European Commission

MEMBER STATE DATA

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

Year 2019

Health Connect Partners
supporting trust in data

Authors:
Petra Wilson
Isabelle Andoulsi
Caitlin Wilson

Health and Food Safety

Table of Contents

List of Tables

List of Figures

Note: *The information and views set out in this report are those of the authors and do not necessarily reflect the opinions of the Commission. The Commission does not guarantee the accuracy of the data included in this study. Neither the Commission nor anyone acting on the Commission's behalf may be held responsible for the use that may be made of the information contained therein. The authors of this study were Petra Wilson, Isabelle Andoulsi and Caitlin Wilson.*

Executive summary

Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (the Directive) codifies patients' rights to reimbursement for healthcare received in another EU Member State. In accordance with the Directive, Member States are asked to complete a questionnaire each summer to report on the use of the Directive in the preceding year. The data are collected within the National Contact Points (NCPs) of each MS and transmitted to the European Commission based on the questionnaire. The data collected cover requests for information about treatment abroad, treatment provided with prior authorisation from the Member State of Affiliation (where the patient is insured); as well as treatment where such prior authorisation is not required; as well as aggregated data on reimbursements made.

The present report provides an overview of patient mobility in 2019 based on data collected between June and October 2020. Fully or partially filled questionnaires were received from all thirty countries contacted (being the EU 27 plus UK which was still a Member State in 2019 and the EFTA countries Norway and Iceland). As several Member States were not able to provide data on each question asked and returned only partially filled questionnaires, the baseline numbers referred to in different sections vary and percentages should be interpreted with caution.

The introduction of this report sets out in broad terms the functioning of the Directive as well as outlining similar rights of reimbursement for cross-border care provided in the Regulations 883/2004 and Regulation 987/2009 on the Coordination of Social Security Systems (the Regulations) and various regional and bi-lateral agreements tools. Sections one to five of the report discuss the data returned by the Member States, Iceland and Norway, following the format of the questionnaire and include the raw data submitted by the Member States, Iceland, and Norway at the end of each section. The concluding chapter reviews the data reported for 2019 in comparison to the data provided on mobility in 2018, as well as providing an overview of the data on patient mobility under the Regulations as reported for 2019 by De Wispelaere[1] et al and a short discussion of the bi-lateral scheme operated in the French-Belgian border region known as the Zones Organisées d'Accès aux Soins Transfrontaliers' (ZOAST).

Information requests received by National Contact Points (NCPs)

The data reported by the NCPs show that in total 115,459 requests for information about access to healthcare were received in the EU28, Norway and Iceland in 2019, with more than half of the Member States reporting fewer than 1,000 requests. Estonia, Lithuania, Poland, and Sweden were the outliers receiving over 10,000 requests for information each. However, in each of these cases, the correspondent for the country noted that the NCPs do not distinguish between requests for information concerning possible care funded under the Directive and the Regulations, or indeed other enquiries concerning care in another country. The data show that over two-thirds of the requests for information were made by telephone, with the remainder being made either in writing (email) or made in person. The number of requests reported for 2019 represents an increase in the number reported for 2018. However, this is entirely attributable to the fact that Sweden was able to report data for 2019, but was not able to do so in previous years. If the data provided by Sweden for 2019 are excluded, the total number of requests for information received across the NCPs, who were able to report data, was very stable (95,565 in 2018 and 95,689 in 2019); despite that fact the some countries saw significant variation between the years.

Limitations for patient in-flow

Article 4(3) of the Directive provides that Member States may adopt mechanisms to limit access to healthcare by a citizen coming from another Member States , however, only four Member States (Denmark, Estonia, Romania, Wales in the UK) and Iceland reported that they had put in place such measures. Only Denmark reported having used these measures, noting that the measure had been used with respect to three requests for care from a citizen from another Member State.

1. Available via the website of DG Employment https://ec.europa.eu/social/home

Reimbursement of costs for healthcare following prior authorisation

In the interests of healthcare planning, the Directive offers Member States the possibility of putting in place a system of prior authorisation for certain types of healthcare, including those which require at least one night in hospital. Twenty Member States and Iceland reported that they had adopted such a prior authorisation system, of whom all but Germany were able to return data on patient mobility based on prior authorisation. In total, 7,171 requests for patient mobility with prior authorisation were reported. However, ten countries[2] reported fewer than 20 requests for prior authorisation. In the majority of cases (78%) requests for prior authorisation were granted, and while not all Member States were able to indicate the reason for authorisation being granted, where the reason was reported the data show that over 99% of cases for prior authorisation were based on the fact that medical intervention required an overnight stay. Some 16% of requests for prior authorisation were reported as having been refused, with this arising most frequently because the medical intervention was available within a reasonable time in the Member States of affiliation (66% of all refused cases). The total reported spend across the fourteen MS which provided this information was 6,773,982.88€, with a high of 5.83M€ in the UK, but all other countries who were able to give details on their spend reported a total spend on care with prior authorisation under 500,000€. While the reported spend is a significant drop from the 16,806,793 € reported in 2018, this is an artefact of Ireland, who reported spending some 11M€ in 2018, but were not able to report the total spend in 2019. Of those Member States who were able to report their spend in both 2018 and 2019, the majority reported a slight increase. The data provided on where patients travelled to when prior authorisation had been granted show that 70% of all such mobility is between groups of neighbouring countries, notably the UK and Ireland, Luxembourg and Germany, and France with its neighbours.

Reimbursement of costs for healthcare without prior authorisation

The Directive also provides for citizens to travel to another Member States for care without prior authorisation and then to seek reimbursement upon return. In 2019 twenty-five Member States and Norway and Iceland reported that they had received a total of 283,719 requests for such reimbursement; of which 85% were accepted for reimbursement, this being the same ratio of acceptance as in 2018. The total reported spend across the twenty-four MS who were able to provide this information, was just over 85.3M€. This ranged from a high of almost 25M€ in Sweden to 900€ in Spain. While the figures show a reported increase since 2018, this must be read carefully since in 2019 twenty-four countries reported their total spend, while in 2018 only seventeen provided this information. Alongside the system of reimbursement without prior authorisation, MS may also offer a system of prior notification of reimbursed costs. This is not the same as a prior authorisation, because it does not provide a guarantee of reimbursement, but it does give the patient a clear indication of the level of reimbursement that can be expected. In 2019 nine[3] countries indicated that they had put such a system in place.

Total amount of patient mobility in the European Union in 2018

The grand total of cases of patient mobility, both with and without prior authorisation reported for the year 2019 was 290,890, a slight increase from 2018 that saw 232,054 cases of reimbursement for care received in another EU Member State or EFTA country, indicating that the use of the Directive for patient mobility has remained stable.

[2] AT, BG, HR, MT, PL, PT, RO, SL, ES, IS

[3] DK, ET, EL, IE, IT, PL, SE, UK, NO

Introduction

1. An overview of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare

In 1998 the European Court of Justice established in the joined cases of Kohll and Decker[4] that no prior authorisation is required for scheduled outpatient care in another Member State (Kohll) and that no prior authorisation is required for the purchase of medical devices or medical products on prescription (Decker) in another Member State. The two cases marked the beginning of a series of cases whose judgements were, more than a decade later, codified in Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (hereinafter 'the Directive'), clarifying the rights of patients to be reimbursed for healthcare received in another Member State. The Directive does not deal solely with the rights to reimbursement, but also introduces several significant flanking measures to support patients in using these rights in practice. As a result, there is now a set of minimum requirements, which applies to all healthcare provided to patients in the EU. These requirements relate to transparency, information to patients, and safety and quality of care.

The Directive provides that patients who are entitled to a particular health service under the statutory healthcare system in their home country (Member State of affiliation), are generally also entitled to be reimbursed if they choose to receive such treatment in another Member State. The Directive applies to care delivered by both private and public sector healthcare establishments. The Directive requires that the patient should receive the same level of reimbursement as they would receive if the treatment had been received in the Member State of affiliation. Member States may choose to reimburse the full costs incurred in the Member State of treatment, but this is not required by the Directive, which may mean that in some cases a patient will be required to meet some of the costs of care provided in another Member State out of their own pocket. The Directive states that the reimbursement provided may never exceed the actual costs of the healthcare received, even if a higher amount would have been reimbursed if the care had been provided in the Member State of affiliation.

Following the cases of Geraets-Smits v Stichting Ziekenfonds VGZ and Peerbooms v Stichting CZ Groep Zorgverzekeringen[5], the European Court of Justice recognised that Member States have the right to determine the scope of implementation of their health systems and confirmed that the balanced financing of social healthcare requires the rules on the freedom of goods and services must respect each Member State's freedom to organise their healthcare system. As a result, the Directive applies generally to care provided without any form of prior agreement from the insurance funding body in the country of affiliation, but also allows Member States to adopt rules that require patients to seek prior authorisation under certain conditions.

In practice, such prior authorisation is limited to treatment requiring at least one overnight stay in hospital, or treatment requiring highly specialised or cost-intensive medical equipment or infrastructure and subject to planning requirements. Prior authorisation may be refused under

[4] Cases C-120/95 and C-158/96
[5] Case C-157/99

certain circumstances, of these the most significant is that the requested treatment is not included in the 'basket of care' (entitlements under the insurance) of the Member State of affiliation. Member States only have the obligation to reimburse cross-border healthcare under the Directive if such healthcare is among the benefits to which the patient is entitled within the Member State of affiliation. Prior authorisation may also be refused if the patient can be offered the treatment in the Member State of affiliation within a time period which is medically justifiable, or if particular risks to the patient, or the general population have been identified.

Most of the Member States have chosen to introduce a system of prior authorisation for health care which involves overnight hospital accommodation or requires use of highly specialised and cost intensive medical infrastructure or medical equipment. However, even though the Directive provides the possibility of requiring prior authorisation, the Directive also provides that claims for reimbursement for care provided in a Member State other than the Member State of affiliation may not be unreasonably rejected, meaning that in some Member States rejections of claims for prior authorisation are overturned on appeal. In addition, Article 4(3) of the Directive also gives the opportunity to Member States of adopting special mechanisms to limit access to public or private providers to citizens from outside their territory where such mechanisms are necessary and proportionate to fulfilling its fundamental responsibility to ensure sufficient and permanent access to healthcare within its territory.

To assist patients and advise them on their rights under the Directive (e.g. entitlement to healthcare, level of reimbursement etc.), each Member State is required to set up a National Contact Point (NCP). The NCP is required to provide information about its healthcare system to patients from other Member States, such as information about healthcare providers, quality and safety standards, complaints and redress procedures, etc.

The healthcare services covered by the provisions of the Directive are defined as 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. The Directive does not apply to long term care, such as residential care services for older people. The provisions of the Directive apply to those persons defined as insured persons by Article 1(c) of Regulation (EC) No 883/2004, as well as those third-country nationals covered by Regulations (EC) No 859/2003 or 1231/2010 or who are otherwise entitled to benefits in the Member State of residence.

2. Other legal instruments on access to healthcare in another Member State

2.1 The Regulations on the coordination of social security systems.

The benefits provided under the Directive exist alongside the benefits provided under Regulation (EC) No 883/2004 on the coordination of social security systems and its implementation rules laid down in Regulation (EC) No 987/2009. The two pieces of legislation are referred to collectively as 'the Regulations' in this report. The Regulations cover three main cross-border healthcare situations:

- Unplanned healthcare – based on the European Health Insurance Card (EHIC) which certifies the entitlement to necessary healthcare during a temporary stay in a Member State other than their competent Member State (Member State of insurance);

- Planned healthcare – based on Portable Document S2 (PD S2), which certifies the entitlement to planned healthcare in a Member State other than the competent Member State;
- Healthcare in the Member State of residence, other than the competent Member State based on Portable Document S1 (PD S1) which certifies the entitlement to benefit from healthcare in the Member State of residence, outside the competent Member State. This is used mainly by pensioners residing abroad and cross-border workers who work in one Member State but reside in another.

Planned and unplanned care are therefore covered by both the Directive and the Regulations and European citizens may choose to apply for reimbursement of care received in another Member State or EFTA country under either the Directive or the Regulation. In order to understand why patients may choose to apply for reimbursement under the Regulations or the Directive, it is important to understand the key similarities and differences between the two routes.

- Under the Regulations, prior authorisation is generally a requirement for receiving planned treatment in another Member State. Under the Directive, a requirement of prior authorisation is not the rule, although it may be required for treatment requiring at least one overnight stay in hospital, or treatment requiring highly specialised or cost-intensive medical equipment or infrastructure and subject to planning requirements.
- The Directive covers all providers, including private (non-contracted) providers, while the Regulations covers healthcare providers under the public scheme.
- Under the Regulations, reimbursement of healthcare received in a Member State which is not the State of affiliation is made in accordance with the legislation and tariffs of the Member State of treatment. Under the Directive, reimbursement is made in accordance with the legislation and tariffs of the Member State of affiliation.
- A patient receiving care under the Directive will have pay for the treatment out of pocket and then claim reimbursement, while under the Regulations reimbursement is made between competent institutions (except where a system of co-payment exists in the Member State of treatment).

Given the differing rules applicable under the two routes, it may often be advantageous for patients to seek care under the Regulations, rather than the Directive. This issue is recognised within the Directive, which provides that the Directive applies without prejudice to, and in coherent application with, the Regulations. As a general principle therefore, when the terms of the Regulations are met, treatment should be delivered under the Regulations, unless a patient (who has been fully informed about his/her rights), requests otherwise.

A more detailed discussion of reported patient mobility under the Regulations is provided in the concluding chapter of this report.

2.2 Parallel Cross-border Care Agreements between Member States

The Regulations and the Directive are not the only routes by which care may be provided in another Member State. Several Member States have adopted bi-lateral and multi-lateral parallel procedures to address the needs of care in their countries. These parallel procedures are mostly the result of agreements between Member States or regions, and in some Member States account for a much more significant patient flow abroad than under the Directive or Regulations. However, at present no uniform reporting is in place to cover all the schemes that exist; accordingly, it is not possible to

offer a complete assessment of the share of cross-border patient mobility covered by the parallel agreements that exist.

Cross-border care reimbursed under the Regulations and the parallel agreements are not the subject of this report, but it is important to note that they are well used and will therefore have an impact on the figures for cross-border care provided under the Directive. A snapshot from one such parallel scheme operating in the French-Belgian border region is outlined in the concluding chapter of this report, as well as an overview of the reported mobility under the Regulations in 2019.

3. Data collection methodology

Member States were required to transpose the Directive into national legislation by 25 October 2013, although transposition in all Member States was not complete until late 2015. While the Directive is not applicable in all EFTA counties, Norway transposed in 2015 and Iceland in late 2016. Article 20 requires the Commission to draw up a report on the operation of this Directive and submit it to the European Parliament and to the Council every three years of the Directive's operation. The required report shall in particular include information on patient flows, financial dimensions of patient mobility, and the functioning of the national contact points. In order to comply with this requirement, the Member States, Norway and Iceland are sent a questionnaire each year to report the relevant data. The questionnaire contains five sections covering the following issues:

Section One: Requests received by the National Contact Points, and the mode of communication used (writing, phone or in person).

Section Two: Limitations to patient inflow adopted under Article 4(3) of the Directive.

Section Three: Requests, authorisations and refusals for care in another country based on prior Authorisation and details of the countries to which patients had travelled.

Section Four: Requests, payments and refusal for reimbursement of costs for care provided in another country for which prior Authorisation was not required; and details of the countries to which patients had travelled.

Section Five: Free text on any issue on which the respondent wanted to provide further details.

The questionnaire also provides a guiding section, which provides definitions to the terms used in the questionnaire based on the terminology used in Article 3 of the Directive, and a webinar was held in early 2020 to provide further guidance and information on the completion of the questionnaire to the national correspondents. The body of this report discusses the aggregated data provided in response to questions in sections one to four of the questionnaire. Tables presenting the raw data are provided at the end of each section of the report for the reader who wishes to look at data in more detail, while annex 1 provides the full text of the additional comments provided by the NCPs.

