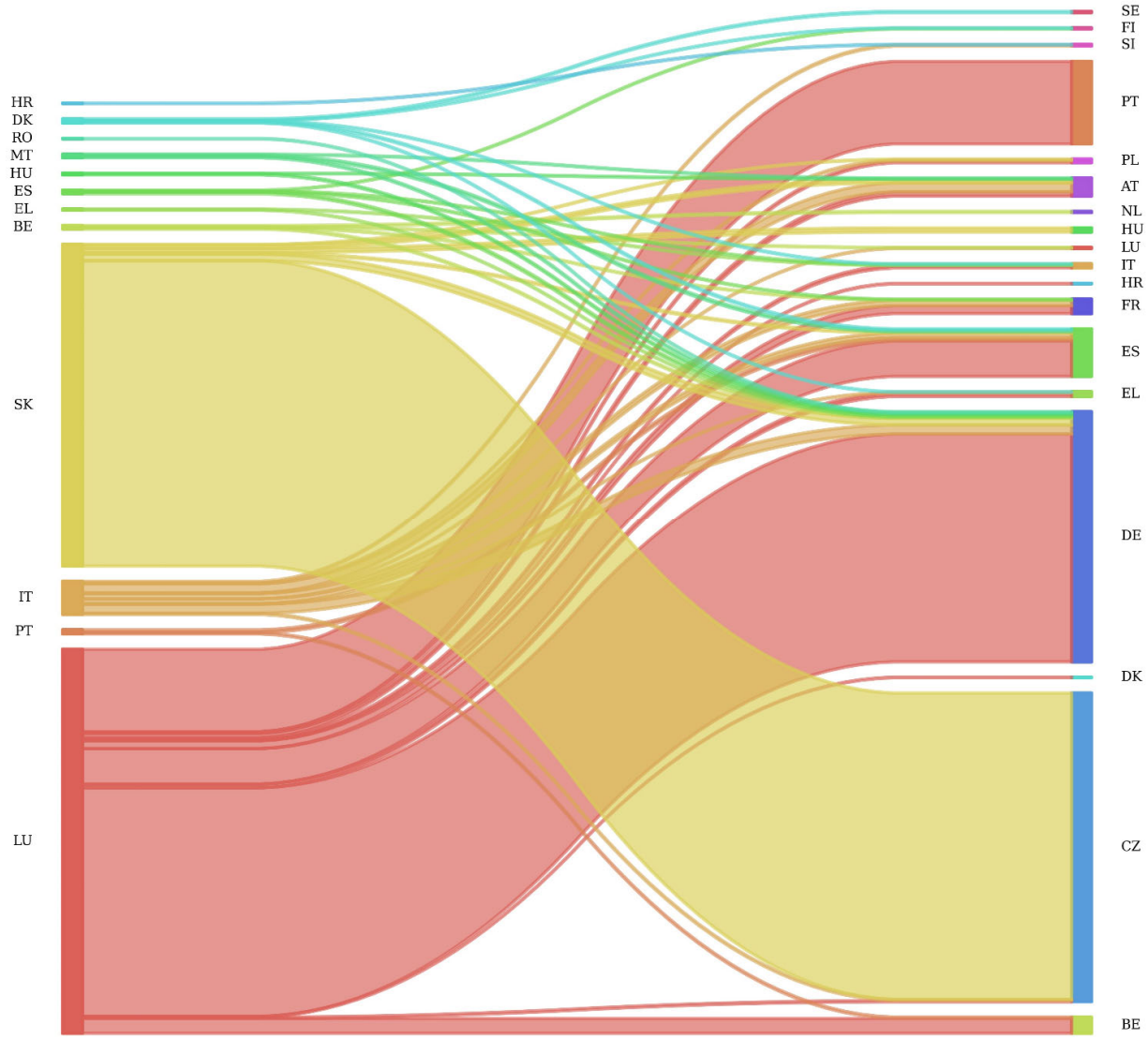
The questionnaire asked each country to report a breakdown of the number of authorised requests for healthcare subject to prior authorisation by country of treatment. The table on the next page reports the data collected. It can be noted that the countries that reported the number of requests received, authorised, and refused (as seen in Section 6.2) is equal to 17, while the table presented on the next page includes only 12 countries (of affiliation). This is due to the fact that the country breakdown includes only requests authorised, and three countries (Bulgaria, Hungary, and Poland) received but did not authorise any request in 2022, while Ireland did not receive and therefore did not authorise any requests in 2022. Additionally, Germany, the country that received and authorised the most requests in 2022, is unable to provide a breakdown of this kind, because of the impossibility for them to filter out the data by country of treatment.

Country of affiliation	Country of treatment																		TOT
		BE	CZ	DK	DE	EL	ES	FR	HR	IT	LU	HU	NL	AT	PL	PT	SI	FI	SE	
	BE		0	0	2	0	0	1	0	0	1	0	2	0	0	0	0	0	0	6
	DK	0	0		0	1	2	0	0	1	0	0	0	0	0	0	0	1	2	7
	EL	0	0	0	1		0	0	0	1	0	0	0	0	0	0	0	0	0	2
	ES	0	0	0	3	0		1	0	1	0	0	0	0	0	0	0	1	0	6
	HR	0	0	0	0	0	0	0		0	0	0	0	0	0	0	1	0	0	1
	IT	0	2	0	15	1	8	9	0		1	0	0	15	2	0	2	0	0	55
	LU	25	2	1	380	6	59	13	1	4		0	0	7	3	137	0	0	0	638
	HU	0	0	0	2	0	0	0	0	0	0		0	1	0	0	0	0	0	3
	MT	0	0	0	2	0	3	0	0	0	0	0	0	1	0	0	0	0	0	6
	PT	2	0	0	0	0	5	0	0	0	0	0	0	0	0		0	0	0	7
	RO	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	SK	0	509	0	11	0	2	0	0	0	0	7	0	6	1	0	0	0	0	536
TOT		27	513	1	417	8	79	24	1	7	2	7	2	30	6	137	3	2	2	

Table 8 – Authorised requests for prior authorisation by country of treatment

Overall, the countries to which patients travelled the most to receive healthcare subject to prior authorisation are Czechia (513), Germany (417), and Portugal (137). It can be observed that cross-border healthcare concerns mostly neighbouring countries. Taking as an example the three countries that reported the highest number of authorised requests in the country breakdown, it can be seen that most of the requests authorised by Slovakia come from Czechia, the most requests authorised by Luxembourg come from Germany, and the most requests authorised from Italy come from Austria and Germany. Interestingly, a great number of requests authorised by Luxembourg come from Portugal and Spain, two countries that do not share any border with Luxembourg. These two however seem to be the only big exceptions, and generally, even for countries that authorised very few requests in 2022, most of them were received from neighbouring countries. The graph below represents visually the flow of patients between countries and depicts visually the trends just described.

