European Commission

MEMBER STATE DATA

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

Year 2016

Health Connect Partners
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Executive summary

Directive 2011/24/EU codifies patients' rights to reimbursement for healthcare received in another EU Member State (MS) and obliges MS to provide information about access to such care through their National Contact Points. In order to assess the impact of the Directive, a questionnaire was sent to all MS in 2015, 2016 and 2017 to collect information on patient mobility in the preceding year. The data collected each year address treatment provided with Prior Authorisation (PA) from the Member State of affiliation (where the patient is insured); as well as treatment where such prior-authorisation is not required.

This report provides an overview of the data on patient mobility in 2016, collected from July to November 2017. Returns were received from all thirty countries contacted (EU 28 plus Norway and Iceland). It should be noted however that several Member States had difficulties in reporting all the requested data. Accordingly, the baseline numbers referred in different sections vary, and percentages should be interpreted with caution.

Information requests received by National Contact Points

MS reported the number of enquiries about access to care under the Directive received by National Contact Points. A total of 69,723 requests for information were received, with most Member States receiving fewer than 1,000 requests in 2016. Poland, Lithuania and Austria were outliers of this trend with 16,139, 15,052 and 9,826 requests respectively. The data show that almost half requests for information were made by telephone, with the remainder spread equally between written (email) requests made in person.

Limitations for patient inflow

Although Article 4(3) of the Directive provides that MS may adopt mechanisms to limit access to healthcare by a citizen coming from another MS, only four MS (UK, Denmark, Estonia and Romania) reported that they had put in place such measures, however none reported having used them.

Healthcare subject to Prior Authorisation (PA)

Twenty-three Member States reported that they had adopted Prior Authorisation systems, and twenty returned data on patient mobility based on PA. with the majority of the MS reporting fewer than 100 requests for PA for treatment. In total 5,538 requests for patient mobility with PA were reported, with just under two thirds of requests (64%) being accepted. The most common reason for granting authorisation was that the medical intervention required an overnight stay (83% of all cases). Where requests for PA were refused, this arose most frequently because the medical intervention was available within a reasonable time in the MS of affiliation (approx. 50% of all cases). Seventeen MS reported having set a maximum time for giving a response to a PA request, ranging from 5 to 60 days, the most common being 30 days. Sixteen MS provided data on the time taken to make a reimbursement for a treatment with PA, with the length of time ranged from 19 to 255 days, the average being 42 days (if the outlier at 255 days is removed). The total reported spend across the twelve MS who provided this information was 24,654,929€, this ranged from a high of 21,750,698.€ in France to 396€ in Croatia. France therefore accounted the vast majority of the spend.

Healthcare not requiring Prior Authorisation (PA)

The Directive also provides for citizens to travel to another MS for care without PA and seek reimbursement upon return. In 2016 the MS reported that they received 239,684 requests for such reimbursement, of which over 85% were accepted. The total reported spend across the twenty-one MS who reported was just around 41M€. This ranged from a high of 20M€ in France to 2,657€ in Spain. These figures should however be interpreted carefully, as detailed in the report.

The grand total of cases of patient mobility, both with and without PA reported for the year 2016 was 213,134.

Introduction

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

Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (hereinafter 'the Directive') codified and clarified the jurisprudence of the European Court of Justice with regard to the rights of patients to be reimbursed for healthcare received in another Member State. The Directive did not just deal with the rights to reimbursement, but also introduced a number of significant flanking measures to ensure that patients could use these rights in practice. As part of this there is now, a minimum set of requirements which apply 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 entitled to be reimbursed if they choose to receive such treatment in another Member State. The Directive requires that the patient should generally receive the same level of reimbursement as if the treatment had been received in the Member Sate of affiliation. However, the level of reimbursement can 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.