4. Data quality

The five-part questionnaire was sent in June 2019 to the EU 28 and Iceland and Norway. All countries responded to the request for information, making 2019 the first year since data collection began in 2015 for which data from the full complement of countries are discussed. It should be noted, however, that many countries were able to provide only limited information. Of particular note is Germany, which was able to provide data only on information requests but not on prior

authorisation requests or reimbursements made, this arose because the data are collected by over one hundred Health Insurance funds and collation of the data at a national level was not possible.

Section one of the report discuss the volume of requests for information received by the NCPs, while section two outlines the use of the procedures for limitation of patient inflow and prior notification of possible reimbursement as provided for in the Directive. The data discussed in these sections covers information from all countries except Cyprus. Portugal, UK and Iceland who were not able to provide this information.

Section three discusses the data on patient mobility subject to prior authorisation. The data provided in this section cover only twenty countries since Cyprus, Czechia, Estonia, Finland, Latvia, Lithuania, the Netherlands, Sweden, and Norway have not implemented a system of prior authorisation and accordingly had no data to report in this section. As noted above, Germany was not able to report on prior authorisations granted, even though the system has been implemented in Germany. Furthermore, the number of requests for prior authorisation reported by Luxembourg and France include some requests made under both the Directive and Regulation.

Section Four discusses the data on mobility not subject to prior authorisation. It should be noted however that the discussion is based on data from only twenty-five countries, as Belgium, Germany, Hungary, Luxemburg and the Netherlands were not able to provide data on patient mobility not subject to prior authorisation. Of these five countries Belgium, the Netherland and Germany provided explanations for the absence of data. Belgium reported that they were not able to provide data because not all health insurance funds were able to report, and they preferred not to provide partially complete data. The Netherlands reported that the Dutch healthcare system is implemented by private health insurers, with a range of data recording systems varying widely and making it very difficult to aggregate data at a national level. Germany, as noted above, was also unable to aggregate the data collected by its many health insurance providers.

Fuller details of the numbers reported by the Member States are given in the following sections, but here it should be noted that due to a variety of reasons outlined above , the portrayal of patient mobility under the Directive presented in this report is not as complete as it might be. Furthermore, it is significant to note that no data on mobility without prior authorisaton were returned for just over 23.5% of the potential total patient mobility population. This is because the sum of the populations of those countries who were unable to return data on such patient mobility data (as opposed to information on request for information) amounts to roughly 122.1 million, which is 23.5% of the total population of all countries asked to participate (519.2 Million total population in EU plus Iceland and Norway).

5. Data from the EFTA countries

Norway has reimbursed healthcare provided in another EEA country since 1st of January 2011 (except for hospital care), and has since 1st of March 2015, implemented the Directive (without introducing Prior Authorisation system). Norwegian citizens count amongst the more frequent users of patient mobility under the Directive. Iceland implemented the Directive on 1st of July 2016, and have returned a full set of data for the first time in the 2019 survey.

Liechtenstein was not included in data collection as they do not participate to the cross-border healthcare expert group set up by the European Commission (DG SANTE) and have therefore not been included in this exercise. In Switzerland, the Directive is not applicable (as it is not an EFTA

country), but bi-lateral agreements exist with some Member States to apply the Directive. Where Member States reported data on patient mobility to Liechtenstein or Switzerland the data were excluded, and the reported numbers adjusted accordingly.

6. Exchange rates

Certain parts of the questionnaire asked Member States to provide amounts of money spent on reimbursing care provided in another Member State under the Directive. Tables showing this data can be found in Sections 3 and 4. The tables show all data in Euros, using the conversion rate given the Official Journal on 2nd January 2019.

Table 1: Exchange Rates

Country	Currency	Exchange Rate 1 EUR =
Bulgaria	Bulgarian Lev	1.95
Croatia	Croatian Kuna	7.42
Czechia	Czech Koruna	25.75
Denmark	Danish Krona	7.46
Hungary	Hungarian Florin	322.37
Poland	Polish Zloty	4.29
Romania	Romanian Leu	4.66
UK	Pound Sterling	0.90
Norway	Norwegian Krone	9.91
Iceland	Iceland Krone	133.40

Section One
Information requests received by National Contact Points (NCPs)

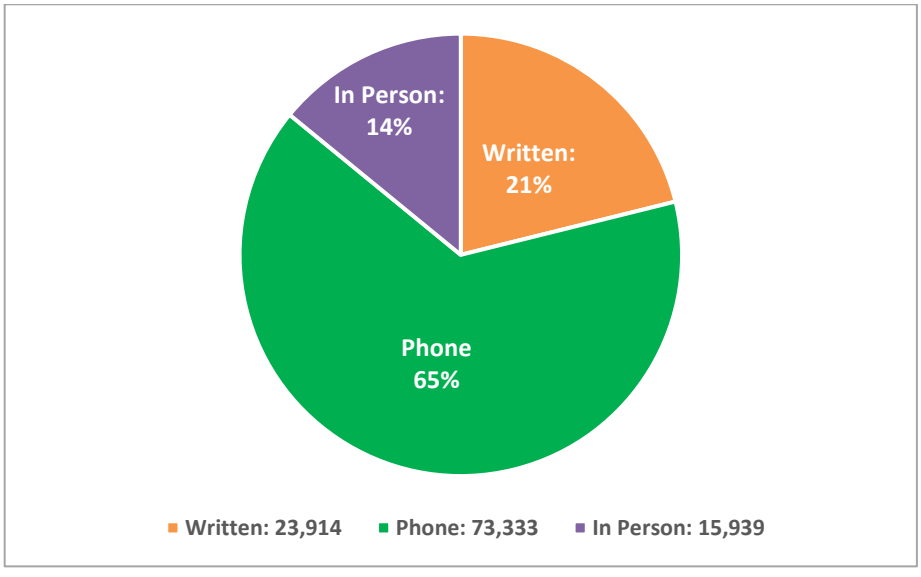
The National Contact Points (NCPs) are the main channel for information to be provided to patients and the public. The Directive requires each Member State to provide at least one NCP. However, a Member may choose to create more than one, including regional contact points, and each can decide and how information is provided. Each Member State was requested to present data regarding the number of information requests received from the public through both National and Regional Contact points. These data were provided in question 1.2 of the questionnaire and Member States were asked, where possible, to break these requests down by media: written (letters, email, fax, web-forms, IMI), telephone, and desk (in person).

1. Requests for information on cross-border care received by NCPs

In 2019, a total of 115,459 enquiries were made across the 27 NCPs providing data (Portugal, UK, and Iceland were not able to provide data). Luxemburg provided contact details of two NCPs, but data was only available for the second. Finland noted that Kela (the government agency in charge of settling benefits under national social security programs), has a phone service that advises on social security matters, rights to healthcare, and reimbursements in international situations, but that these requests were not counted in the data provided. Note also that Denmark was not able to specify the number of NCP requests by media, and accordingly returned only the total number of requests for the year 2019.

While most Member States received fewer than 1,000 requests, Lithuania, Estonia, and Sweden, stand out in receiving 26,897; 20,576, and 19,770 respectively. However, in all three of these countries, the NCPs noted that the reported requests for information on mobility cover both the Directive and the Regulation, making these numbers necessarily much larger than those reported for other countries where the respondents were able to separate the requests between the two reimbursement mechanisms.

Figure 1 Requests for information on cross-border care received by National and Regional Contact Points



The 2019 data show an increase in requests for information since 2018, when a total of 95,565 requests were received in 27 Member States. The increase is due entirely to the reporting of data from Sweden in 2019, which was not available in 2018. Although the number shows an increase year on year, in reality, the number of requests has remained stable.

Table 2 Raw Data: Requests for information on cross-border care received by NCPs

NCP information requests	Total Number of Requests	written	phone	in person
Austria	188	188	0	0
Belgium	111	111	0	0
Bulgaria	7	6	1	0
Croatia	1,099	523	576	0
Cyprus	31	6	25	0
Czech Republic	105	50	50	5
Denmark	2,324	/	/	/
Estonia	20,576	9,901	9,555	1,120
Finland	268	268	0	0
France	668	668	0	0
Germany	4,028	7	3,367	654
Greece	2,539	414	1,940	185
Hungary	311	282	29	0
Ireland	3,317	460	2,875	0
Italy	655	649	6	0
Latvia	8,391	1,390	6,548	543
Lithuania	26,897	640	14,361	11,896
Luxembourg	68	26	36	6
Malta	88	57	9	22
Netherlands	270	270	0	0
Poland	10,192	890	7,808	1,494
Portugal	0	0	0	0
Romania	5,400	3,500	1,900	0
Slovakia	37	19	16	2
Slovenia	2,370	699	1,671	6
Spain	1,369	217	1,146	6
Sweden	19,770	1,963	17,807	n/a
UK	0	0	0	0
Norway	4,380	710	3,607	0
Iceland	0	0	0	0
totals	115,459	23,914	73,333	15,939

Section Two
Limitation of patient inflow and Prior Notification

1. Limitation of Patient Flow

In Section two of the questionnaire, Member States, Norway and Iceland were asked to provide information relating to any mechanisms they had put in place to limit access to healthcare as provided for in Article 4(3) of the Directive, which allows that Member States may limit access to treatment for visitors from another EU Member State where this is justified by overriding reasons of general interest, such as healthcare planning requirements.

Of the twenty-eight countries who replied, five (Denmark, Estonia, Romania, UK and Iceland) have implemented mechanisms that can be used to limit access to cross-border healthcare according to Article 4(3) of the Directive. In the case of the UK, this applies only to Wales. However, these mechanisms have, as far as data are available, barely been used. In 2019, Denmark reported three cases of patients whose access to treatment had been limited on the grounds of overriding reasons of general interest. It is so far the only country to have reported using the mechanism since reporting began in 2015.

2. Voluntary Prior Notification

Sections three and four of the questionnaire asked the respondents to report on the number of cases of patient mobility which fell under the category of care which may be subject to a system of prior authorisation (sections three) and those to which for which prior authorisation is not applicable (section four).

Within section four the Member States were also asked to indicate if they had put in place a system of voluntary prior notification of costs, as provided for in Article 9(5). The object of such a prior notification is to allow a patient to receive a written statement of the amount to be reimbursed on the basis of an estimate. This is an optional element and has been adopted by some countries to support patients who may wish to have greater clarity on the costs they might incur up-front and which they can expect to have reimbursed. This system may apply for any type of care or treatment, whereas prior authorisation, discussed in section three of this report, can be applied to only certain types of care. Of those who replied in 2019, nine Member States reported having such a system in place (Denmark, Estonia, Greece, Ireland, Italy, Poland, Sweden, UK,) and Norway.

Table 3 Raw Data: Limitation of patient inflow

Q2	Limitations adopted Y/N	Limitations imposed #	New measures since 2016
Austria	N	/	N
Belgium	N	/	/
Bulgaria	N	/	N
Croatia	N	/	N
Cyprus	N	/	N
Czechia	N	/	N
Denmark	N	3	N
Estonia	Y	/	N
Finland	N	/	N
France	N	/	N
Germany	N	/	N
Greece	N	/	N
Hungary	N	/	N
Ireland	N	0	N
Italy	/	/	/
Latvia	N	/	N
Lithuania	/	/	/
Luxembourg	N	/	N
Malta	N	0	N
Netherlands	N	/	N
Poland	N	0	N
Portugal	N	/	N
Romania	Y	0	N
Slovakia	N	/	N
Slovenia	N	0	N
Spain	N	/	N
Sweden	N	0	N
UK	Y	0	N
Norway	N	/	N
Iceland	Y	0	N

Section Three
Healthcare subject to prior authorisation

Section three of the questionnaire asked respondents to provide information relating to healthcare for which prior authorisation may be granted. As outlined in the introduction, Member States may adopt a system by which patients must seek prior authorisation for certain categories of treatment; notably treatment requiring at least one overnight stay in hospital, or treatment which is highly specialised and cost-intensive or uses specialised or cost-intensive medical infrastructure or equipment.

The following nine countries reported that in 2019 that they had not introduced a prior authorisation system: Cyprus, Czech Republic, Estonia, Finland, Latvia, Lithuania, Netherlands, Sweden, and Norway. Accordingly, they did not complete section three of the questionnaire.

The questions in section three were divided into two subsections:

- 3.1 relating to requests for prior authorisation, and
- 3.2 relating to reimbursement for such pre-authorised care.

1. Number of requests for prior authorisation: requests, authorisations, refusals and withdrawals

As noted in the introduction, the Directive is not the only route in EU law under which a patient may receive reimbursement for treatment in an EU Member State other than their state of affiliation (the country where they usually live and where they have public health insurance). Alongside the Directive, the Regulations on the coordination of social security systems also provides an administrative mechanism for patients to receive treatment in another Member State. In many cases, receiving treatment under the Regulations route may be favourable to the patient, not only because they will not have to make a payment upfront and then claim a reimbursement but also because the Regulations provide for reimbursement of costs at the rate applicable in the country of treatment. The Directive, in contrast, provides for reimbursement at the rate that would apply if the treatment had been provided in the Member State of affiliation. The data provided concerning the application of the Directive should therefore be analysed in relation to the number of prior Authorisations issued in accordance with the Regulations (known as Portable Document S2)[6].

In 2019, twenty Member States, and Iceland, reported that they had implemented a system of prior authorisation and provided data on their use of the system. The number of requests for prior authorisation under the Directive made in 2019 remains low and showed a slight decrease from those reported in 2018. In total 7,171 requests for prior authorisation were received, down from the 7,297 requests received in 2018.

Of the twenty-one countries who reported having a system of prior authorisation in place, thirteen Member States reported having received fewer than 100 requests. Amongst those

[6] Planned cross-border healthcare: report on S2 portable documents issued in 2013, available on http://ec.europa.eu/social/contentAdmin

reporting a low number of prior authorisation requests, Denmark (reporting 81 requests of which 19 were accepted) provided interesting further information to the numbers they reported. The respondent for Denmark noted that according to national legislation, Danish insured citizens, who have been referred for hospital treatment, may, within certain limits, freely choose any public and some private hospitals. If the Danish region of residence cannot ensure that treatment will be initiated within 30 days, patients have the right to a so-called 'extended free choice of hospital'. This means that patients may choose to go to a private hospital in Denmark or to a public or private hospital abroad at the expense of the region. Accordingly, care which in some countries might have been allocated to reimbursement through the Directive mechanism, in Denmark will be absorbed centrally.