Figure 5 – Authorised request by country of treatment



Compared to last year, the first difference observable is the absence of France, for the same reasons as explained in section 6.2 of this report. Then, regarding countries of affiliation, as mentioned in section 6.2, there are minimal observable differences, with Luxembourg and Slovakia being the two countries that receive and authorise the most requests (together with

Germany, not included in this graph due to the reasons explained above). The main differences between the two years can be observed in the variation in numbers for the countries of treatment. In 2021, Spain was the most prominent country of treatment, with (1 209). In 2022, the number reduced drastically, as only 79 requests were received from Spain. This is mostly due to the absence of data from France, as in 2021 96% of all authorised requests received by Spain as a Member State of treatment originated from France. Germany and Czechia, which were respectively the second and third most prominent countries of treatment (780 requests and 682 requests respectively) in 2021, become the first (Czechia, 513) and second (Germany, 417) countries for number of treatments performed in 2022. The major flows of patients remain similar between years and continue to involve mostly neighbouring regions, with most patients from Slovakia being treated in Czechia, and most patients from Luxembourg being treated in Germany.

6.7. Financial implications

Out of the 17 countries that reported data relative to healthcare requiring prior authorisation, 10 were able to provide information about the total expenditure relative to year 2022. Overall, EUR 7 708 041 were spent in the EU to reimburse patients who engaged in cross-border treatment or care requiring prior authorisation. The table below displays the amount reimbursed for healthcare not subject to prior authorisation for the year 2022 and 2021 (extracted from the previous year's report). Croatia reported no data in 2021 but was able to do so for the year 2022.

Country	Amount reimbursed 2021 (€)	Amount reimbursed 2022 (€)
Belgium	22 363	11 880
Denmark	119 097	76 285
Germany	525 871	6 822 642
Greece	1 821	46 865
Spain	11 818	5 700
Croatia	n.a.	620
Italy	200 485	139 975
Malta	79 695	54 069
Slovenia	14 523	20 580
Slovakia	493 302	529 425
TOTAL	**1 468 975**	**7 708 041**

Table 9 – Amount reimbursed 2021 and 2022 (healthcare subject to prior authorisation)

The country that has spent the most money in 2022 is Germany with EUR 6 822 642 reimbursed. Germany alone represents 88% of the total amount reimbursed in the EU. Slovakia with EUR 529 425 and Italy with EUR 139 975 are respectively the second and third countries that spent the most to reimburse cross-border patients. These three countries are the only three with an overall expenditure higher than EUR 100 000.

Compared to last year, the amount reimbursed increased substantially, being the total amount reimbursed for 2022 around five times greater than the amount reimbursed for 2021. This is mostly due to the big increase registered in Germany and can be due to several reasons. According to the national NCP, the reasons for claiming benefits abroad are not collected by the health insurance funds. Demand from health insurance companies has shown that the increase was mainly observed in border regions, particularly in the border regions with Switzerland, Austria, and Poland. Furthermore, the funds see signs that the increases in the volume of reimbursement claims under Article 7 of Directive 2011/24/EU stem mainly from dental prostheses. The background should be that the costs of dental prostheses abroad are significantly cheaper compared to Germany and that dentures are therefore increasingly used there because the insured can thus reduce their own financial contributions. Other causes could be due to an improved database, accompanied by the high EU-wide inflation (9.2 %) of the price increases for health services in 2022, and the “follow-up effects” after the COVID-19 pandemic and the associated elimination of travel restrictions.

Concerning the other variations observed, the total amount reimbursed increased in four countries (Germany, Greece, Slovenia, and Slovakia), and decreased in five countries (Belgium, Denmark, Spain, Italy, and Malta). Since Croatia did not provide any data in 2021, no comparison between years is possible.

7. Healthcare Not Subject to Prior Authorisation

The Directive covers also cross-border care provided without prior authorisation, whether it concerns planned or unplanned healthcare. Unplanned healthcare that might become necessary on medical grounds during a temporary stay in another EU/EEA country does not require prior authorisation and is received from public healthcare providers by using the European Health Insurance Card. This specific issue falls under the Regulations on Social Security Coordination, and not the Directive. Planned healthcare requires prior authorisation only for certain types of care, and for specific exceptions, at the discretion of each country of affiliation. Therefore, the majority of the instances of planned cross-border care do not require prior authorisation. This section reports results from the chapter of the questionnaire that collected data concerning these types of cross-border treatments and care.

7.1. How to request reimbursement?

Similar to the section of the questionnaire on healthcare subject to prior authorisation, also the section on healthcare not subject to prior authorisation includes a question (since 2021) on the ways a request for reimbursement can be requested (in person, online, via mail, etc). All countries replied to this question, except for Hungary and the Netherlands (26 countries out of 28). The table below reports the answers collected.

Country	In person	Online	Mail/post/fax
Belgium	X		X
Bulgaria	X		
Czechia	X		X
Denmark			X
Germany	X		X
Estonia	X		X
Ireland	X		X
Greece	X		X
Spain	X	X	X
France	X	X	X
Croatia	X		X
Italy	X	X	X
Cyprus	X		X
Latvia	X		X
Lithuania	X		X
Luxembourg	X		X
Malta	X		X
Austria	X		X

Country	In person	Online	Mail/post/fax
Poland	X	X	X
Portugal		X	
Romania	X		
Slovenia	X		X
Slovakia	X		X
Finland	X	X	X
Sweden	X	X	X
Norway		X	X

Table 10 - Ways in which a request for reimbursement can be made

In 23 out of the 26 countries that replied to this question, a request for reimbursement can be made in person. Out of these, in Bulgaria and Romania this is the only mean for patients to request a reimbursement concerning healthcare not subject to prior authorisation. A request can be made online in eight countries of the 26 that replied to this question. Again, Portugal is the sole country in which request for reimbursement can be made only online. All countries except for Bulgaria, Portugal, and Romania (23 out of 26) allow their patients to make requests via mail, post, or fax. Out of these, Denmark allows only this mean as a way for patients to present a request for reimbursement. Spain, France, Italy, Poland, Finland, and Sweden are the only six countries that allow their patients to make requests by all three means (in person, online, via mail/post/fax). 16 countries out of 26 accept requests made both in person and via mail, post, and fax. Norway is the only country that allows their patients to present requests for reimbursement both Online and via mail/post/fax, but not in person.

7.2. Requests for reimbursement received for healthcare not subject to prior authorisation

The questionnaire asked countries to share the total number of requests for reimbursement received, granted, and refused in year 2022, concerning healthcare not subject to prior authorisation. As in 2021's questionnaire, countries were not asked anymore to report the number of withdrawn/inadmissible requests, as they have been low through the years, and proved to be difficult to distinguish and report for most countries.

23 countries out of 28 managed to fill in this section of the questionnaire with data. Belgium did not provide any data because not all health insurance funds have provided the NCP with data. Hence the NCP preferred not to provide partial data as it would have not reflected the actual situation. Hungary did not provide any data, explaining that planned treatments of Hungarian insured persons in other MSs (over 500 cases each year) are based on the Regulations. The Netherlands did not provide any data because health insurers all have their own procedures, and this makes it not possible for the NCPs to get generic data on cross-border health care. Finally, Austria did not provide any data for the same reasons explained in Section 6.2 about healthcare subject to prior authorization. In Austria, no specific records are kept providing data on treatments under the Directive, because the reimbursement of costs of private medical treatments already existed in the national regulations before the entry into force of the Directive and therefore its adoption did not bring any significant innovation. There is no

distinction made between cases covered by the Directive and national cases due to a private medical visit, as the reimbursement system is the same.