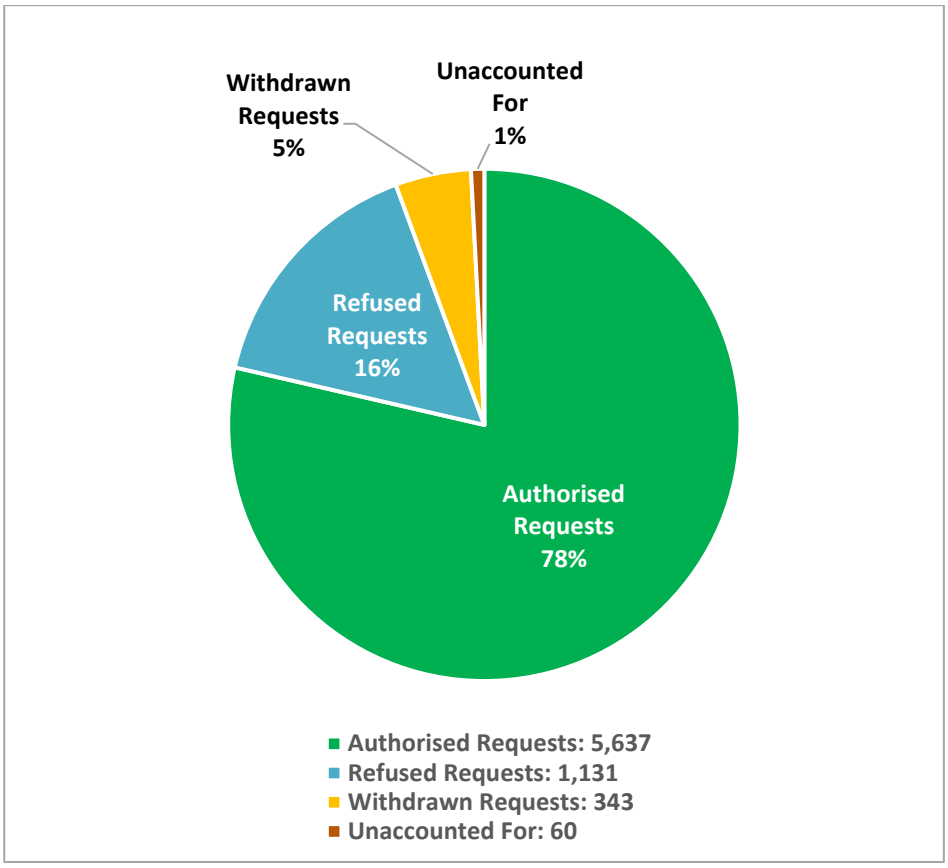
The relatively high number of requests for prior authorisation reported by Ireland may be attributed to the fact that although prior authorisation is only required for Enzyme Replacement Therapy (ERT), a system of prior authorisation is provided to patients requesting any in-patient care as an option, so the patient may ensure compliance with public patient pathways. The exercise of the option therefore protects the interests of the patient, ensuring that the patient will be eligible for reimbursement on completion of treatment accessed under the Directive. If at any stage during the application stage for prior authorisation the patient does not comply with public patient pathways and thus would not be eligible for reimbursement, the patient is advised of how they can correct the pathway and thus be eligible for reimbursement after receiving the treatment. With respect to the 1,583 requests for prior authorisation reported for the UK, it should be noted that 1,383 related to residents of Northern Ireland. Of those requests 1,023 were authorised for treatment in the Republic of Ireland.

The overall low number of requests for prior authorisation included in the report is impacted also by the fact that one of the largest Members States of the Union, Germany, was not in a position to report these data, notwithstanding that it has put a system of prior authorisation in place. As noted in the section on data quality, Germany has not been able to report on the numbers of patients travelling to access healthcare abroad (be that funded under the Regulation or the Directive) because that information is only available within each Statutory Health Insurance Fund and the private German Health Insurance Companies and is not aggregated at national level.

Furthermore, it should be noted that in some countries the system of prior authorisation operates more significantly within the context of specific parallel agreements, the correspondent for Belgium in particular noted that low number of prior authorisation requests in BE is the result of the existence of many different parallel schemes using the mechanism provided for under the Regulations.

Member States were also asked to indicate if the requests were accepted, withdrawn or refused. No significant pattern was discernible, with the acceptance ratio ranging from 0% in some cases up to 92% in others. However, the countries reporting a high level of rejection of requests for prior authorisation had generally received a very low number of such requests. Therefore, the use of percentages could be misleading.

Figure 2 Prior authorisation requests (authorised, refused or withdrawn)



2. Basis of request for prior authorisation where authorisation was granted

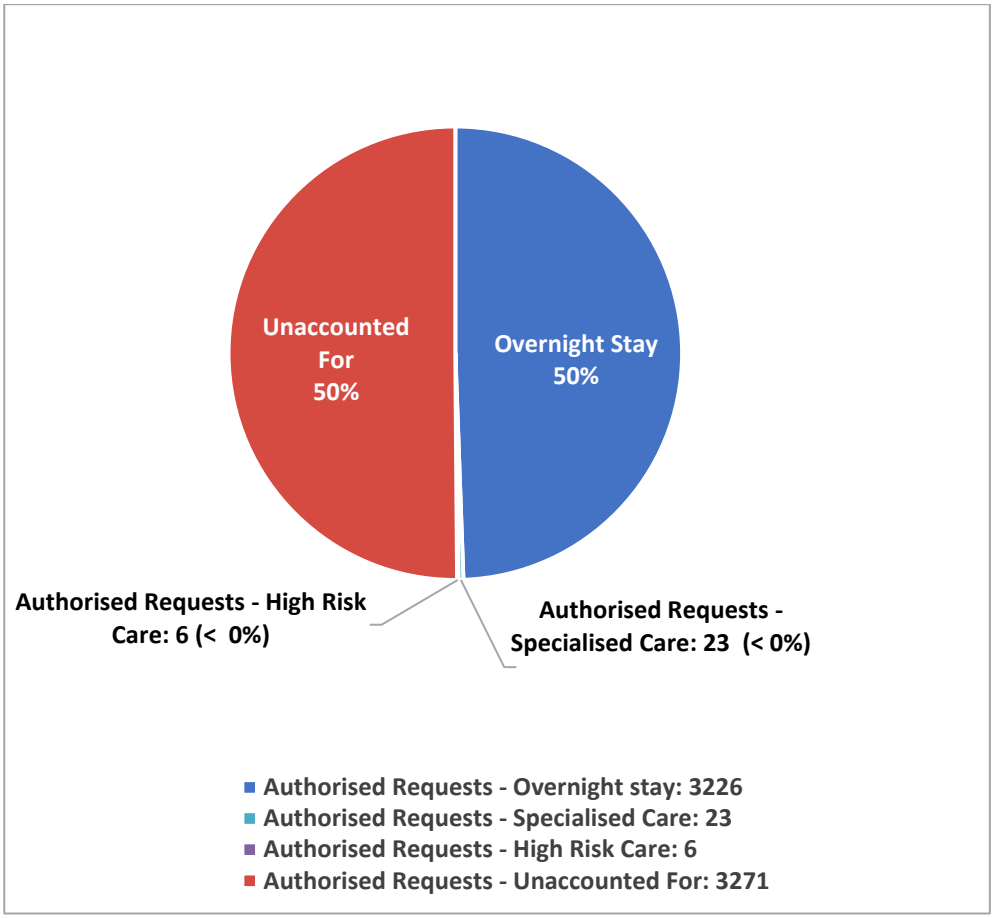
Member States were asked to indicate the basis on which authorisation had been authorised, based on three groups of reasons as follows:

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.
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.
3. Healthcare which involves treatments presenting a particular risk for the patient. 4. Healthcare which involves treatments presenting a particular risk for the population. 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.

However, not all Member States were able to give answers to this section, with only 3,255 of the 5,637 authorisations being assigned to one of the three reasons for authorisation.

Amongst those Member States who were able to provide this data, 99% of the authorised requests were for cases where the requests had been made on the basis that the treatment required at least one night's hospital stay in another Member State. This percentage has remained roughly the same for the past two years. The data for the reporting year of 2019 are represented in Figure 3 below.

Figure 3 Reasons for granting prior authorisation of requests



3. Reasons for refusal of prior authorisation

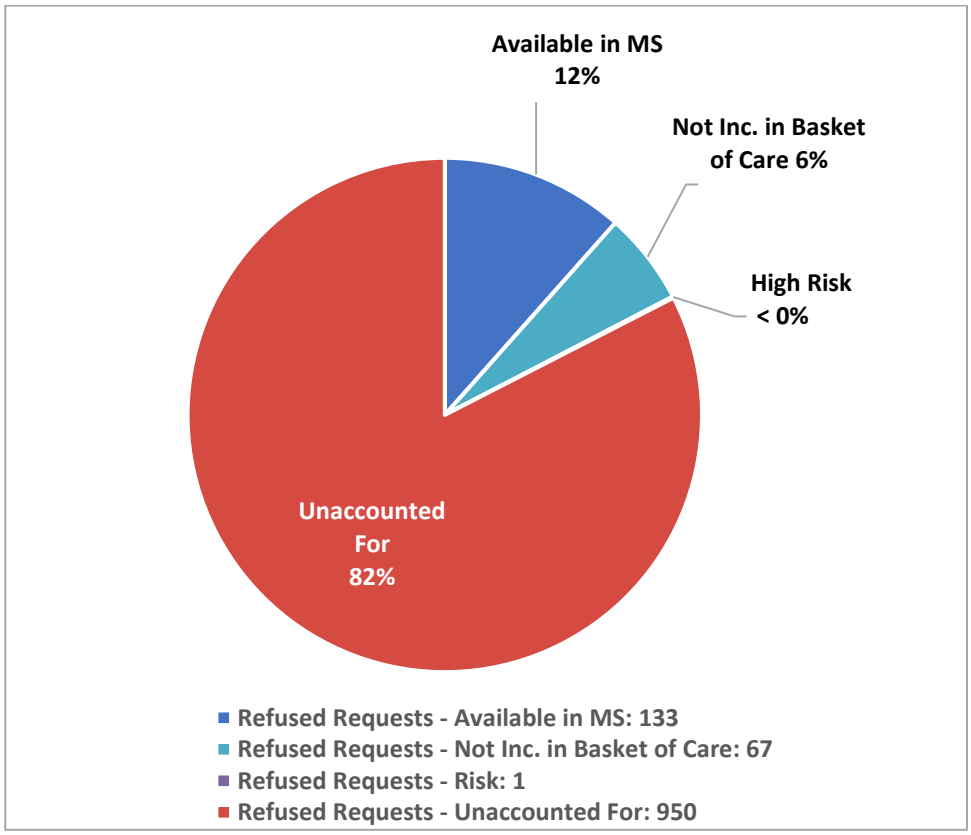
Member States were also asked to indicate the basis on which authorisation was refused, based on the 3 groups of reasons provided for in the Directive:

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.
2. The healthcare is not included among the national healthcare benefits of the Member State of affiliation.

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.
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.
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.

As in the case of granted authorisations, most correspondents were not able to indicate the reason for the refusal of authorisation within one of the three groups of reasons for refusal provided in the questionnaire. Of the 1,131 reported refusals, only 201 were allocated to one of the categories of reasons for refusal, with 133 of those arising because the treatment was available in a reasonable timeframe in the home country.

Figure 4 Reasons for refusal of prior authorisation requests



4. Processing times relating to requests for prior authorisation

The questionnaire also asked for information on the amount of time (in days) taken to process a request for prior authorisation. The information provided here, is limited but also shows significant variation across the Member States. Only fourteen of the twenty-one countries who

answered this question reported having a maximum number of days set for giving a response to a request of prior authorisation. This number of maximum days ranged from 14 (Malta) to 90 days (Portugal and Spain), with the most common being between 30 and 60 days.

Fourteen countries provided data on the average time it took them to respond to a request for prior authorisation, with the length of time-varying between 14 and 69.5 days. In practice, the average time taken to process a request was 20 days, which indicates that the Member States are broadly within their self-imposed targets.

Full details on these numbers are in Table 4.4 provided at the end of this chapter.

5. Amounts reimbursed for treatment requiring prior authorisation

In comparison to 2018, the total amount of aggregated reimbursements reported for 2019 has gone down considerably. However, this is attributable entirely to the fact that in 2018 Ireland reported over 11M€ spending on treatment with prior authorisation, while in 2019 Ireland stated that it was not possible to provide a reimbursement amount specific to prior approvals as approval is issued for a proposed and not a definitive treatment. Prior authorisation is not a confirmation of the value of reimbursement as the value of reimbursement is only known at reimbursement stage. The reported spend across twelve Member States, and Iceland who provided data for this part of the questionnaire, ranged from a high of 5.8€ in Sweden, with all other countries reporting under 500,000€ in reimbursements made. The total spend across all countries reported for 2019 amounted to 6.7M€

6. Where do patients travel when prior authorisation is required?

One of the most interesting points to emerge from the data reported by the Member States is that relating to the countries to which patients travel in order to seek treatment after prior authorisation is given.

The full raw data set can be found below in table 4.5 but a graphic representation allows one to see easily that the biggest trend for patient mobility with prior authorisation is between countries that share borders. The data are represented in a flow map (Figure 5), which shows clearly that this type of patient mobility in Europe is much more significant between neighbouring countries than between those which are geographically distant. The flow maps show only the data on mobility, as reported, the picture presented is therefore not as complete as it could have been if all Member States had been able to report on all the questions in the questionnaire.

We see in the flow map and the data presented in table 4.5 that by far those most significant flow of patients is as follows:

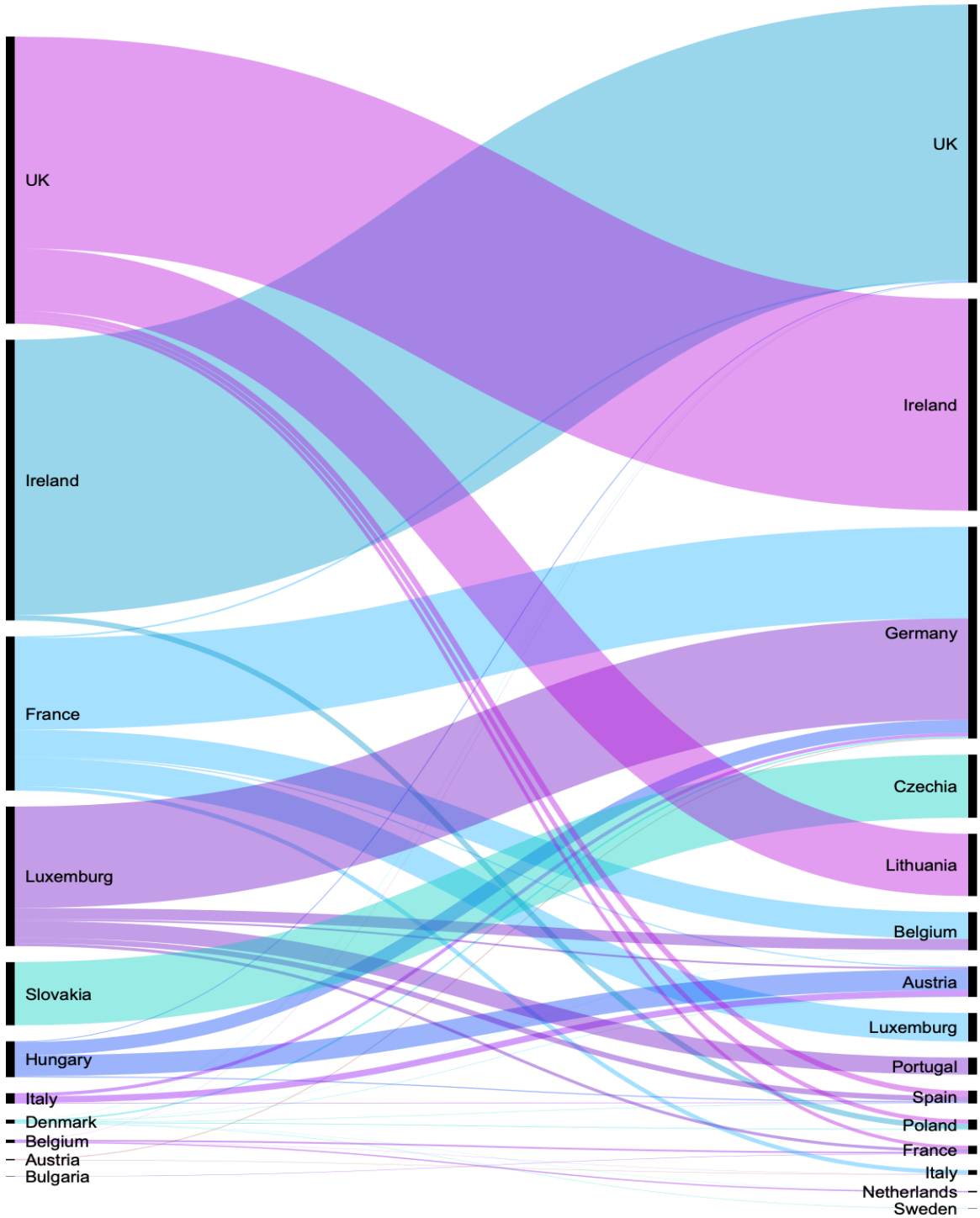
- Ireland to UK (1330)
- UK to Ireland (1024)
- Luxembourg to Germany (490)
- France to Germany (442), to Luxembourg (138), and Belgium (130)
- Slovakia to Czechia (305)

These five country groupings represent over 78% of all the cases of patient mobility under the Directive where prior authorisation had been granted. In all other cases, the numbers of patients travelling were in low double digits.