Similar to the data presented in Section 6.2 of this report concerning healthcare subject to prior authorisation, also here it is important to notice that in some cases the number of requests granted and refused does not equal the number of requests received (e.g., Denmark, Ireland). In one specific case (France), the number of granted and refused requests is even greater than the total number of requests received. This is again a consequence of the fact that some requests are received later in the year and are not processed until the following year, and the number of granted and refused requests can also include requests received in the previous year but processed only in 2022.

The table below reports all the collected data, specifying in brackets the percentage of requests granted and refused over the total number of requests received.

Country	Received	Granted (%)	Refused (%)
Bulgaria	8	7 (87.5%)	1 (12.5%)
Czechia	440	380 (86.4%)	60 (13.6%)
Denmark	23 415	18 038 (77%)	3 402 (14.5%)
Germany	160 647	141 411 (88%)	19 236 (12%)
Estonia	90	89 (99%)	1 (1%)
Ireland	1 841	1 041 (56.5%)	101 (5.5%)
Greece	56	54 (96.4%)	2 (3.5%)
Spain	9	8 (89%)	1 (11%)
France	300 254	253 419 (84.4%)	111 383 (37%)
Croatia	192	123 (64%)	69 (36%)
Italy	149	118 (79.2%)	31 (20.8%)
Cyprus	44	43 (97.7%)	1 (2.3%)
Latvia	19	15 (79.9%)	2 (10.5%)
Lithuania	131	125 (95.4%)	6 (4.6%)
Malta	10	10 (100%)	0
Poland	14 176	11 862 (83.7%)	332 (2.3%)
Portugal	27	0	27 (100%)
Romania	889	512 (57.6%)	28 (3.14%)
Slovenia	2 190	1 980 (90.4%)	61 (2.8%)
Slovakia	13 904	13 161 (94.6%)	723 (5.2%)
Finland	5 652	n.a.	n.a.
Sweden	16 008	9 077 (56.7%)	831 (5.2%)
Norway	7 739	6 133 (79.2%)	1 929 (24.9%)
TOTAL	**547 890**	**457 606 (83.5%)**	**138 227 (25.2%)**

Table 11 - Number of requests for reimbursement (received/authorised/refused)

Out of the 23 countries that reported data concerning requests received for healthcare not subject to prior authorisation, France (300 254) and Germany (160 647) reported receiving much greater numbers than the other countries, as together these two countries constitute the 84% of the total amount of requests received in the EU in 2022. All the other 21 countries reported low numbers of requests received, with only four countries receiving more than 10 000 requests (Denmark 23 415, Poland 14 176, Slovakia 13 904, Sweden 16 008). A total of 12 countries reported receiving less than 1 000 requests in 2022 (Bulgaria eight, Czechia 440, Estonia 90, Greece 56, Spain nine, Croatia 192, Italy 149, Cyprus 44, Latvia 19, Lithuania 131, Malta 10, Portugal 27, Romania 889).

The data from Germany is significantly higher than most other countries due to the fact that, as explained in Section 6.2, the data collected also contains cases that are not explicitly covered by the Directive. According to the German Law, the rules of the Directive are to be applied not only to applications for reimbursement of benefits during a temporary stay in another EU/EEA country, but also to claims for reimbursement of benefits for entitlement to benefits (see section 6.2). This means that it is not possible to evaluate cases relating only to the Directive. France, that reported the highest number of requests received, faced a similar challenge, being unable to distinguish cases relating to the Directive and cases relating to the Regulations. According to the NCP, this is due to the IT tool adopted, and it should change for year 2023.

Only one country did not grant most of the requests received. Portugal refused all 27 requests received in 2022. Then, other than Finland, that was able to report the total number of requests received but not the number of requests granted and refused, every other country granted more than 50% of the received requests. Of these 21 countries, 12 managed to grant more than 80% of the requests received (Bulgaria, Czechia, Germany, Estonia, Greece, Spain, France, Cyprus, Lithuania, Malta, Poland, Slovenia, and Slovakia).

Compared to last year, four more countries managed to report data concerning requests received, granted, and refused for reimbursement of healthcare not subject to prior authorisation, while one country that managed to report data in 2021, was not able to do so in 2022. (20 countries in 2021, 23 in 2022). The new countries are Bulgaria, Cyprus, Germany, and Portugal. Austria was not able to provide data in 2022, but it should be noted that numbers were very low in 2021, with only one request received. The total number of requests received remains very similar, with a total of 569 776 requests for reimbursement in 2021, and 547 890 requests for reimbursement in 2022. The number of granted requests increased compared to last year. 360 249 requests for reimbursement were granted in 2021, consisting of 55.5% of the total number of requests received. In 2022, this number increased to 457 606 granted requests, consisting of the 83.5% of the total number of requests received. Even the number of refused requests raised significantly, 55 333 requests for reimbursement were refused in 2021, consisting of 9.7% of the total number of requests received. In 2022, this number increased to 138 227 refused requests, consisting of the 25.2% of the total number of requests received. Analysing the variation in numbers reported by the countries that were able to provide data for both years, it can be observed that the number of requests received remained stable for most countries, with very few exceptions. France received significantly fewer requests for reimbursement compared to last year, having received 490 464 requests in 2021, and 300 254 requests in 2022. The other country that reported significantly lower numbers is Poland, with 24 312 requests received in 2021 and 14 176 requests received in 2022. Three countries reported significant increases in the number of requests received. Sweden received 11 445 requests in 2021 and 16 008 requests in 2022. Slovakia received 9 280 requests in 2021 and 13 904 requests in 2022. Finally, Norway received 3 880 requests in 2021 and 7 739 requests

in 2022. Concerning the percentage of authorised and refused requests, no differences can be observed with last year's data, where again every country reported granting most of the requests received. The only country that did not do so in 2022 is Portugal, which was unfortunately unable to provide data in 2021, making any comparison impossible.

7.3. Processing times

As for healthcare subject to prior authorisation, the questionnaire also collected data on the average processing times for the reimbursement for healthcare not subject to prior authorisation and the time limit to process a request for reimbursement. The table below reports the average processing times and time limit, expressed in the number of days.

Country	Number of days	Time Limit
Bulgaria	60	60
Czechia	15	30
Denmark	40	No limit
Germany	n.a.	No limit
Estonia	24	30
Ireland	45	30
Greece	40	40
Spain	104.7	90
France	278	No limit
Croatia	90	60
Italy	41.5	60
Cyprus	300	n.a.
Latvia	20	365
Lithuania	20	30
Luxembourg	40	No limit
Malta	365	524
Poland	n.a.	180
Portugal	n.a.	90
Romania	69.5	n.a.
Slovenia	32	60
Slovakia	33	180
Finland	33.7	No limit
Sweden	115.7	90
Norway	32	60

Table 12 - Average processing times and time limit for processing requests for reimbursements

Overall, 21 countries provided information regarding average processing times for reimbursement for healthcare not subject to prior authorisation. Germany, Poland, and Portugal were not able to provide any data. The average European processing time is 85.7 days. The longest average processing time comes from Cyprus, with an average of 300 days. The shortest processing time comes from Czechia, with an average of 15 days.