The flow chart in Figure 5 shows these data.

Figure 5 Flow Map of all patient mobility with Prior Authorisation in Europe in 2018

(The flows are based on the data reported by Member States - Table 4.5)



Section 3 Raw Data

Table 4.1 Raw Data: System of prior authorisation

Country of affliliation	Prior authori- sation Y/N	Number of received requests	Number of authorised requests	Number of refused requests	Number of withdrawn / inadmissible requests
Austria	Y	17	6	11	0
Belgium	Y	28	16	12	0
Bulgaria	Y	3	2	0	1
Croatia	Y	4	0	4	0
Cyprus	N	n/a	n/a	n/a	n/a
Czechia	N	n/a	n/a	n/a	n/a
Denmark	Y	81	19	38	21
Estonia	N	n/a	n/a	n/a	n/a
Finland	N	n/a	n/a	n/a	n/a
France	Y	1,370	760	610	n/a
Germany	Y	n/a	n/a	n/a	n/a
Greece	Y	27	5	19	3
Hungary	Y	1,125	919	206	n/a
Ireland	Y	1,615	1,386	8	221
Italy	Y	120	60	59	1
Latvia	N	n/a	n/a	n/a	n/a
Lithuania	N	n/a	n/a	n/a	n/a
Luxembourg	Y	803	703	100	n/a
Malta	Y	15	8	5	2
Netherlands	N	n/a	n/a	n/a	n/a
Poland	Y	18	0	0	18
Portugal	Y	5	0	0	0
Romania	Y	3	2	0	1
Slovakia	Y	330	311	9	0
Slovenia	Y	13	3	9	1
Spain	Y	3	2	1	0
Sweden	N	n/a	n/a	n/a	n/a
UK	Y	1,583	1,427	40	74
Norway	N	n/a	n/a	n/a	n/a
Iceland	Y	8	8	0	0
totals		7,171	5,637	1131	343

Table 4.2 Raw Data: Authorised Requests

Country of affiliation	Authorised requests - overnight stay Reason 1	Authorised requests - specialised care reason 2	Authorised requests - high risk care reasons 3-5
Austria	6	0	0
Belgium	2	14	0
Bulgaria	2	0	0
Croatia	0	0	0
Cyprus	n/a	n/a	n/a
Czech Republic	n/a	n/a	n/a
Denmark	15	4	0
Estonia	n/a	n/a	n/a
Finland	n/a	n/a	n/a
France	n/a	n/a	0
Germany	n/a	n/a	n/a
Greece	5	0	0
Hungary	n/a	n/a	n/a
Ireland	1386	0	0
Italy	50	4	6
Latvia	n/a	n/a	n/a
Lithuania	n/a	n/a	n/a
Luxembourg	n/a	n/a	n/a
Malta	8	0	0
Netherlands	n/a	n/a	n/a
Poland	0	0	0
Portugal	0	0	0
Romania	2	0	0
Slovakia	311	0	0
Slovenia	3	0	0
Spain	2	0	0
Sweden	n/a	n/a	n/a
UK	1426	1	0
Norway	n/a	n/a	n/a
Iceland	8	0	0
totals	3226	23	6

Table 4.3 Raw Data: Refused Requests

Country of affiliation	Refused requests - available in MS reason 1	Refused requests - not inc in basket of care reason 2	Refused requests - risk reasons 3-5
Austria	11	0	0
Belgium	4	2	0
Bulgaria	0	0	0
Croatia	4	0	0
Cyprus	n/a	n/a	n/a
Czech Republic	n/a	n/a	n/a
Denmark	20	18	0
Estonia	n/a	n/a	n/a
Finland	n/a	n/a	n/a
France	n/a	n/a	n/a
Germany	n/a	n/a	n/a
Greece	19	0	0
Hungary	n/a	n/a	n/a
Ireland	0	0	0
Italy	45	14	0
Latvia	n/a	n/a	n/a
Lithuania	n/a	n/a	n/a
Luxembourg	n/a	n/a	n/a
Malta	0	5	0
Netherlands	n/a	n/a	n/a
Poland	0	0	0
Portugal	0	0	0
Romania	n/a	n/a	n/a
Slovakia	5	4	0
Slovenia	9	0	0
Spain	1	0	0
Sweden	n/a	n/a	n/a
UK	15	24	1
Norway	n/a	n/a	n/a
Iceland	n/a	n/a	n/a
totals	133	67	1

Table 4.4 Raw Data: Processing Time and Reimbursements with prior authorisation

Country of affiliation	Maximum time for processing (Y/N)	Maximum time	Average Processing time (days)	aggregated amount reimbursed	in Euro
Austria	N	/	5-75	97,975.30	97,975.30
Belgium	N	/	/	18,729.46	18,729.46
Bulgaria	Y	66	45	0.00	0.00
Croatia	Y	60	/	0.00	0.00
Cyprus	N	/	/	n/a	n/a
Czech Republic	n/a	n/a	n/a	n/a	n/a
Denmark	N	/	36	374,583.7 DKK	50,165.81
Estonia	n/a	n/a	n/a	n/a	n/a
Finland	n/a	n/a	n/a	n/a	n/a
France	N	n/a	n/a	n/a	n/a
Germany	N	/	n/a	n/a	n/a
Greece	Y	40	40	24,889.19	24,889.19
Hungary	N	/	60	n/a	n/a
Ireland	Y	30	84	0.00	0.00
Italy	Y	60	/	212,398.00	212,398.00
Latvia	n/a	n/a	n/a	n/a	n/a
Lithuania	n/a	n/a	n/a	n/a	n/a
Luxembourg	N	/	40	n/a	n/a
Malta	Y	14	7	12,926.00	12,926.00
Netherlands	n/a	n/a	n/a	n/a	n/a
Poland	n/a	n/a	n/a	n/a	n/a
Portugal	Y	90.00	n/a	6,990.28	6,990.28
Romania	N	n/a	69.5	14,462.74 RON	3,103.59
Slovakia	Y	30	30	451,566.02	451,566.02
Slovenia	Y	60	45	11,227.86	11,227.86
Spain	Y	90	53	8,958.58	8,958.58
Sweden	n/a	n/a	n/a	n/a	n/a
UK	Y	20-30	12.0	5,264,719.77 GBP	5,838,983.83
Norway	n	n/a	n/a	n/a	n/a
Iceland	N	/	20	4811599 ISK	36,068.96
TOTAL		49.50	41.65		6,773,982.88

Table 4.5 Raw Data: Patient Mobility with prior authorisation – where patients travel (part 1)
(Those countries not providing data are left blank).

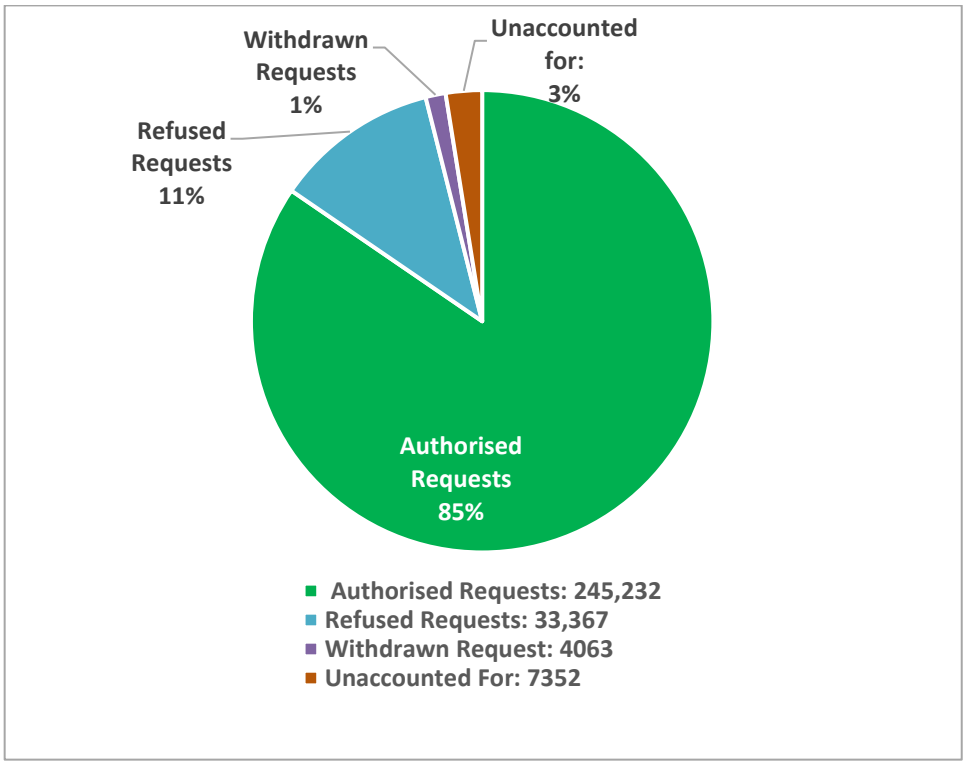
Country of Affiliation	Country of Treatment: AT	BE	BG	HR	CY	CZ	DK	EE	FI	FR	DE	EL	HU	IE	IT	LV	LI	LT	LU	MT	NL	PL	PT	RO	SK	SL	ES	SE	UK	NO	IC	SENT
Austria		0	0	0	0	0	0	0	0	0	4	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**6**
Belgium	0		0	0	0	0	0	0	0	8	0	0	0	0	0	1	0	0	0	0	0	6	0	0	0	0	0	0	1	0	0	**16**
Bulgaria	0	0		0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Croatia																																
Cyprus																																
Czechia																																
Denmark	2	1	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	1	3	0	0	0	2	2	1	0	0	**19**
Estonia																																
Finland																																
France	6	130	2	1	0	0	0	0	1	0	442	0	2	0	20	0	0	0	138	1	3	4	0	1	0	0	0	1	8	0	0	**760**
Germany																																
Greece	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	**5**
Hungary	100	3	0	0	0	0	0	0	0	3	64	0	0	0	4	0	0	0	0	0	0	1	0	0	0	0	5	0	4	0	0	**184**
Ireland	0	4	0	1	0	1	0	0	1	1	6	0	0	2	0	3	1	0	5	0	0	26	1	1	0	0	3	0	1330	0	0	**1386**
Italy	31	1	0	0	0	2	0	0	0	3	16	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	3	1	1	0	0	**60**
Latvia																																
Lithuania																																
Luxembourg	9	53	3	0	1	4	1	0	0	14	490	2	2	2	0	6	0	0	1	0	0	1	5	82	0	0	0	26	3	0	0	**703**
Malta	0	0	0	0	0	0	0	0	0	0	3	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	2	0	0	**8**
Netherlands																																
Poland																																
Portugal																																
Romania	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Slovakia	4	0	0	0	0	305	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**311**
Slovenia	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
Spain	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Sweden																																
UK	0	1	1	0	9	2	0	1	0	16	4	2	2	1024	7	5	0	301	0	0	2	20	0	2	1	0	26	1	0	0	0	**1427**
Norway																																
Iceland	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	5	0	0	0	0	0	0	1	0	0	**8**
TOTALS RECEIVED	153	196	6	4	10	314	1	1	2	49	1041	5	8	1024	44	7	0	307	139	1	13	64	83	4	1	0	67	5	1353	0	0	

Section Four
Healthcare not subject to prior authorisation

1. Number of requests for reimbursement for cross-border care where prior authorisation is not required under the Directive

In the survey of mobility in 2019, twenty-three Member States reported having received a total of 283,719 requests for reimbursement. Of these, 85% were authorised, with 11% being refused and less than 1% withdrawn. The fact that Sweden was able to report data for 2019 created an increase in the total amount of reimbursements requested and made by approximately 5%, however, if the data from Sweden had been missing in 2019 (as they were in 2018) the number of claims in 2019 compared to 2018 would have been down by approximately 2.5%.

Figure 6 Reimbursement Requests (grounds for reimbursement or refusal)



The average number of reimbursements made per Member State was generally low, with the number reported by France being the only significant outlier. France reported 170,872 requests for reimbursement of which 148,263 were granted. These figures should, however, be treated with caution when compared with other Member States because, as France has stated, the data provided under the section on treatment not requiring prior authorisation includes almost all reimbursements made to directly insured persons for treatment abroad whether authorised under the Directive or the Regulation. France reported that while certain treatments were identifiable as being reimbursed under the Regulations and were therefore excluded from the figures reported in the survey, in the majority of cases it was not possible to identify which legal instrument was used and accordingly

much of the data reported in the table shown below will pertain to treatment reimbursed under the Regulations.

The data on patient mobility not requiring prior authorisation in 2019, as reported in table 5.1 at the end of this chapter, does not include data from Belgium, Germany, Hungary, Luxemburg, and Netherlands. Belgium noted that this arose because not all health insurance funds were able to report, and they preferred not to provide partially complete data. The Netherlands reported that the Dutch healthcare system is implemented by private health insurers, with a range of data recording systems varying widely, making it very difficult to aggregate data at a national level. This is very similar to the reason set out by Germany, who also cited the high number of health insurers who each handle patient claims independently and do not report their data at national level. Hungary and Luxemburg did not provide any data on mobility requiring not prior authorisation but did not provide any reason as to why the data were missing. As noted in the section on data quality in chapter 1, this means that 23.5% of the potential population who can avail of the right to receive health care in another country under the rules of the Directive were not covered in the data reported.

Of the Member States which were able to provide data on patient mobility without prior authorisation, Denmark and Sweden are significant making 25,482 and 17,315 reimbursements respectively in 2019. Denmark has been an outlier in this way for the past four years of reporting, noting on each occasion that dental care has made up the majority of the reimbursements, in 2019 amounting to 84% of all reimbursements made, while Sweden did not include data on reimbursements for dental care in their data. An interesting note was provided also by the respondent for Austria who indicated that the low number of requests for reimbursement (11) must be understood in the national context which means that reimbursement applications from insured persons who received cross-border health treatments that do not require prior approval are usually treated as domestic reimbursement claims and are therefore not specifically recorded. All three of these comments added by national respondents indicate that a certain level of caution must be exercised when comparing the data reports made for each country.

2. Processing times relating to requests for reimbursement

In 2019, sixteen Member States and Norway provided data on the time taken to process a request for reimbursement for treatment. The average amount of time was 56 days, which is somewhat longer than the average reported in 2018. However, several Member States noted that the time taken to make a reimbursement vary considerably between patients depending on the particular circumstances of the case, and therefore the average number may be of limited interest.

3. Amount reimbursed

The total amount reimbursed across the nineteen countries who reported in 2019, amounted to 85,302,625€ this ranged from a high of almost 25M€ in Sweden to 899€ in Spain. Comparing the number of requests received and reimbursements made between 2019 and 2018, we see a significant increase, as shown in figures 8 and 9 in the conclusion chapter of this report. However, this is due almost entirely to the fact Sweden reported in 2019 but was not able to do so in 2018.