Concerning the time limit for the processing of a request for reimbursement for healthcare not subject to prior authorisation, 22 countries provided information in the questionnaire. In five countries (Denmark, Germany, France, Luxembourg, and Finland) there is no time limit. The average European time limit of the remaining 17 countries equal 116.5 days. The longest time limit comes from Malta with a maximum of 524 days. The shortest time limit comes from Czechia, Estonia, Ireland, and Lithuania, all with a maximum of 30 days.

7.4. Country breakdown

In this section, the questionnaire asked each country to report a breakdown of the number of granted requests for reimbursement for healthcare not subject to prior authorisation by country of treatment. The table in the next page reports the data collected. It can be noted that the countries that reported the number of requests received, granted, and refused (as seen in Section 7.2) is equal to 23, while the table presented in the next page includes only 21 countries (of affiliation). This is due to the fact that the country breakdown includes only requests granted, and Portugal received but did not grant any request in 2022. Additionally, Germany, that is the country that received and granted the second most requests in 2022 (behind France), is unable to provide a breakdown of this kind, because of the impossibility for them to filter out the data by country of treatment.

Country of Affiliation \ Country of Treatment	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	IS	NO	TOTAL
BG	1		0	0	2	0	0	0	2	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	7
CZ	5	8		1	60	0	1	8	8	20	1	12	0	0	0	0	0	0	3	83	75	5	1	3	86	0	0	0	0	380
DK	8	59	19		12188	28	4	188	1451	156	31	117	25	23	55	2	375	7	174	215	751	62	29	1	11	17	2019	4	19	18038
EE	2	5	0	0	22		0	0	11	3	1	1	1	13	1	0	0	1	4	1	1	1	0	0	1	19	0	1	0	89
IE	3	1	9	0	29	3		1	201	0	2	3	0	32	174	0	7	0	1	1	223	2	8	0	9	0	0	0	0	709
EL	2	0	0	0	17	0	0		4	7	0	7	3	0	0	4	0	0	6	0	0	0	0	1	0	1	2	0	0	54
ES	0	0	0	0	0	0	0	0		2	0	2	0	0	0	0	0	0	2	0	0	2	0	0	0	0	0	0	0	8
FR	19000	1101	361	108	74	4706	471	21756	103002		1785	19112	285	66	119	10351	1992	1491	1778	5900	2242	59640	1448	122	97	437	1077	90	118	258729
HR	12	1	1	0	35	0	1	2	14	9		3	0	0	0	3	2	1	7	14	0	0	0	14	0	0	3	0	1	123
IT	5	0	5	0	13	0	0	3	21	3	7		0	0	0	1	0	1	2	66	0	0	0	1	0	0	0	0	0	128
CY	1	0	0	0	2	0	0	7	0	0	0	0		0	0	0	34	0	0	0	0	0	0	0	0	0	0	0	0	44
LV	0	1	0	0	2	3	0	1	7	0	0	0	0		1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15
LT	5	0	0	0	13	3	0	1	3	1	0	2	0	59		1	0	0	0	1	31	0	0	0	5	0	0	0	0	125
MT	0	0	0	0	2	0	0	0	0	4	0	1	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	7
PL	0	1	10427	0	1222	0	0	2	49	6	1	2	0	0	140	1	0	0	0	9		1	0	1	0	0	0	0	0	11862
RO	6	1	0	0	20	0	0	0	5	10	0	8	0	0	0	0	422	0	1	38	0	0		1	0	0	0	0	0	512
SI	2	0	25	0	25	0	0	1	4	0	1501	309	0	0	0	0	13	0	2	96	0	0	0		1	1	0	0	0	1980
SK	26	7	6219	1	220	0	0	10	14	36	50	35	1	0	0	2	1024	1	23	493	4967	8	10	4		3	6	0	1	13161
FI	34	26	11	4	84	4511	0	11	481	81	19	34	5	28	53	1	37	0	15	2	128	10	11	8	2		32	0	4	5632
SE	31	38	16	780	323	41	0	357	5277	214	93	55	319	15	61	8	41	3	33	132	234	53	53	7	2	872		6	13	9077
NO	29	13	13	186	157	4	5	81	4705	171	22	34	40	14	72	0	94	4	52	56	216	44	20	4	17	14	48	17		6132
TOTAL	19172	1262	17106	1080	14510	9299	482	22429	115259	723	3513	19737	679	250	676	10374	4041	1509	2104	7108	8868	59828	1580	167	231	1364	3187	118	156	

Table 13 - Authorised requests for reimbursement by country of treatment

Overall, the countries in which patients travelled the most to receive healthcare not subject to authorisation are Spain (115 259) and Portugal (59 828), followed by Greece (22 429), Italy (19 737), and Belgium (19 172).

It can be observed that also for cross-border healthcare not subject to prior authorisation most movements concern mostly neighbouring countries. Taking examples from the countries that reported the highest number of authorised requests in the country breakdown, it can be seen that most of the requests granted by France come from Spain, Italy, and Belgium, most of the request granted by Denmark come from Germany, and most of the requests granted by Poland come from Czechia. Interestingly, a great number of requests granted by France comes from Portugal and Greece, two countries that do not share any border with France. These two however seem to be the only big exceptions, and generally, even for countries that granted few requests in 2022, most of them were received from neighbouring countries. The graph below represents visually the flow of patients between countries and depicts visually the trends just described.

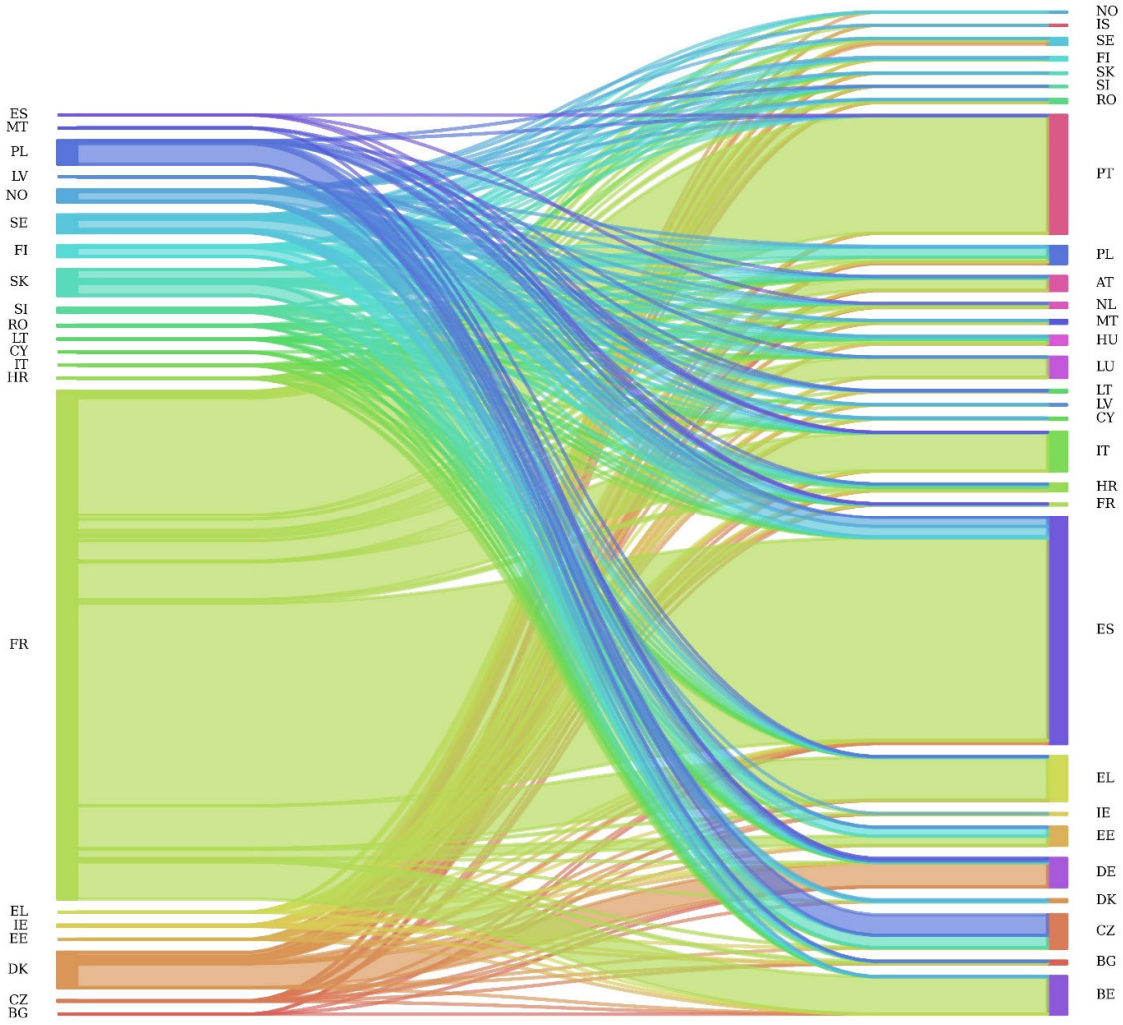


Figure 6 - Granted request by country of treatment

Compared to the previous year, regarding countries of affiliation, as mentioned in section 6.2, there are minimal observable differences, with France, Poland, Denmark, and Slovakia being

the four countries that received and granted the most requests (together with Germany, not included in this graph, due to the reasons explained above). Some slight differences between the two years can be observed when analysing the countries of treatment. The most prominent countries of treatment remained mainly the same across 2021 and 2022, but there have been some variations in numbers. For example, Spain is still the country where most cross-border patients have been treated, but the total amount of granted requests for treatment increased between the two years, with 82 498 granted requests in 2021 compared to 115 259 granted requests in 2022. The only other noticeable difference can be found in the data concerning Belgium, with 64 826 granted requests in 2021 compared to 19 172 granted requests in 2022. Even for healthcare not subject to prior authorisation the major flows of patients remain similar between years, and continue to involve mostly neighbouring regions, with most cases of cross-border patient mobility involving the same countries as in 2021.

7.5. Financial implications

All 23 countries that reported data relative to healthcare not subject to prior authorisation were able to provide information about the total expenditure relative to the year 2022. Overall, EUR 86 461 491 were spent in the EU to reimburse patients that engaged in cross-border treatment or care not requiring prior authorisation. The table below displays the amount reimbursed for healthcare not subject to prior authorisation for years 2022 and 2021 (extracted from the previous year report). Bulgaria and Cyprus reported no data in the year 2021 but were able to do so for year 2022.

Country	Amount reimbursed 2021 (€)	Amount reimbursed 2022 (€)
Belgium	6 448 551	7 566 882
Bulgaria	n.a.	1 513
Czechia	116 339	154 833
Denmark	2 522 780	2 836 897
Germany	5 953 279	30 391 998
Estonia	71 000	238 000
Ireland	7 811 328	4 323 231
Greece	14 982	12 131
Spain	184	7 197
France	214 292 169	14 123 939
Croatia	18 787	21 544
Italy	48 222	102 571
Cyprus	n.a.	379 964
Latvia	29 475	14 183
Lithuania	95 502	140 950
Malta	15 270	10 724
Poland	4 288 925	5 925 573

Romania	433 737	644 168
Slovenia	483 147	793 879
Slovakia	1 372 334	2 741 784
Finland	175 989	214 531
Sweden	13 509 933	11 161 854
Norway	1 374 085	4 654 145
TOTAL	**259 076 018**	**86 462 491**

Table 14 - Amount reimbursed 2021 and 2022 (healthcare not subject to prior authorisation)

The country that spent the most money in 2022 is Germany, that with EUR 30 391 998 reimbursed it alone represents the 32.2% of the total amount reimbursed in the EU. France with EUR 14 123 939 and Sweden with EUR 11 161 854 are respectively the second and third country that spent the most to reimburse cross-border patients. These three countries are the only three with an overall expenditure higher than EUR 10 000 000.

Compared to last year, the amount reimbursed decreased dramatically, being the total amount reimbursed for 2022 around three times smaller than the amount reimbursed for 2021. This is mostly due to the big decrease registered in France, which went from spending EUR 214 292 169 in 2021 to spending EUR 14 123 939 in 2022. According to the NCP, this decrease is partially explained by the fact that the data presented in the 2022 questionnaire excludes all data not relating to reimbursement under the Directive, an exclusion that was not possible the prior year, where the NCP lamented the inability to distinguish between reimbursements granted under the Regulation and reimbursement granted under the Directive. Additionally, the massive difference is a consequence of the country's responses to the COVID-19 pandemic. France, in fact, made it compulsory to present a negative PCR test in order to enter France, and to have the PCR or antigenic test carried out abroad under certain conditions. The most significant increase was observed for Germany, where the total amount reimbursed went from EUR 5 953 279 in 2021 to EUR 30 391 998 in 2022. This is probably due to the same reasons explained in section 6.7.

Concerning the other variations observed, the total amount reimbursed increased in 15 countries (Belgium, Czechia, Denmark, Germany, Estonia, Spain, Croatia, Italy, Lithuania, Poland, Romania, Slovenia, Slovakia, Finland, and Norway), and decreased in six countries (Ireland, Greece, France, Latvia, Malta, and Sweden). Since Bulgaria and Cyprus did not provide any data in 2021, no comparison between years is possible.

Annex I – Questionnaire

DIRECTIVE 2011/24/EU
REPORTING ON PATIENT MOBILITY IN 2022

Thank you for agreeing to provide the information needed for reporting on the operation of Directive 2011/24/EU as foreseen in Article 20 of Directive 2011/24/EU. This exercise is done on a yearly basis to monitor the application of Directive 2011/24/EU and to create comparable statistics that can be evaluated over longer periods of time.