4. Where do patients travel when prior authorisation is not required?

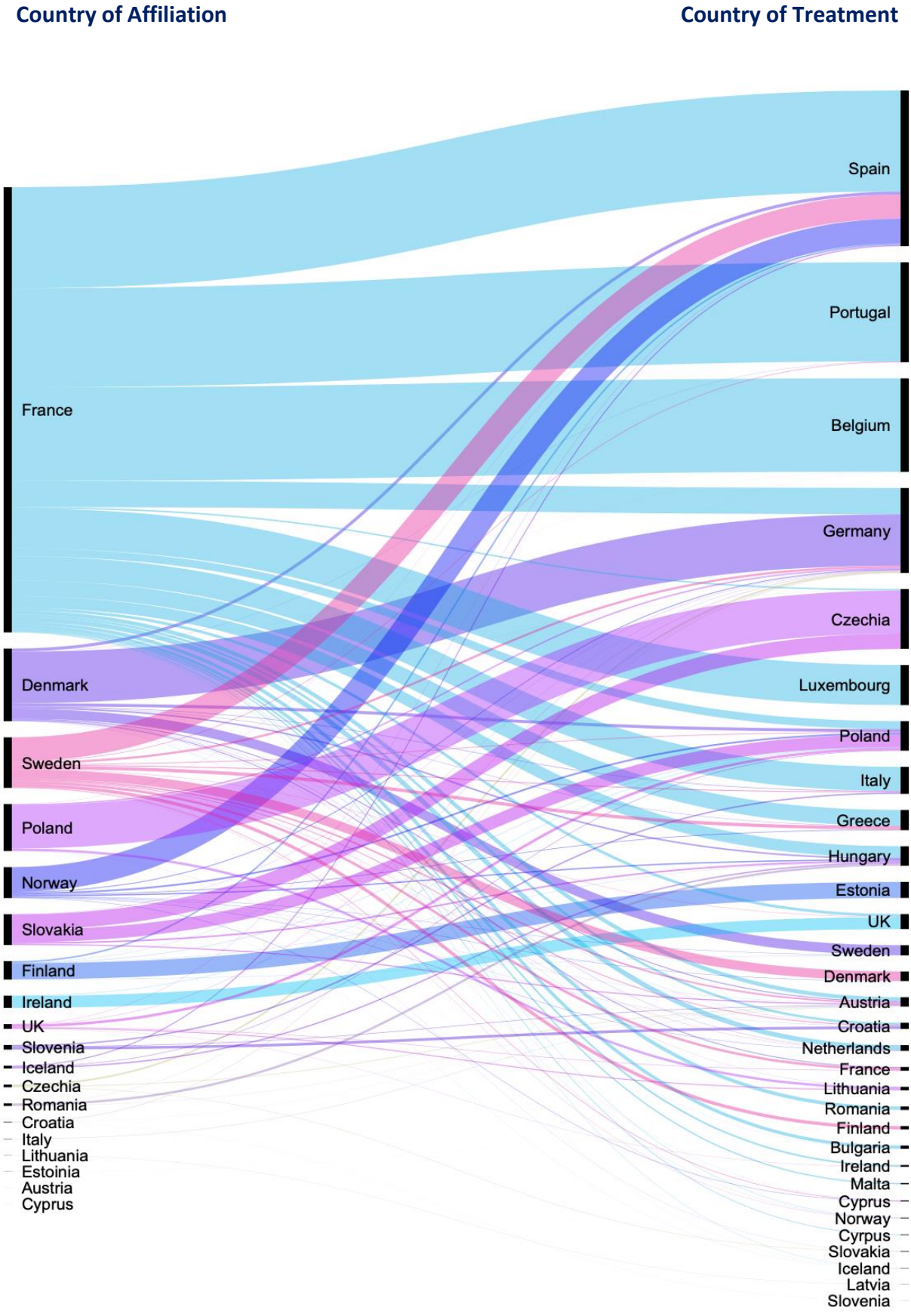
As with travel for cross-border care with prior authorisation, in the case of patient mobility where prior authorisation is not required, a pattern emerges. As in the case of mobility with prior authorisation, movement from France dominated the picture, representing 60% of all patient mobility where prior authorisation was not required.

Setting aside the movement from France, the biggest flow being from Denmark to Germany, Poland to the Czech Republic, Norway to Spain, and Sweden to Spain. It is notable that, as with care delivered on the basis of a prior authorisation, Germany and Czech Republic again feature among the biggest recipients of patients, and again from their neighbouring Member States. It is interesting to note also that two significant patient flows are seen that are not to neighbouring countries: Norway and Sweden both see a significant flow to Spain – 8,148 and 7,926 cases of reimbursement for cross border care respectively. In correspondence Sweden noted that this arises because tourists who wish to avail of care provided by private doctors established in Spain cannot do so unsighted European Health Insurance Card (EHIC) system. As the EHIC system falls under the Regulations and can only be used for care provided within the publicly funded system, patients using the services of such doctors apply for retrospectively for reimbursement under the Directive.

The full detail of patient flows, shown in Table 5.3 at the end of this section, shows that a significant number of countries reported reimbursement for cases of care provided in another country in single figures. However, despite the fact that the numbers in some cases are small, it is worth noting that patient mobility across all the Member States of the EU and EFTA shows a picture of a slow but steady trend towards greater patient mobility.

Figure 7: Flow Maps of all patient mobility not requiring Prior Authorisation

(The flows are based on data received from Member States and Norway shown in Table 5.3).



Section 4 Raw data

Table 5.1 Mobility not requiring prior authorisation

Country of Affiliation	Prior notification system adopted Y/N	Number of received requests for reimbursement	Number of authorised requests for reimbursement	Number of refused requests for reimbursement	Number of withdrawn requests for reimbursement
Austria	N	11	7	4	0
Belgium	N	0	0	0	0
Bulgaria	N	3	0	0	0
Croatia	N	339	221	108	10
Cyprus	N	16	13	3	0
Czech Republic	N	948	916	32	0
Denmark	Y	31,471	25,482	4,694	574
Estonia	Y	119	116	3	0
Finland	N	6,295	n/a	n/a	n/a
France	N	170,872	148,263	23,088	n/a
Germany	N	n/a	n/a	n/a	n/a
Greece	Y	66	64	1	1
Hungary	N	n/a	n/a	n/a	n/a
Ireland	Y	6,882	4,138	92	2,652
Italy	Y	190	159	32	0
Latvia	N	13	15	3	n/a
Lithuania	N	157	143	14	n/a
Luxembourg	N	n/a	n/a	n/a	n/a
Malta	N	14	14	0	0
Netherlands	N	n/a	n/a	n/a	n/a
Poland	Y	14,741	15,575	392	257
Portugal	N	11	0	0	11
Romania	N	1,488	901	80	23
Slovakia	N	11,232	10,302	660	21
Slovenia	N	1,668	1,575	50	43
Spain	N	9	5	2	2
Sweden	Y	20,620	17,315	1,706	3
UK	Y	3,125	2,046	338	466
Norway	Y	12,343	10,673	1,975	n/a
Iceland	N	1086	994	90	0
TOTALS		283,719	238,937	33,367	4063

Table 5.2 Mobility not requiring prior authorisation – reimbursement processing time and amount

Country of Affiliation	Average time for processing reqests for reimbursement		If yes # of days	Total reimbursed in euro
Austria	3-5	N	/	26,383.56
Belgium	0	N	/	8,161,835.37
Bulgaria	45	Y	66	0.00
Croatia	88	Y	60	40,623.76
Cyprus	45	Y	30	159,557.31
Czech Republic	15	Y	30	314,493.66
Denmark	14	N	/	1,763,453.78
Estonia	27	Y	30	96,000.00
Finland	57	N	/	357,763.91
France	25	N	/	12,333,970.00
Germany	n/a	N	/	n/a
Greece	40	Y	40	50,377.79
Hungary	n/a	n/a	n/a	n/a
Ireland	84	Y	30	13,121,258.72
Italy	34	Y	60	26,770.16
Latvia	80	Y	240	21,766.19
Lithuania	20	Y	30	113,615.71
Luxembourg	40	N	/	n/a
Malta	300	N	/	6,521.00
Netherlands	n/a	N	/	n/a
Poland	n/a	Y	*	7,451,865.82
Portugal	n/a	Y	90	n/a
Romania	70	N	n/a	1,013,470.33
Slovakia	30	Y	120	1,583,825.85
Slovenia	27	Y	60	339,569.86
Spain	63	Y	90	899.72
Sweden	46	Y	90	24,972,889.68
UK	22	Y	20-39	3,402,476.43
Norway	26	Y	60	8,988,105.29
Iceland	20	N	/	955,132.06
TOTALS	51		70	85,302,625.96

* 30-60 days or up to 6 months

Table 5.3 Mobility not requiring Prior Authorisation – where patients travel (part 1)
(Those countries not providing data are left blank).

Country of Affiliation	Country of Treatment: AT	BE	BG	HR	CY	CZ	DK	EE	FI	FR	DE	EL	HU	IE	IT	LV	LI	LT	LU	MT	NL	PL	PT	RO	SK	SL	ES	SE	UK	NO	IC	SENT
Austria	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	**7**
Belgium																																
Bulgaria																																
Croatia	22	11	0	0	1	6	0	0	0	4	7	123	1	3	1	5	0	0	0	1	0	6	0	2	0	1	20	3	2	1	0	**221**
Cyprus	0	0	0	0	0	0	0	0	0	0	0	2	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	**13**
Czech Rep	197	1	2	0	0	0	0	0	0	0	4	539	3	0	0	6	0	0	0	1	0	3	17	1	0	130	1	7	0	4	0	**916**
Denmark	311	18	32	57	32	25	0	1	13	288	17352	119	7	528	182	18	0	52	2	35	103	1007	74	26	10	1	1813	3298	35	40	3	**25,482**
Estonia	0	1	6	0	2	2	1	0	21	2	16	4	0	0	1	26	0	3	0	1	5	2	0	0	0	0	0	17	3	0	3	0	**116**
Findland	7	23	10	6	1	11	4	5301	0	35	65	17	2	57	16	38	0	12	0	0	9	90	16	9	13	3	489	53	6	2	0	**6,295**
France	1295	30881	1058	784	211	479	60	46	284	0	8661	5240	3794	549	8006	108	8	111	13235	405	1575	2584	32766	1146	128	132	33427	179	900	116	95	**148,263**
Germany																																
Greece	1	13	0	0	7	1	0	0	0	10	10	0	0	0	10	0	0	0	2	0	0	0	0	0	0	0	0	1	0	8	1	0	**64**
Hungary																																
Ireland	0	3	1	1	0	3	0	1	0	3	21	0	2	0	3	4	0	19	0	0	3	122	0	1	1	0	7	0	3943	0	0	**4,138**
Italy	112	3	0	13	0	1	0	0	0	7	20	2	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	**159**
Latvia	0	0	0	2	0	0	0	2	0	0	6	0	0	0	0	0	3	0	0	0	0	1	0	0	0	0	1	0	0	0	0	**15**
Lithuania	1	1	0	0	0	1	0	7	0	2	22	0	0	0	0	64	0	0	1	0	0	25	0	0	11	0	2	4	2	0	0	**143**
Luxembourg																																
Malta	0	1	0	0	0	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	9	0	0	**14**
Netherlands																																
Poland	13	1	0	3	0	14171	0	0	0	6	453	0	0	3	22	0	0	783	0	0	1	0	0	0	53	0	63	0	2	0	0	**15,574**
Portugal																																
Romania	53	3	0	0	0	0	0	0	0	13	60	2	729	0	28	0	0	0	0	0	2	0	3	0	0	0	5	0	3	0	0	**901**
Slovakia	361	7	6	11	2	5109	0	0	0	11	88	4	529	0	11	1	0	2	4	0	11	4121	2	5	0	1	7	1	8	0	0	**10,302**
Slovenia	179	0	0	890	0	5	0	0	0	0	28	0	19	0	442	0	0	0	0	0	2	0	0	1	0	0	3	0	6	0	0	**1,575**
Spain	1	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	**5**
Sweden	529	79	83	282	209	50	3040	37	1082	802	784	1084	53	12	319	25	0	42	12	34	107	240	192	47	9	14	7926	0	117	86	19	**17,315**
UK	19	12	56	6	17	44	0	6	0	136	107	24	45	70	33	83	0	318	0	0	19	850	8	44	49	4	94	0	0	1	1	**2,046**
Norway	43	24	36	51	123	18	124	8	19	88	270	212	429	7	34	27	1	84	2	0	121	577	35	13	18	6	8148	103	32	0	20	**10,673**
Iceland	1	1	0	0	0	5	3	2	1	5	5	3	413	3	3	3	0	6	0	0	3	181	1	3	0	2	326	6	16	2	0	**994**
TOTALS RECEIVED	3,145	31,083	1,290	2,106	605	19,931	3,232	5,411	1,424	1,422	28,633	6,724	6,601	654	9,123	397	12	1,432	13,260	475	1,972	9,817	33,100	1,295	424	184	52,343	3,649	5,097	252	138	**245,231**

Section Five
Comments from Member States

Free text space is provided at the end of each section to allow the respondents from the NCPs to provide additional information which clarifies the numbers they were able to report. Twenty-three countries took the opportunity to share more information, with the most common comments being related to the questions in parts 3 and 4 of the questionnaire, which asked for the average length of time between a request for prior authorisation and decision, and between a request for reimbursement and payment. Five Member States noted that they did not collect this information in the format requested and accordingly did not complete these questions.

Belgium, Germany, and the Netherlands explained in depth why data were not available to answer the questions on authorisation and reimbursement processing times. Belgium explained that not all health insurance funds provided data on the average time for dealing with requests for prior authorisation or data on the average time for dealing with requests for reimbursement. The situation was reported as being the same in the Netherlands where the government relies on the accounting systems of private health insurers for healthcare data. It appears that the data recorded in their administration systems are not identical for each insurer. Germany also explained that data are not available because of the way health insurance funds collect and provide information for statistical purposes. Estonia underlined that the data collected are not complete as there are no data available about requests made at the desk or by phone, while Iceland noted that they Directive has only recently been fully implemented, and so data available on its use were limited.

Finally, it is worth mentioning that some questionnaires were very thoroughly completed and provided a wealth of information. This is the case for Demark and Finland, which also included references to national legislation in order to reimburse planned treatment given in Switzerland where the Directive does not apply for Danish and Finnish patients.

A full list of the comments is reproduced in Appendix 1.

Conclusion

1. Cross-Border Healthcare in the EU under the Directive in 2019 compared to 2018

The data collected on patient mobility in 2019 demonstrate that the uptake of patient rights to cross-border healthcare, as provided for under the Directive is growing slowly; both for healthcare requiring prior authorisation and for that not requiring prior authorisation. The grand total of cases of patient mobility, both with and without prior authorisation reported for the year 2019 was 290,890 up from 232,054 in 2018. The growth occurred predominantly in cross-border care not requiring prior authorisation. While these numbers are not direct comparisons because of slight variations between the lists of countries reporting, the overall trend regardless of these variations is upward. The total spend on all reimbursements reported by the Member States also rose in 2019 for which a spend of approximately 92M€ was reported, while in 2018 it was 73.3M€.

Figures 8, 9, and 10 demonstrate these results.