To help you fill out the questionnaire, additional information has been included in the questionnaire. Further information can also be found in the new Guidance Manual distributed together with the questionnaire.

The questionnaire contains questions relating to four main sections:

1. National Contact Points;
2. Limitations for patient inflow;
3. Healthcare subject to prior authorisation;
4. Healthcare not subject to prior authorisation.

The questionnaire also contains a fifth section for providing additional information. If you prefer, you can also attach a note (in Word) to your reply. It is helpful if the information is provided in English, but not a requirement. For information about what to include, please see the information provided in connection with each question and in the beginning of each section (in the questionnaire and in the Guidance Manual). In addition, please provide information about possible other data quality issues and, if available, also other information that can help put the figures provided in context (see the Guidance Manual for further information).

Please indicate clearly if there is any additional information provided that cannot be included in the annual report. You will be able to review the report before it is published to verify any comments that are included.

Please note that the deadline for submitting the completed questionnaire is Friday 15 September 2023.

Index to sections	Content
1. National Contact Points (NCPs)	Please provide updated contact information to all National Contact Points
2. Limitations for patient inflow	Please indicate if any limitation on patient inflow were adopted pursuant to Article 4(3)
3. Healthcare subject to prior authorisation (PA)	Please report all mobility subject to prior authorisation as provided for in Articles 7, 8 and 9
4. Healthcare not subject to prior authorisation (PA)	Please report all mobility NOT subject to prior authorisation as provided for in Articles 7 and 9
5. Additional information	Please provide additional information explaining the figures provided
Definitions	Terms as defined in Directive 2011/24/EU

1. NATIONAL CONTACT POINTS

This section contains a question related to your National Contact Point(s). The number of information requests received is no longer collected through this questionnaire. Data relating to information requests are instead collected as part of the data collection done under the Single Digital Gateway Regulation.

1.1 Identification details

Please verify the information you provided last year. The information can be found in Annex V, Fact sheets, in the European Commission's 2021 report (https://health.ec.europa.eu/publications/data-cross-border-patient-healthcare-following-directive-201124eu-reference-year-2021_en).
Is the information still correct?

- [x] Yes
- [ ] No, please provide updated identification details below relating to all your National Contact Points (NCPs)
- [ ] Did not reply last year, please provide identification details below relating to all your National Contact Points (NCPs)

NCP 1

Name	
Affiliation/Organisation	
Website	
E-mail	
Phone	

NCP 2

Name	
Affiliation/Organisation	
Website	
E-mail	
Phone	

NCP 3

Name	
Affiliation/Organisation	
Website	
E-mail	
Phone	

NCP 4

Name	
Affiliation/Organisation	
Website	
E-mail	
Phone	

NCP 5

Name	
Affiliation/Organisation	
Website	
E-mail	
Phone	

2. LIMITATIONS ON PATIENT INFLOW

The questions in this section relate to implementation of any measures to limit access to healthcare according to Article 4(3) of Directive 2011/24/EU.

a) Measures regarding access to treatment according to Article 4(3) of Directive 2011/24/EU

Denmark, Estonia and Romania reported having introduced mechanisms to limit access to healthcare as provided for in Article 4(3) of Directive 2011/24/EU. Further information can be found in chapter 3, Limitation of patient inflow, and in Annex V, Fact sheets, in the European Commission's 2021 report (https://health.ec.europa.eu/publications/data-cross-border-patient-healthcare-following-directive-201124eu-reference-year-2021_en).

Denmark, Estonia and Romania, please verify if you still have mechanisms to limit access to healthcare as provided for in Article 4(3) of Directive 2011/24/EU.

☐ Yes, please reply to the questions below
☐ No, please provide in section 5 or in a separate note information about the changes made

All other countries, please inform if you have introduced any mechanisms to limit access to healthcare as provided for in Article 4(3) of Directive 2011/24/EU.

☐ Yes, please reply to the questions below
☉ No

b) Number of patients

Please provide the number of patients whose access to treatment have been limited in 2022 on the grounds of overriding reasons of general interest.	

c) Please provide reference to the national legislation imposing restrictions under Article 4(3) of Directive 2011/24/EU and information about its application in practice in 2022

• A vertical scroll bar will appear to enable you to scroll down if the text inserted is longer than the size of the textbox.

3. HEALTHCARE SUBJECT TO PRIOR AUTHORISATION

The questions in this section relate to healthcare subject to prior authorisation. The questions are divided into two subsections:
3.1 Requests for prior authorisation
3.2 Requests for reimbursement

If no distinction can be made between Directive 2011/24/EU and the Social Security Coordination Regulations (Regulation (EC) No 883/2004 and Regulation (EC) No 987/2009), please provide additional information in section 5 or in a separate note explaining exactly which elements are affected and why. Please pay specific attention in relation to the number of received, authorised, or refused requests for prior authorisation, as well as the amount reimbursed.

Please indicate whether or not you have implemented a system of prior authorisation

- [x] Yes, please respond to the questions in sections 3.1 and 3.2 below
- [ ] No, please go to the next section - 4. Healthcare not subject to prior authorisation

If a system of prior authorisation is no longer in place, if the system was changed, or if a system of prior authorisation was introduced, please provide this information in section 5 or in a separate note.

3.1 Requests for prior authorisation

a) How can a request for prior authorisation be made (in person, post, e-mail, online, other means)?

- A vertical scroll bar will appear to enable you to scroll down if the text inserted is longer than the size of the textbox.

b) Number of requests for prior authorisation

Please provide the number of requests received (excluding withdrawn/inadmissible requests), authorised (regardless of the year of receipt) and refused (regardless of the year of receipt) in 2022.The number of withdrawn/inadmissible requests is not requested anymore due to low data quality in previous years. Be aware that the sum of the number of authorised and refused requests can but does not have to equal the number of received requests, as some requests are received later in the year and are not processed until the following year. The number of authorised and refused requests may also relate to requests received in the previous year.

Number of received requests	
Number of authorised requests	
Number of refused requests	

c) Processing times

Please respond to the questions below relating to your processing times in 2022. In addition, please provide in section 5 or in a separate note information about events that have increased the processing times and/or steps taken to reduce the processing times, such as the introduction of electronic applications to speed up the processing procedures.

Average processing time

Please provide the average time (in working days) for processing requests for prior authorisation in 2022.

Maximum time limit

Please provide the maximum time limit allowed according to your national legislation (specifically related to cross-border healthcare or as part of the general administrative legislation) for processing requests for prior authorisation. Please specify the unit as specified in your legislation (days, working days etc.). In addition, please specify if the maximum time limit is related specifically to cross-border healthcare or if it is part of the general administrative legislation.

Time limit	Legislation

d) Authorised requests for prior authorisation by type of healthcare

Please provide the number of authorised requests for prior authorisation by type of healthcare. The boxes for providing your reply are automatically marked red if the total number of authorisations does not correspond to the figure provided under section 3.1 b). Please mention in section 5 or in a seperate note if more than one reason is indicated in relation to one authorised request, in which case you can ignore the boxes turning red.

Type of healthcare	Number of requests
• Healthcare which is made subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources and involves overnight hospital accommodation of the patient in question for at least one night (Article 8(2)(a)(i) of Directive 2011/24/EU).	
• Healthcare which is made subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources and requires use of highly specialised and cost-intensive medical infrastructure or medical equipment (Article 8(2)(a)(ii) of Directive 2011/24/EU).	

• Healthcare which involves treatments presenting a particular risk for the patient (Article 8(2)(b) of Directive 2011/24/EU).	
• Healthcare which involves treatments presenting a particular risk for the population (Article 8(2)(b) of Directive 2011/24/EU).	
• Healthcare which is provided by a healthcare provider that, on a case-by-case basis, could give rise to serious and specific concerns relating to the quality or safety of the care, with the exception of healthcare which is subject to Union legislation ensuring a minimum level of safety and quality throughout the Union (Article 8(2)(c) of Directive 2011/24/EU).	

e) Authorised requests for prior authorisation by country of treatment

Please provide the number of authorised requests for prior authorisation by country of treatment. The boxes for providing your reply are automatically marked red if the total number of authorisations does not correspond to the figure provided under section 3.1 b).

Country of treatment	Number of requests
Austria	
Belgium	
Bulgaria	
Croatia	
Cyprus	
Czechia	
Denmark	
Estonia	
Finland	
France	
Germany	
Greece	
Hungary	
Iceland	
Ireland	
Italy	
Latvia	
Liechtenstein	
Lithuania	
Luxembourg	
Malta	
Netherlands	
Norway	
Poland	
Portugal	
Romania	
Slovakia	
Slovenia	
Spain	
Sweden	

f) Refused requests for prior authorisation by reason for refusal

Please provide the number of refused requests for prior authorisation by reason for refusal. The boxes for providing your reply are automatically marked red if the total number of refusals does not correspond to the figure provided under section 3.1 b). Please mention in section 5 or in a separate note if more than one reason is indicated in relation to one refused request, in which case you can ignore the boxes turning red.

Reason for refusal	Number of requests
• This healthcare can be provided on its territory within a time limit which is medically justifiable, taking into account the current state of health and the probable course of the illness of each patient concerned (Article 8(6)(d) of Directive 2011/24/EU).	
• The healthcare is not included among the national healthcare benefits of the Member State of affiliation (Article 7(1) of Directive 2011/24/EU).	
• The patient will, according to a clinical evaluation, be exposed with reasonable certainty to a patient-safety risk that cannot be regarded as acceptable, taking into account the potential benefit for the patient of the sought cross-border healthcare (Article 8(6)(a) of Directive 2011/24/EU).	
• The general public will be exposed with reasonable certainty to a substantial safety hazard as a result of the cross-border healthcare in question (Article 8(6)(b) of Directive 2011/24/EU).	
• This healthcare is to be provided by a healthcare provider that raises serious and specific concerns relating to the respect of standards and guidelines on quality of care and patient safety, including provisions on supervision, whether these standards and guidelines are laid down by laws and regulations or through accreditation systems established by the Member State of treatment (Article 8(6)(c) of Directive 2011/24/EU).	

3.2 Requests for reimbursement

If a distinction cannot be made between requests for reimbursement related to treatments with prior authorisation and requests for reimbursement related to treatments not requiring prior authorisation, please provide further information in section 5 or in a separate note.

a) How can a request for reimbursement be made (in person, post, e-mail, online, other means)?

- A vertical scroll bar will appear to enable you to scroll down if the text inserted is longer than the size of the textbox.

b) Processing times

Please respond to the questions below relating to your processing times in 2022. In addition, please provide in section 5 or in a separate note information about events that have increased the processing times and/or steps taken to reduce the processing times, such as the introduction of electronic applications to speed up the processing procedures.

Average processing time

Please provide the average time (in working days) for processing requests for reimbursement in 2022.

Maximum time limit

Please provide the maximum time limit allowed according to your national legislation (specifically related to cross-border healthcare or as part of the general administrative legislation) for processing requests for reimbursement. Please specify the unit as specified in your legislation (days, working days etc.). In addition, please specify if the maximum time limit is related specifically to cross-border healthcare or if it is part of the general administrative legislation.

Time limit	Legislation

c) Amount reimbursed

Please provide the aggregated amount reimbursed in 2022.

4. HEALTHCARE NOT SUBJECT TO PRIOR AUTHORISATION

The questions in this section relate to healthcare not subject to prior authorisation.

If no distinction can be made between Directive 2011/24/EU and the Social Security Coordination Regulations (Regulation (EC) No 883/2004 and Regulation (EC) No 987/2009), please provide additional information in section 5 or in a separate note explaining exactly which elements are affected and why. Please pay specific attention in relation to the number of received, granted, or refused requests for reimbursement, as well as the amount reimbursed.

System of prior notification according to Article 9(5) of Directive 2011/24/EU

Denmark, Estonia, Greece, Ireland, Italy, Malta, Poland, Sweden and Norway reported of having a system of prior notification according to Article 9(5) of Directive 2011/24/EU. Further information can be found in chapter 4, Prior notification, and in Annex V, Fact sheets, in the European Commission's 2021 report (hhttps://health.ec.europa.eu/publications/data-cross-border-patient-healthcare-following-directive-201124eu-reference-year-2021_en).

Denmark, Estonia, Greece, Ireland, Italy, Malta, Poland, Sweden and Norway, please verify if you still have a system for prior notification according to Article 9(5) of Directive 2011/24/EU.

- [ ] Yes
- [ ] No, please provide in section 5 or in a separate note information about the changes made

All other countries, please inform if you have introduced a system for prior notification according to Article 9(5) of Directive 2011/24/EU.

- [ ] Yes, please provide in tab 5 or in a separate note information about the changes made
- [ ] No

4.1 Requests for reimbursement

If a distinction cannot be made between requests for reimbursement related to treatments with prior authorisation and requests for reimbursement related to treatments not requiring prior authorisation, please provide further information in section 5 or in a separate note.

a) How can a request for reimbursement be made (in person, post, e-mail, online, other means)?

- A vertical scroll bar will appear to enable you to scroll down if the text inserted is longer than the size of the textbox.

b) Number of requests for reimbursement

Please provide the number of requests received (excluding withdrawn/inadmissible requests), granted (regardless of the year of receipt) and refused (regardless of the year of receipt) in 2022. The number of withdrawn/inadmissible requests is not requested anymore due to low data quality in previous years. Be aware that the sum of the number of granted and refused requests can but does not have to equal the number of received requests, as some requests are received later in the year and are not processed until the following year. The number of granted and refused requests may also relate to requests received in the previous year.

Number of received requests	
Number of granted requests	
Number of refused requests	

c) Processing times

Please respond to the questions below relating to your processing times in 2022. In addition, please provide in section 5 or in a separate note information about events that have increased the processing times and/or steps taken to reduce the processing times, such as the introduction of electronic applications to speed up the processing procedures.