Figure 8 Patient mobility with prior authorisation in 2019 and 2018

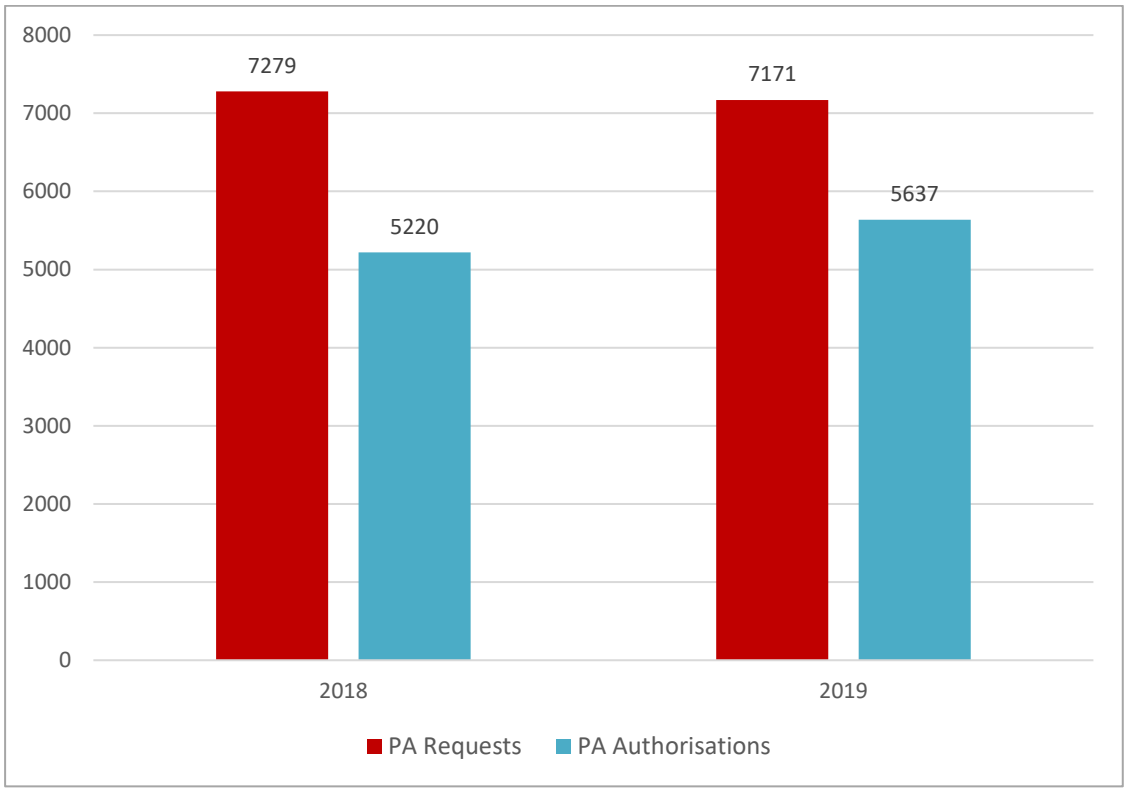


Figure 9 Patient Mobility not requiring prior authorisation 2019 and 2018

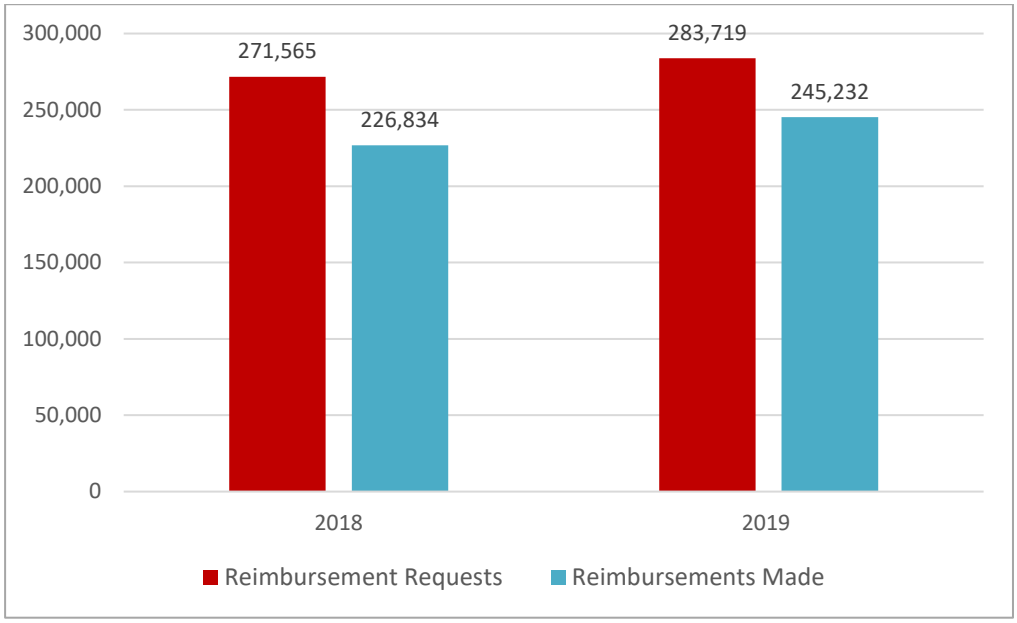
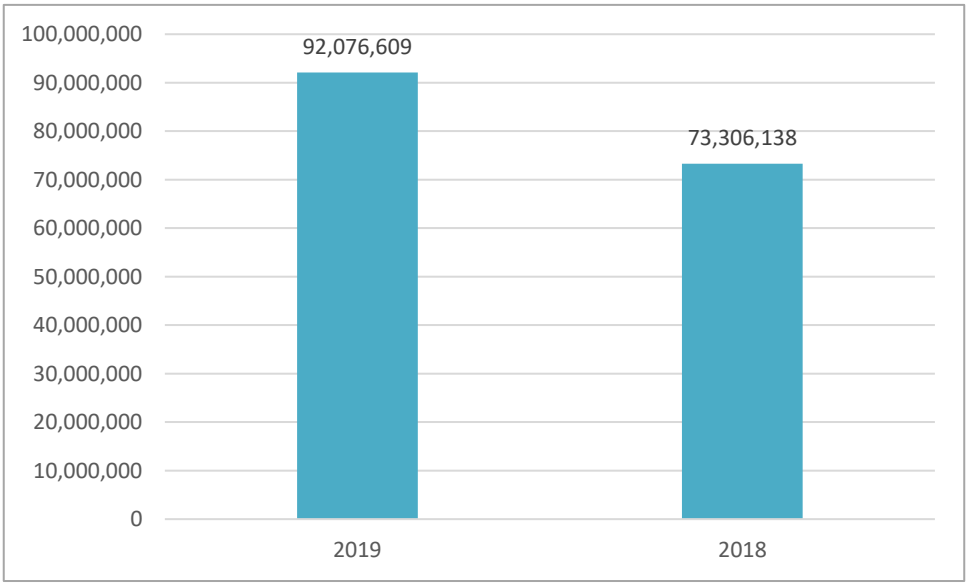


Figure 10 Total Reported Spend on Reimbursements 2019 and 2018 (with and without prior authorisation)



The data depicted in the flow maps for 2019 demonstrate clearly that the flow of patients between countries is highly concentrated in countries with shared borders, with around 70% cases of all mobility being accounted for by mobility between neighbouring countries; noting the exception of two Nordic countries with a flow of patients to Spain.

However, while the data show some interesting trends, the overall numbers are too small to draw very significant conclusions. Furthermore, the discrepancy between total requests reported, both for treatment requiring prior authorisation and that not requiring authorisation, and the data on

the outcome of such requests makes some interpretations less authoritative than they could be if all Member States were able to provide full information. It is hoped that as the Member States become more accustomed to processing these requests, more robust data will be available.

2. Cross-Border Healthcare in the EU under the Directive, Regulations and Parallel Schemes

The Cross-Border Care Directive is not the only legal tool under which European citizens can seek funding for care in a Member State other than the country in which their healthcare insurance is provided. As noted in the introductory chapter, Regulation (EC) No 883/2004 on the coordination of social security systems and its implementation rules laid down in Regulation (EC) No 987/2009 (the Regulations), as well as a number of parallel schemes in the border regions, also provide routes for patient mobility. The Regulations cover both unplanned care, which arises as a matter of necessity when a patient needs care when away from home; as well as planned care, when a patient travels expressly to receive care in another EU country. In this section we provide a very brief overview of the reported use of the Regulations, full details are available in the annual report on the Cross-border healthcare in the EU under social security coordination.[7] We also provide some comment on the parallel schemes which exist in some border regions, but for which no formal reporting to the European Commission is required in EU level legislation.

2.1 Unplanned Care reimbursed under the Regulations

Unplanned care or treatment that becomes necessary when a citizen is in a country other than the country in which they are insured for healthcare is covered by the Regulations. The country in which the patient is insured is known as the 'competent Member State', while the other is known as the Member State of stay. Unplanned care is usually organised administratively through the European Health Insurance Card (EHIC), which the patient presents at the point of care. There are currently over 250 million EHICs in circulation, which indicates that over half of all EU citizens are in possession of an EHIC, although the share of insured persons with an EHIC differs greatly between Member States. When an EHIC is used, reimbursement claims are settled either directly between the Member State of stay and the competent Member State or, if the insured person has paid out of pocket, they make a claim for reimbursement in their home Member State. This model is however rarely used, with nine out of ten reimbursement claims for unplanned necessary treatment settled between the Member States directly. The data reported on reimbursement by either route indicates that unplanned care does not have a very significant budgetary impact on the Member States, amounting to approximately 0.1% of total healthcare expenditure related to sickness benefits in kind.

The Regulations also cover planned care, for which a certificate of coverage, referred to as Portable Document S2 (PD S2), must be issued. In 2019 approximately 10 out of 100,000 insured persons received a PD S2, with only Luxembourg showing a significantly higher volume of patient mobility using the PD S2 route, with some 13 out of 1,000 insured persons in Luxembourg receiving a PD S2 in 2019.

The total reported patient mobility under using PD S2s shows a very concentrated use of planned

[7] Available via the website of DG Employment https://ec.europa.eu/social/home

cross-border healthcare within a limited number of Member States. The data reported for 2019 on the number of PD S2s issued for care in one Member State for treatment in another are as follows:

- France to Belgium (21,310)
- Luxembourg to Germany (6,452)
- Germany to Austria (4,841)
- Germany to CH Switzerland (4,731)
- Austria to Germany (4,489)
- Luxembourg to Belgium (4,483)
- Belgium to Luxembourg (3,595)

The country pairs shown above are very similar those seen the flow maps depicting cross border care under the Directive.

However, the data reported on the use of the Regulations has some gaps, similar to those on the reporting of the use of the Directive. With respect to treatments provided to patients on the basis of a PD S2 issued in another country Germany, Greece, Spain, Poland, Portugal, Lithuania and Norway were unable to provide numbers; while Germany and Norway were also unable to provide data on PD S2 forms they issued for treatment.

The data from the countries which were able to report show that 34,762 PD S2 forms were issued and 52, 916 forms were received; these reported numbers allow the authors of the report to estimate that approximately 70,000 PD S2 forms were issued in 2019. Luxembourg was the heaviest user of the system with approximately 12,000 PD S2 forms issued, with France and Austria the next biggest users with approximately 3,500 SPD 2 forms issued each. The financial impact of patient mobility using the PD S2 route however amounts to less than 0.02% of the total of healthcare spending related to sickness benefits in kind. As in the case of unplanned care it therefore has limited impact.

2.2. Parallel schemes for funding cross-border patient mobility

Alongside the procedures covered by the Regulations and the Directive, several Member States have adopted bi-lateral parallel procedures with neighbouring countries. The exact number of parallel schemes in operation is not known, however Cross Border.CARE[8], a study funded by the European Commission to map EU funded cross-border healthcare initiatives, identified 423 initiatives undertaken between 2008 and 2018 which addressed some element of cross-border care. The initiatives described in the study were wide ranging and included many focussed on training, knowledge sharing and resource development. Of the 423 initiatives studied, just under 100 focused on some aspect of diagnostics or care provision.

An example of such an initiative for care provision is the Franco-Belgian 'Zones Organisées d'Accès aux Soins Transfrontaliers' (ZOAST), which comprises seven separate agreements as depicted in figure 11 below. The ZOAST agreements allow the population covered by health insurance residing in the border region to travel to health care facilities that are partners in the agreement without any administrative or financial barriers, with care reimbursed at the rate of the country in which the care is provided.

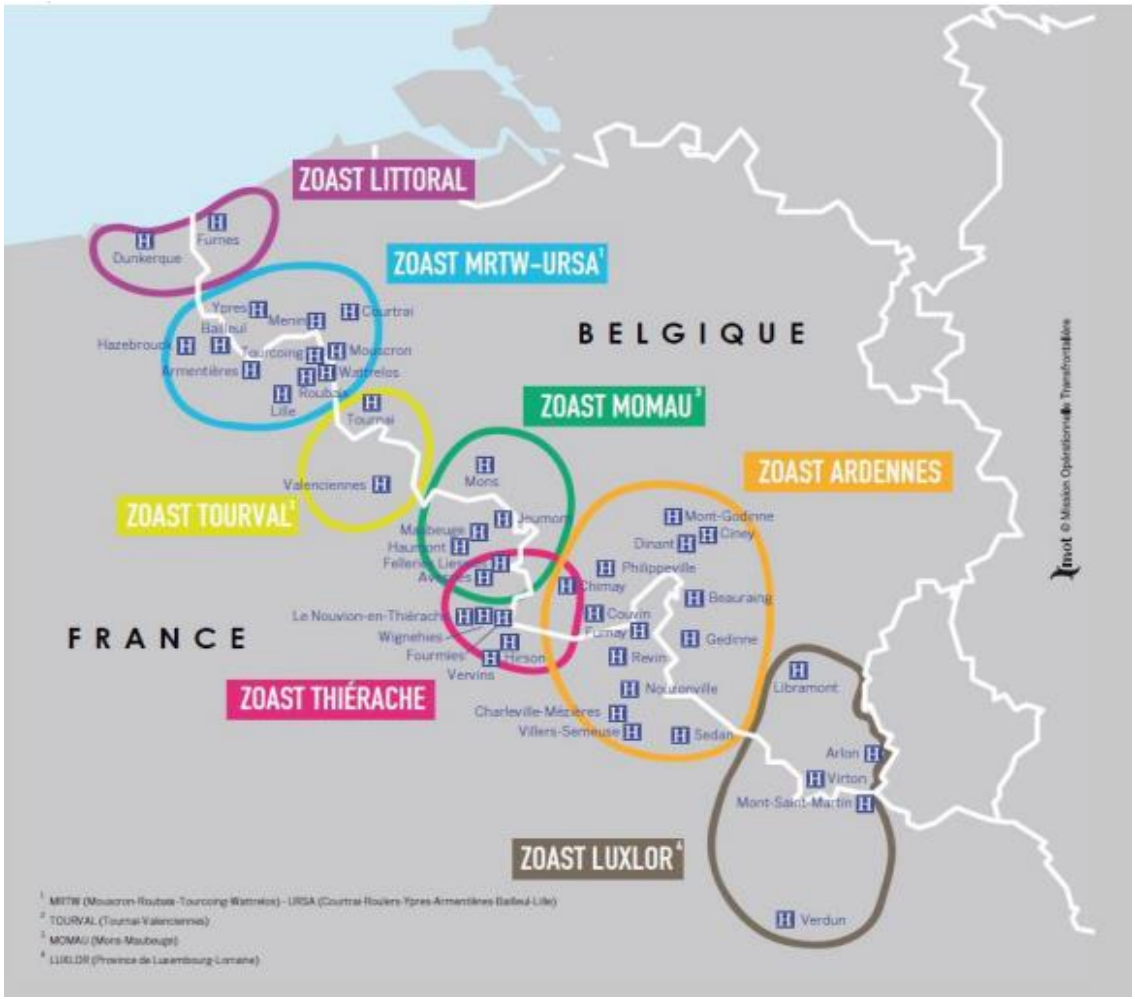
[8] Available at https://ec.europa.eu/health/sites/health/files/cross_border_care/docs/2018_crossbordercooperation_frep_en.pdf

A study published in 2018[9] shows that 15,653 patients from France received care in Belgian hospitals within the framework of the ZOAST agreements in 2017. Nearly two thirds of the treatments related to traditional admissions, and the remainder to day-hospitalisation and ambulatory care. A total of €28.2 million was paid in 2017 by the two mutual insurance funds which are party to the agreements. The largest share of in-patient interventions provided was in internal medicine and surgery (including disease-related operations), abdominal and gastroenterological procedures, cardiovascular interventions, abdominal and gastroenterologicalorthopedic and urological), intensive care/resuscitation, geriatrics and rehabilitation. For day-hospital and ambulatory care, the most common interventions involved ophthalmological operations (mainly for cataract). In addition, there were also other cases of outpatient care, in particular hemodialysis, EMR/emergency patient transport, radiotherapy and medical imaging.

Seen in perspective to total care provided in Belgium, the patient in-flow from France under ZOAST in 2017 represented 9.6% of all care provided to foreign patients, who as a whole made up 1.53% of all patients who receive care in Belgian hospitals. Although the aggregated data on healthcare spending at the federal level signifies that the proportion of patient care under the ZOAST-arrangements amounts to less than 2% of total expenditure, its impact at local level, i.e., at the level of the hospitals in the border areas involved in the ZOAST arrangements, is significant, with ZOAST providing a very important and well used service in the French-Belgium border-region.

[9] Available at https://www.mc.be/media/rapport-flux-zoast_tcm49-55254.pdf

Figure 11 The 7 ZOAST Agreements[10]



3. Impact of the Directive, Regulations and parallel schemes

The figures on patient mobility based on the Directive reported in the preceding chapters, as well as snap shots on the use of the Regulations and the parallel schemes, indicate that while some patients in Europe make use of the existing frameworks to access care outside their countries of usual residence, patient mobility remains limited. The data presented indicate that the highest mobility is in the border regions, and that since in some border regions parallel schemes also exist, patients in these areas may be quite well served in terms of access to cross-border care.

The report on the use of the Regulations states that on average somewhere in the region of 0.01% of all persons in Europe covered by public health insurance were persons entitled to receive planned cross-border healthcare on the basis of a PD S2 by issuing Member State in 2019. This figure must however be interpreted with caution as this number was calculated based upon those Member States for which both the number of PD S2 issued and the number of insured persons was available, this means that the data for Ireland, Portugal, Sweden and , Norway were omitted. Performing the same calculation for the number of cases of care reimbursed on the basis of the Directive, recognizing that in this case there are no data for Germany, the total proportion people making use of the Directive can be estimated at approximately 0.05%. In terms of budgetary

[10] Source: the report "European Union. (2017). Cooperation Cross-Border Healthcare: Principles and Practices". Luxembourg: Publications Office of the Union European.

impact, planned care under the Regulations in 2019 amounts to costs in the region on 140M€ or 0.02-0.03% of the total healthcare spending, while care under the Directive in 2019 amounted to 88M€.

As noted in the report on the use of the Regulations and in this present report, the numbers and proportions must be interpreted cautiously. In both cases data from some Member States are excluded and the excluded data are note the same in each report. However, it is clear from the data that are available that European citizens are making use of the right to cross-border care as provided for in the Regulations and the Directive.

Appendix 1
Specific Comments from the respondents

Country of affiliation	Comment
Austria	Section 3. Please note that treatments approved in 2018 are usually only billed in 2019. Regarding the average time for dealing with requests for reimbursement, it has to be noted that necessary research and inquiries can take up to three months to answer. Regarding the maximum time limit for dealing with requests for reimbursement, some institutions have internal deadlines (10 days). Other institutions base initial reimbursement on their own tariffs if it is foreseeable that the information retrieval will take longer than a month. Section 4. Some institutions give non-binding information about the expected reimbursement amount upon presentation of the cost estimate. Reimbursement applications from insured persons who received cross-border health treatments that do not require prior approval are usually treated like domestic reimbursement claims and are therefore not specifically recorded. Only cases in which prior authorisation did not take place due to a medical emergency are recorded separately
Belgium	Section 3.1.b) - authorisation/processing times (line 25) : not all health insurance funds provided data on the average time for dealing with requests for prior authorisation. The data we did receive, are provided in such a way that they do not allow us to identify a (national) average time for dealing with such requests. However, on the basis of the data provided, we may conclude that all decisions were taken within the maximum time limit set for dealing with such requests. Section 3.1.b) - authorisation/processing times (line 25) : according to our legislation the maximum time limit for dealing with requests for prior authorisation is 45 calendar days and not working days Section 3.2.a) - reimbursement/processing times : not all health insurance funds provided data on the average time for dealing with requests for prior authorisation. The data we did receive, are provided in such a way that they do not allow us to identify a (national) average time for dealing with such requests. Sections 3.1.a) and 3.2.b) - number of authorised requests & reimbursement : FYI (not included in the data) ; BE decided unilaterally to apply the principles of Directive 2011/24/EU also in relation with Switzerland ; for the reference year 2019, we granted 1 prior authorisation (hospital treatment requiring a stay of at least one night) ; amount of reimbursement is € 59,40. Section 3.1.e) - reasons of refusal : in three cases the PA was refused for "other reasons". Section 4.1.a) - number of requests for reimbursement: not all health insurance funds have provided data on the number of requests received/ granted/refused/withdrawn or inadmissible. Hence, we prefer not to provide you with only partial data as they do not reflect the actual situation. Section 4.1.b) - reimbursement/processing times: not all health insurance funds provided data on the average time for dealing with requests for reimbursement. The data we did receive are provided in such a way that they do not allow us to identify a (national) average time for dealing with such requests. Section 4.1.c) - amount reimbursed: (a) FYI (included in the data) - we have a special arrangement, called "Ostbelgien-Regelung", for the German speaking population in the Eastern part of Belgium with special rules on access to specialist health care in

	Germany as well as special rules on reimbursement based on Directive 2011/24/EU. (b) FYI (not included in the data) - BE decided unilaterally to apply the principles of Directive 2011/24/EU also in relation to Switzerland ; for the reference year 2018, we reimbursed a total amount of € 4.689,36 for health care provided in Switzerland not requiring a prior authorisation. Section 4.1.d) - reimbursement/granted requests : not all health insurance funds have provided data on the number of granted requests for reimbursement. Hence, we prefer not to provide you with only partial data as they do not reflect the actual situation.
Bulgaria	/
Cyprus	/
Croatia	/
Czechia	Section 4. - All together there were 2783 requests for reimbursement: - 948 cases were solved under the Directive, - 1835 cases under the Regulation 883/2004, 987/2009
Denmark	Section 1. Re Section 1.2 - Unfortunately, we are not able to specify the number of NCP requests by media, we only have data on the total number of requests. Furthermore, the number of requests only includes requests received by the *Regional National NCPs***.** The Danish Patient Safety Authority, which is the Danish Coordinating NCP, is not able to provide valid data on the number of requests for the year 2019. Section 3. Please note that the figures in section 3.1.d and 3.1.e remain red even though the total number of authorisations and refusals correspond with the number in section 3.1.a. According to Danish legislation Danish insured citizens, who have been referred for hospital treatment, may, within certain limits, freely choose any public and some private hospitals. If the Danish region of residence cannot ensure that treatment will be initiated within 30 days, patients have the right to a so-called 'extended free choice of hospital'. This means that patients may choose to go to a private hospital in Denmark or to a public or private hospital abroad at the expense of the region. One of the five regions in Denmark has informed us that many patients prefer to receive hospital treatment according to this set of rules as they do not have to pay for the treatment themselves. Section 4. Re section 4.1.a - About 84 % of the received requests for reimbursement in 2019 concerned dental treatment.
Estonia	Section 1. Estonia does not have independent National Contact Point; it is integrated into Estonian Health Care Fund institution. First level clerks are answering all the requests. Requests are separated by the topics and it is done by first level clerks. Numbers given in question 1.2 are indicated as NCP requests from overall requests to Estonian Health Insurance Fund.
Finland	Section 1. Kela advices in social security matters and reimbursements in international situations by phone, desk, e-service and website. Section 3. Finland does not have a prior authorisation according to Directive. However, it has a prior authorisation according to Regulation. Section 4. 4.1.D Even if Switzerland has not implemented the Directive, Finland according to national law reimburses planned treatment given in Switzerland. Therefore, in addition to the numbers reported: Switzerland 9 requests, 572,5 euros.
France	Section 1. Certain telephone calls received by CLEISS may concern Directive 2011/24 / EU but they are not included in the above figures. Indeed, the CLEISS

	service dealing with them also takes care of all calls relating to international agreements in the field of social security and no distinction in the accounting of calls is made according to the subject of the call.
Germany	Section 2. The German National Contact Point for Cross-Border Healthcare is Part of the German Liaison Agency Health Insurance - International (DVKA). The DVKA is a department of the German National Association of Statutory Health Insurance Funds. Therefore, we have no information about the access or their limitations of patients in practice. This information is only available at the German Statutory Health Insurance Companies and the German private Insurers. As the NCP we got no complaints of patients whose access to treatment have been limited in 2019 in cases of the Directive. Section 3. The German National Contact Point for Cross-Border Healthcare is Part of the German Liaison Agency Health Insurance - International (DVKA). The DVKA is a department of the German National Association of Statutory Health Insurance Funds. Therefore, we have no information about the access or their limitations of patients in practice. This information is only available at the German Statutory Health Insurance Companies and the German private Insurers. There is no maximum time limit for reimbursement in the German Law. Section 4. The German National Contact Point for Cross-Border Healthcare is part of the German Liaison Agency Health Insurance - International (DVKA). The DVKA is a department of the German National Association of Statutory Health Insurance Funds. Therefore, we have no information about the number of requests for reimbursement or the requests by countries. This information is only available at the German Statutory Health Insurance Funds and the private German Health Insurance Companies.
Greece	Section 3. Regarding 3.1a data, in 2019 EL had 916 requests for prior authorisation for cross-border healthcare under the Social Security Regulations and the Directive in total. EL granted 889 S2 authorizations and 5 under the Directive. 19 requests were refused because the treatment could be provided in EL within a time limit which was medically justifiable for the patient's health condition. 3 requests for authorization under the Directive were inadmissible because they were submitted after the provision of the healthcare abroad. The data provided for points 3.1b, 3.1c, 3.1d and 3.2 refer only to requests under the Directive.
Hungary	/
Ireland	Section 1. The figures provided above are for new queries only submitted by email or telephone. These figures do not include all other activity regarding active claims. For example, a new query may result in numerous follow up queries/clarifications from the same patient, but these subsequent communications are not recorded. Section3. Prior Authorisation is only required for Enzyme Replacement Therapy (ERT). This is the only procedure that the Republic of Ireland have notified the European Commission of requiring Prior Authorisation. However, a system of Prior Authorisation is provided to patients as an option so the patient may ensure compliance with public patient pathways and thus with a view to protecting the applicant. It is only applicable to inpatient episodes of care. By applying for prior authorisation, the patient can ensure he/she will be eligible for reimbursement on completion of treatment accessed under the Directive. If at any stage during the application stage for prior authorisation the patient does not comply with public patient pathways and thus would not be eligible for reimbursement, the patient is advised of how he/she can correct the pathway so he/she will be eligible for reimbursement after receiving the treatment.

	We have implemented a system of prior approval for planned inpatient episodes of care that provide the applicant with confirmation that they have followed a public patient pathway and an estimate of the amount that they can expect to be reimbursed based on the information provided by their treating consultant abroad and the DRG code identified prior to treatment. 3.2 b) It is not possible to provide a reimbursement amount specific to prior approvals as this approval is issued for proposed and not definitive treatment. Prior authorisation is not confirmation of the value of reimbursement as value of reimbursement is only known at reimbursement stage. All figures provided are based on applications received from 01/01/2019 to 31/12/2019 and their status as of 31/12/2019. 3.1 a) All information provided is specific to applications both received and actioned in 2019 solely. Prior authorisations deemed withdrawn/inadmissible are applications where the patient either withdrew their application, submitted an invalid application or their application was not completed on 31/12/2019. 3.1 e) Refused requests for prior authorisation by reason for refusal. The 8 applications refused prior authorisation were for the following reasons: - 2 applicants did not provide a valid path of referral in line with the member state. - 1 applicant accessed private consultations in Ireland and therefore were not eligible under the Cross Border Directive. - 1 applicant did not attend an initial consultation abroad prior to their treatment and therefore did not follow the public patient pathway in Ireland. - 1 applicant accessed treatment that is not available in the public health system in the Republic of Ireland. - 2 applicants applied for treatment that was not medically necessary. - 1 applicant was not ordinarily resident in the Republic of Ireland. Section 4. All figures provided are based on applications received from 01/01/2019 to 31/12/2019 and their status as of 31/12/2019. While Enzyme Replacement Therapy is the only procedure requiring prior authorisation, we have implemented a system of prior approval for planned inpatient episodes of care that provide the applicant with confirmation that they have followed a public patient pathway and an estimate of the amount that they can expect to be reimbursed based on the information provided by their treating consultant abroad and the DRG code identified prior to treatment. This is a safeguard so that patients can ensure they will be eligible for reimbursement prior to accessing expensive inpatient treatments. 4.1 c) This figure reflects the total amount paid out through the Cross-Border Directive for 2019 and includes applications that applied for prior approval that were later reimbursed. Of the 108 refused requests, 16 applications went through an appeals process and had the decision overturned. These 16 applications were then reimbursed. The other 92 claims declined reimbursement did not fulfil the criteria under the Cross-Border Directive and therefore were not eligible for reimbursement.
Italy	/
Latvia	/

Lithuania	Section 1. Information requests (point 1.2.) indicate all requests concerning the Regulations on the coordination of social security systems as well as Directive 2011/24/EU. The statistics involves the requests regarding cross-border healthcare, European Health Insurance Card, Regulations in general, etc. We are not collecting separate information concerning the cross-border healthcare.
Luxemburg	Section 1. No detailed information concerning the requests for the NCP1 (CNS) is available. The CNS has integrated the missions of the NCP in the existing structures of the institution and it is not possible to sort out the communication related to the role of the NCP. Section 3. Please note that the authorization procedure in Luxembourg treats requests concerning the Regulation 883/04 and the Directive 2011/24 equally in a first step. Only later, according to the social security organization in the place of treatment an S2 or an authorization under the scheme of the Directive is established.
Malta	/
Netherlands	Section 4. The Dutch healthcare system is implemented by private health insurers. The government relies on the accounting systems of private health insurers for this healthcare data. The data recorded in their administration systems is not identical with each insurer. These systems vary widely. As a result, it is not possible to collect aggregate data administered by the insurers. The questions in section 4 can for this reason not be answered
Poland	Section 1.2. Please note that the total number of requests does not include the data provided by the telephone information service for patients (800 190 590 or +48 22 125 66 00 from abroad), since these requests are not registered. Section 3.1 b. It is difficult to indicate precisely the average time of processing the request for prior authorisation, because the data reported by the Regional Branches of the NFZ do not allow to calculate the average time for dealing with the requests (sometimes they do not indicate days which should not be included in the time limit). Section 4.1 b. In respect of 'the average time (in working days) for dealing with requests for reimbursement in 2019 - the way the data are provided by some of regional branches of the NFZ do not allow to calculate the average time for dealing with requests (because sometimes they do not indicate days which should not be included in the time limit). However, on the basis of the data provided, it may be concluded that almost all decisions were taken within the maximum time limit set for dealing with such requests. Section 4.1 b. In respect of 'the maximum time limit (in working days) - the deadline for the assessment of requests for reimbursement in Poland depends on the need of initiating investigation procedure during the assessment. In general assessment of the request with no need for further investigation takes 30 days from the date of initiation of proceedings. If the assessment of the request requires an investigation the deadline is 60 days In the investigation requires involvement of the national contact point of other Member State, the deadline may be extended to 6 months.
Portugal	Section 3. The National Health System ensures the provision of highly specialized healthcare outside the national territory, under national legislation (Decree-Law No. 177/92), which due to lack of technical or human resources cannot be provided in the Country and covers all citizens who are beneficiaries of the National Health Service. The costs related to medical care, travel and accommodation, for the User and companion (when necessary), are borne by the National Health Service, without any cost to the User. Taking into account this legislation and coverage of expenses by the National Health Service, requests for the provision of healthcare under the Directive are very low, since the rights deriving from national legislation are more advantageous for the User. Section 4. The information presented in 2018 and previous years, considered requests with and without prior authorisation. The 2019 amounts included in

	this session already only consider refund requests submitted without the need for prior authorisation. Applications submitted in 2019 are covered by Community Regulations, as they occurred in situations of temporary stay
Romania	Section 1. At pnt. 1.2 at the heading "Desk (in person)" the value is 0 because we do not provide information in this way. We only answer to the requests by written (letters, e-mail and fax) and by telephone. Section3. At pnt 3.2 let a), at the heading "Do you have a maximum time limit for dealing with requests for reimbursement?": - reasons: this maximum time limit is not regulated at national level. - steps taken to improve the available statistics: in case we will be asked imperiously the adoption of this deadline, we will try to stay within the limits required, depending on available human and financial resources. Section 4. At pnt 4.1 let b), at the heading "Do you have a maximum time limit for dealing with requests for reimbursement?": - reasons: this maximum time limit is not regulated at national level. - steps taken to improve the available statistics: in case we will be asked imperiously the adoption of this deadline, we will try to stay within the limits required, depending on available human and financial resources.
Slovakia	
Slovenia	Section 1. 6 requests received by ordinary post Section 3. 45 days - time from receipt of the application for reimbursement of costs until the decision is issued (not just working days) 60 days - time from receipt of the application for reimbursement of costs until the decision is issued (not just working days) Section 4. 27 days - time from receipt of the application for reimbursement of costs until the decision is issued (not just working days) 60 days - time from receipt of the application for reimbursement of costs until the decision is issued (not just working days)
Spain	
Sweden	Section 1. NCP 1: Generally speaking, the Swedish Social Insurance Agency is the government agency that administers the major part of social insurance in Sweden. The agency has a common customer service that is responsible for all questions regarding social insurance that are administered by Försäkringskassan. The unit working with cross-border healthcare is only a small part of the Swedish Social Insurance Agency. In the framework of Directive 2011/24/EU, the Swedish Social Insurance Agency is both NCP and competent institution to grant decisions on prior notification and decisions on reimbursement. The Swedish Social Insurance Agency is also the Swedish competent institution to grant prior authorisation or to reimburse retroactively when it comes to benefits in kind within the framework of regulation 883/2004. In total, in 2019 the unit working with cross-border healthcare received 17 807 phone calls. However, it is important to point out that we cannot distinguish between NCP requests, questions regarding an ongoing case or combination of both. In total, in 2019 the unit working with cross-border healthcare received 1 963 e-mails. However, it is important to point out that we cannot distinguish between NCP requests, questions regarding an ongoing case or combination of both.