Average processing time

Please provide the average time (in working days) for processing requests for reimbursement in 2022.

Maximum time limit

Please provide the maximum time limit allowed according to your national legislation (specifically related to cross-border healthcare or as part of the general administrative legislation) for processing requests for reimbursement. Please specify the unit as specified in your legislation (days, working days etc.). In addition, please specify if the maximum time limit is related specifically to cross-border healthcare or if it is part of the general administrative legislation.

Time limit	Legislation

d) Amount reimbursed

Please provide the aggregated amount reimbursed in 2022.

e) Granted requests for reimbursement by country of treatment

Please provide the number of granted requests for reimbursement by country of treatment. The boxes for providing your reply are automatically marked red if the total number of authorisations do not correspond to the figure provided under section 4.1 b).

Country of treatment	Number of requests
Austria	
Belgium	

Bulgaria	
Croatia	
Cyprus	
Czechia	
Denmark	
Estonia	
Finland	
France	
Germany	
Greece	
Hungary	
Iceland	
Ireland	
Italy	
Latvia	
Liechtenstein	
Lithuania	
Luxembourg	
Malta	
Netherlands	
Norway	
Poland	
Portugal	
Romania	
Slovakia	
Slovenia	
Spain	
Sweden	

5. ADDITIONAL INFORMATION

In addition to the information requested in sections 1-4 of the questionnaire, you are invited to provide additional information. If you prefer, you can also attach a note (in Word) to your reply. It is helpful if the information is provided in English, but not a requirement. For information about what to include, please see the information provided in connection with each question and in the beginning of each section (in the questionnaire and in the Guidance Manual). In addition, please provide information about possible other data quality issues and, if available, also other information that can help put the figures provided in context (see the Guidance Manual for further information).

Please indicate clearly if there is any additional information provided that cannot be included in the annual report. You will be able to review the report before it is published to verify any comments that are included.

A vertical scroll bar will appear to enable you to scroll down if the text inserted is longer than the size of the textbox.

DEFINITIONS

DIRECTIVE 2011/24/EU	
HEALTHCARE	Means health services provided by health professionals to patients to assess, maintain or restore their state of health, including the prescription, dispensation and provision of medicinal products and medical devices.
INSURED PERSON	(1) persons, including members of their families and their survivors, who are **covered** by Article 2 of Regulation (EC) No 883/2004 **and** who are **insured** persons within the meaning of Article 1(c) of that Regulation. COVERED 1. Nationals of a Member State, stateless persons and refugees residing in a Member State who are or have been subject to the legislation of one or more Member States, as well as the members of their families and their survivors. 2. Survivors of persons who have been subject to the legislation of one or more Member States, irrespective of the nationality of such persons, where their survivors are nationals of a Member State or stateless persons or refugees residing in one of the Member States. INSURED Satisfying the conditions required under the legislation of the Member State competent to have the right to benefits, taking into account the provisions of Regulation (EC) No 883/2004. The insurance is in relation to the social security branches covered by Regulation (EC) No 883/2004. The Member State competent is determined according to the provisions of by Regulation (EC) No 883/2004. (2) nationals of a third country who are **covered** by Regulation (EC) No 859/2003 or Regulation (EU) No 1231/2010, or who satisfy the conditions of the legislation of the Member State of affiliation for entitlement to benefits. COVERED 1. Nationals of third countries who are not already covered by Regulation (EC) No 883/2004 solely on the ground of their nationality, as well as to members of their families and to their survivors, provided that they are legally resident in the territory of a Member State and are in a situation which is not confined in all respects within a single Member State. 2. Nationals of third countries who satisfy the conditions of the legislation of the Member State of affiliation for entitlement to benefits.
MEMBER STATE OF AFFILIATION	(1) For insured persons who are nationals of a Member State, the Member State that is competent to grant to this insured person a prior authorisation to receive appropriate treatment outside the Member State of residence according to Regulations (EC) No 883/2004 and (EC) No 987/2009. (2) For insured persons who are nationals of a third country, the Member State that is competent to grant to the insured person a prior authorisation to receive appropriate treatment in another Member State according to Regulation (EC) No 859/2003 or Regulation (EU) No 1231/2010. If no Member State is competent according to those Regulations, the Member State of affiliation shall be the Member State where the person is insured or has the rights to sickness benefits according to the legislation of that Member State.
MEMBER STATE OF TREATMENT	The Member State on whose territory healthcare is actually provided to the patient. In the case of telemedicine, healthcare is considered to be provided in the Member State where the healthcare provider is established.
CROSS-BORDER HEALTHCARE	Healthcare provided or prescribed in a Member State other than the Member State of affiliation.
HEALTH PROFESSIONAL	Means a doctor of medicine, a nurse responsible for general care, a dental practitioner, a midwife or a pharmacist within the meaning of Directive 2005/36/EC, or another professional exercising activities in the healthcare sector which are restricted to a regulated profession as defined in Article 3(1)(a) of Directive 2005/36/EC, or a person considered to be a health professional according to the legislation of the Member State of treatment.
HEALTHCARE PROVIDER	Any natural or legal person or any other entity legally providing healthcare on the territory of a Member State.
PATIENT	Any natural person who seeks to receive or receives healthcare in a Member State.

MEDICINAL PRODUCT	Means a medicinal product as defined by Directive 2001/83/EC.

MEDICAL DEVICE	Means a medical device as defined by Regulation (EU)2017/745.

PRESCRIPTION	Means a prescription for a medicinal product or for a medical device issued by a member of a regulated health profession within the meaning of Article 3(1)(a) of Directive 2005/36/EC who is legally entitled to do so in the Member State in which the prescription is issued.

NATIONAL CONTACT POINT	Entity(ies) appointed to facilitate the exchange of information in order to enable patients to make use of their rights in relation to cross-border healthcare.

COSTS TO BE REIMBURSED	Means the costs incurred by an insured person who receives cross-border healthcare, if the healthcare in question is among the benefits to which the insured person is entitled in the Member State of affiliation. For the purpose of this Directive, it should cover not only the situation where the patient is provided with healthcare in a Member State other than the Member State of affiliation, but also the prescription, dispensation and provision of medicinal products and medical devices where these are provided in the context of a health service. The definition of cross-border healthcare costs should cover both the situation in which a patient purchases medicinal products and medical devices in a Member State other than the Member State of affiliation and the situation in which the patient purchases such medicinal products and medical devices in another Member State than that in which the prescription was issued. Patients are guaranteed assumption of the costs of that healthcare at least at the level of costs that would have been assumed for the same healthcare, had it been provided in the Member State of affiliation.

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- at the following standard number: +32 22999696,
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EU law and related documents

For access to legal information from the EU, including all EU law since 1951 in all the official language versions, go to EUR-Lex (eur-lex.europa.eu).

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The portal data.europa.eu provides access to open datasets from the EU institutions, bodies and agencies. These can be downloaded and reused for free, for both commercial and non-commercial purposes. The portal also provides access to a wealth of datasets from European countries.

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