	NCP 2: The National Board of Health and Welfare has a common customer service responsible for all questions, including questions regarding cross-border healthcare for in-coming patients. There is no special unit who works with cross-border healthcare. The National Board of Health and Welfare do not keep record of information request received regarding cross-border healthcare. However, we do know that no information requests from patients was received during 2019. The National Board of Health and Welfare received information requests from NCPs sent to all NCPs during 2019, but there is no record of how many requests The National Board of Health and Welfare received. Section 4. In the framework of Directive 2011/24/EU, the Swedish Social Insurance Agency is both NCP and competent institution to grant decisions on prior notification and decisions on reimbursement. Försäkringskassan is also the Swedish competent institution to grant prior or to reimburse retroactively when it comes to benefits in kind within the framework of regulation 883/2004. Therefore, when an insured person applies retroactively for reimbursement of healthcare costs, a patient can choose between three alternatives on the application form. He or she might ask the Swedish Social Insurance Agency to investigate his or her application based on regulation 883/2004, or based on Directive 2011/24/EU, or, which is the most common choice of the patient, to investigate the application based on the legal framework that is most beneficial for the patient. In 2019, the Swedish Social Insurance Agency received 20 620 applications where a patient asked for reimbursement either based only on the framework of Directive 2011/24/EU or based on the most beneficial legal framework. (Applications where the patient only asked for reimbursement according to the rules of regulation 883/2004 are not included in the number of 20 620 application). In 4 338 out of 17 315 cases, the patient was reimbursed with more than 0 SEK, but he/she did not receive the amount that he/she initially had applied for. In the remaining 12 977 cases, the applicants were fully reimbursed.
United Kingdom	Section 3.1(e), refusals. All responses come under second category, all-encompassing in that one or more of the eligibility criteria for funding, were not met. England Section 3.2(b) The information above relates to "specialised" treatments only, which require "Prior Approval" as an eligibility-criteria for funding. - England Local Health Boards (LHBs) in Wales work to process all Prior Authorisation requests within the 20-working day target included in the All Wales Procedure for Welsh Patients Accessing Treatment in Countries of the European Economic Area. However, as per the Procedure the target is suspended when further information needs to be obtained. - Wales Northern Ireland Directive route applications must be authorised by HSCB prior to treatment if subject to “prior authorisation”. You will need prior authorisation providing proof that the treatment is appropriate in your individual circumstances when: (1) You have not been assessed as requiring the treatment you are seeking by a Health and Social Care consultant and the treatment involves at least one-night stay in hospital or requires the use of highly specialized and cost intensive medical equipment. (2) Your proposed treatment is one of a number of specialist services or is one to which the Board has applied commissioning restrictions. (3) You will require significant post-operative local clinical care. The HSCB recommends that all patients seek prior approval in order to make informed financial decisions which avoid disappointment regarding the level of expected reimbursement. 3.2(b) £4.8m amount reimbursed in 2019 relates to 1027 patients who submitted receipts in the 2019 and some of these relate

	Section 4.1 - The information above relates to "non- specialised" treatments only, which do not require "Prior Approval" as an eligibility-criteria for funding. - England Section 4.1 (a) Number of withdrawn/inadmissible requests includes closed / withdrawn / referred elsewhere / not in remit - England. The All Wales Procedure for Welsh Patients Accessing Treatment in Countries of the European Economic Area stipulates a 20-working day target for processing Prior Authorisation requests only and as per the Procedure the target is suspended when further information needs to be obtained. There is no All Wales target for processing requests not requiring Prior Authorisation as depending on the complexity of the case, additional investigation and processing may be required. Local Health Boards (LHBs) in Wales endeavour to process all requests as thoroughly and speedily as possible and some do stipulate local processing targets for requests not requiring Prior Authorisation (with some targets below the 20-working day Prior Authorisation target). If a request for treatment in another EEA country is declined, or a request for reimbursement is not granted in full, the patient has the right to ask for this decision to be reviewed in line with the criteria listed in the All Wales Procedure. There will be a period of 20 working days from the day the LHB decision is received by the patient during which they may request a review by the Review Panel ("the review period"). The Review Panel will aim to hear the review within 20 working days of the request being lodged with the LHB and a decision in writing will be provided to the patient and their clinicians within 5 working days of the Review Panel hearing.
Iceland	Section 1. Iceland National Contact Point is handled by International department at IHI. International department handles all international affairs for IHI. We do not have data on how many calls, written or in person visits are because of cross border matters or other matters.
Norway	/

Appendix 2

National Contact Points

Information for the National Contact Points of the Member States which replied to the questionnaire can be found hereunder. The information is presented as provided for in the questionnaire, with the exception of the telephone numbers for which country codes have been added.

Austria

Name	National Contact Point for Cross-Border Healthcare
Affiliation/Organisation	Austrian National Public Health Institute
Website	www.crossborder-healthcare.gv.at www.gesundheit.gv.at/service/patientenmobilitaet/kontaktstelle-patientenmobilitaet
Telephone	/

Belgium

Name	National contact point for cross-border healthcare
Affiliation/Organisation	Federal Public Service of Health, Food Chain Safety and Environment
Website	www.crossborderhealthcare.be
Telephone	+32 (0)2/290 28 44

Bulgaria

Name	
Affiliation/Organisation	National Health Insurance Fund (NHIF)
Website	www.nhif.bg
Telephone	+359 2 965 9116

Croatia

Name	National Contact Point for Cross-border Healthcare
Affiliation/Organisation	Croatian Health Insurance Fund
Website	www.hzzo.hr/nacionalna-kontaktna-tocka-ncp/
Telephone	+ 385 1 644 90 90

Cyprus

Name	Anastasia Christodoulidou
Affiliation/Organisation	Ministry of Health
Website	www.moh.gov.cy/cbh
Telephone	00357 22605414

Czechia

Name	Kancelář zdravotního pojištění (Health Insurance Bureau)
Affiliation/Organisation	Kancelář zdravotního pojištění
Website	www.kancelarzp.cz
Telephone	+420 236 033 411

Denmark

Name	Capital Region of Denmark
Affiliation/Organisation	Patient Advisors (placed at 11 hospitals in the region)
Website	https://www.regionh.dk/Sider/PageNotFoundError.aspx?requestUrl=https://www.regionh.dk/Sundhed/Patientguiden/Naar-du-skal-undersoeges/Hjaelpere-fagpersoner-du-kan-bruge/Sider/Patientvejlederen-din-vejleder-i-sundhedsvaesenet.aspx
Telephone	/

Name	Denmark: Region Zealand
Affiliation/Organisation	Patients Advisors Office
Website	https://www.regionsjaelland.dk/sundhed/patient-i-region-sjaelland/patientvejledningen/Sider/default.aspx
Telephone	+45 70155001

Name	Denmark: Region of Southern Denmark
Affiliation/Organisation	Patients Advisors Office
Website	www.rsyd.dk/wm406195
Telephone	+45 7841 0444

Name	Denmark: Central Denmark Region
Affiliation/Organisation	Patients Advisors Office
Website	www.patientkontoret.rm.dk
Telephone	/

Name	Denmark: North Denmark Region
Affiliation/Organisation	Patients Advisors Office
Website	http://www.rn.dk/service/english/patient-in-north-denmark-region/cross-border-healthcare-and-patient-mobility--(national-contact-point)
Telephone	+45 97648010

Name	Denmark: Danish Patient Safety Authority
Affiliation/Organisation	EU Health Insurance
Website	https://en.stps.dk/en/citizens/
Telephone	+ 45 72 26 94 90

Estonia

Name	Estonian National Contact Point
Affiliation/Organisation	Estonian Health Insurance Fund
Website	www.haigekassa.ee/en/estonian-national-contact-point
Telephone	(+372)6208471

Finland

Name	Contact Point for Cross-Border Healthcare
Affiliation/Organisation	Kela (Social Insurance Institution)
Website	www.EU-healthcare.fi
Telephone	/

France

Name	Point de contact national
Affiliation/Organisation	CLEISS -Paris
Website	www.cleiss.fr
Telephone	00 33 1 45 26 80 60

Germany

Name	EU-PATIENTEN.DE
Affiliation/Organisation	Part of National Association of Statutory Health Insurances Funds, German Liaison Agency Health Insurance – International (DVKA)
Website	www.eu-patienten.de
Telephone	+49 228 9530 800 or + 49 228 95 30 802

Greece

Name	Hellenic National Contact Point for Cross-border Healthcare
Affiliation/Organisation	National Organization for the Provision of Health Services (EOPYY) under the Ministry of Health
Website	https//eu-healthcare.eopyy.gov.gr
Telephone	+30 210 8110935, +30 210 8110936

Hungary

Name	Hungarian National Contact Point for Cross-border Healthcare in the European Union
Affiliation/Organisation	Integrated Legal Protection Service (Ministry of Human Capacities)
Website	www.patientsrights.hu (www.eubetegjog.hu)
Telephone	Green (free of charge) number: +36/20/9990025

Ireland

Name	Cross-border Directive - National Contact Point
Affiliation/Organisation	Health Service Executive
Website	crossborderdirective.ie
Telephone	+00 353 56 7784546

Italy

Name	National Contact Point
Affiliation/Organisation	Ministry of Health - Health Planning General Directorate
Website	http://www.salute.gov.it/portale/cureUE/dettaglioContenutiCureUE.jsp?lingua=italiano&id=3791&area=cureUnioneEuropea&menu=vuoto
Telephone	+390659943103 -3363

Latvia

Name	The National Health Service
Affiliation/Organisation	The National Health Service
Website	www.vmnvd.gov.lv
Telephone	+ 371 67045005

Lithuania

Name	The National Health Insurance Fund under the Ministry of Health
Affiliation/Organisation	/
Website	www.vlk.lt
Telephone	+370 5 232 2222

Name	State Health Care Accreditation Agency under the Ministry of Health
Affiliation/Organisation	/
Website	www.vaspvt.gov.lt
Telephone	+370 5 261 51 77

Luxembourg

Name	Caisse nationale de santé
Affiliation/Organisation	Public Administration
Website	www.cns.lu
Telephone	+352 2757-1

Name	Service national d'information et de médiation dans le domaine de la santé
Affiliation/Organisation	Governmental entity
Website	www.mediateursante.lu
Telephone	(+352) 24775515

Malta

Name	Anthony Gatt
Affiliation/Organisation	Department for Policy in Health, Ministry for Health, Malta
Website	https://deputyprimeminister.gov.mt/en/cbhc/Pages/Cross-Border.aspx
Telephone	+356 22992381

Netherlands

Name	Netherlands NCP Cross-Border Health Care
Affiliation/Organisation	CAK
Website	www.cbhc.nl
Telephone	+ 31 (0)88 711 45 12

Poland

Name	National Contact Point for cross-border healthcare
Affiliation/Organisation	National Health Fund
Website	www.kpk.nfz.gov.pl
Telephone	+48 22 572 61 13

Portugal

Name	Administração Central do Sistema de Saúde - ACSS
Affiliation/Organisation	Public Institute from the Ministry of Health
Website	www.acss.min-saude.pt
Telephone	+351 21 792 55 00 +351 21 792 58 00

Romania

Name	National Contact Point
Affiliation/Organisation	National Health Insurance House
Website	www.cnas-pnc.ro; pnc@casan.ro
Telephone	+40 (0) 372 309 135

Slovakia

Name	Health Care Surveillance Authority
Affiliation/Organisation	Department of Slovak Health Care Surveillance Authority (established by law)
Website	http://www.udzs-sk.sk/poistenie-v-europskej-unii
Telephone	+421 2 20856 789

Slovenia

Name	Slovenian National Contact Point on cross-border healthcare
Affiliation/Organisation	Health Insurance Institute of the Republic of Slovenia
Website	www.nkt-z.si
Telephone	+386 (0) 1 30 77 222

Spain

Name	National Contact Point for CROSS-BORDER HEALTHCARE
Affiliation/Organisation	Ministry of Health, Consumer Affairs and Social Welfare
Website	http://www.mscbs.gob.es/en/pnc/home.htm
Telephone	+34 90 140 01 00

Sweden

Name	Försäkringskassan
Affiliation/Organisation	Försäkringskassan (The Swedish Social Insurance Agency)
Website	www.forsakringskassan.se
Telephone	+46 (0)771 524 524

Name	Socialstyrelsen (For EU/EEA citizens intending to use Swedish healthcare)
Affiliation/Organisation	Socialstyrelsen (The National Board of Health and Welfare)
Website	www.socialstyrelsen.se
Telephone	+46 (0)75 247 30 00

UK

Name	NHS INFORM
Affiliation/Organisation	SCOTTISH GOVERNMENT
Website	WWW.NHSINFORM.SCOT
Telephone	0800 224488

Name	NHS Direct - National Contact Point
Affiliation/Organisation	NHS 111 Wales - National Contact Point
Website	https://111.wales.nhs.uk/travelhealth/ncps/
Telephone	/

Name	Health and Social Care Board
Affiliation/Organisation	Northern Ireland
Website	http://www.hscboard.hscni.net/travelfortreatment/
Telephone	+44 (0)28 9536 3152

Name	NHS England
Affiliation/Organisation	England
Website	https://www.nhs.uk/using-the-nhs/nhs-services/visiting-or-moving-to-england/
Telephone	/

Name	National Contact Point for Northern Ireland
Affiliation/Organisation	Northern Ireland Health & Social Care Board
Website	http://www.hscboard.hscni.net/travelfortreatment/the-directive-201124eu-on-cross-border-healthcare/
Telephone	02895363152

Iceland

Name	Icelandic Health Insurance (Ice. Sjúkratryggingar Íslands)
Affiliation/Organisation	International Department
Website	www.sjukra.is
Telephone	+354 515 0002

Norway

Name	Veiledning Helsenorge
Affiliation/Organisation	Helfo
Website	https://helsenorge.no
Telephone	+47 23 32 70 00