The Directive allows Member States to adopt rules that require patients to seek prior authorisation for certain treatments. Generally, 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. Prior authorisation may be refused under certain circumstances. Of these the most significant is that the requested treatment is not included in the 'basket of care' 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. In addition, if the patient can be offered the treatment in the Member State of affiliation within a time limit which is medically justifiable, or if particular risks to the patient or the general population have been identified, prior authorisation may also be refused.

In addition to the grounds for refusal of prior authorisation outlined above, Article 4(3) of the Directive provides the opportunity to MS to adopt special mechanisms to limit access to cross-border healthcare 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. In practice however, very few Member States have made use of this provision.

It should be noted that the Directive was developed primarily to address cases of reimbursement for care received in a Member State other than the state of affiliation for which no prior authorisation is required - that is, prior authorisation is the exception, not the rule. However, the

majority of the MS have chosen to introduce a system of prior authorisation for healthcare which involves overnight hospital accommodation or requires use of highly specialised and cost intensive medical infrastructure or medical equipment. Despite the provisions for the possibility of requiring prior authorization, the Directive provides that claims for reimbursement for care provided in a Member State other than the Member State of affiliation may not be unreasonably rejected.

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 National Contact Point is required to provide information about its healthcare system to patients from other Member States, e.g. information about healthcare providers, quality and safety standards, complaints and redress procedures, etc.

This report outlines the number of requests for information received by NCPs and the method by which the request was made (in writing, by telephone or in person); as well as details on the numbers of requests authorised or refused and reimbursements made.

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

a) Regulation (EC) No 883/2004 on the coordination of social security systems

The benefits provided under the Directive exist in parallel to similar benefits provided under Regulation (EC) No 883/2004 on the coordination of social security systems. The procedures for implementing Regulation (EC) No 883/2004 are laid down in Regulation (EC) No 987/2009. Accordingly the two pieces of legislation are hereinafter referred to collectively as 'the Regulations'.

The Regulations and the Directive overlap significantly but are not identical. In order to understand why patients may choose to apply for care under the Regulations or Directive, it is important to understand the key similarities and differences between them:

- Both the Regulations and the Directive apply to planned and unplanned healthcare.
- Under the Regulations prior authorisation is, as a rule, a necessary requirement for receiving planned treatment in another Member State. The document to be obtained certifying prior authorisation under the Regulation is known as Portable Document S2 (PD S2).
- Under the Directive, a requirement of prior authorisation is not the rule. In accordance with Article 8(1) of the Directive, however the Member State of affiliation may set up a system of prior authorisation for certain kinds of cross-border healthcare.
- The Directive covers all providers, including private (non-contracted) providers, while the Regulations do not impose any obligation on the Member States with regards to treatment given by providers outside the public scheme.
- Only the Regulations apply in the field of long-term care.
- Under the Regulations, reimbursement of healthcare received in a Member State other than the State of affiliation is made in accordance with the legislation and tariffs of the Member State where the treatment takes place.
- Under the Directive, reimbursement is made in accordance with the legislation and tariffs of the Member State of affiliation.
- The Directive requires up-front payment by patients to the foreign healthcare provider, while the Regulations organise reimbursement between competent institutions except co-

payment existing in the MS of treatment.

The points set out above indicate that in practice planned and unplanned care may often be provided more favourably under the Regulations. Accordingly patients will often choose to receive care in another Member State under the provisions of the Regulations rather than the Directive, because doing so means they do not have to make an up-front payment and then claim a reimbursement afterwards.

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.

b) Bi-lateral and multi-national agreements

The Regulations and the Directive are however 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 particular needs of care in their border regions; BE, CZ, EE, LU, HU, NL, PT, RO, FI and LI have all adopted such rules in the past[1]. The impact of such parallel procedures on the delivery of cross-border healthcare should not be under-estimated. If one looks carefully at national level reports it is evident that such parallel systems are numerous and well used, ranging from national level agreements between countries, to agreements addressed to particular areas of medicine and bi-lateral agreements between hospitals.

Such 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. The close relationship between the Regulations and the Directive, and the existence of many parallel agreements needs to be kept in mind when interpreting the results presented in this report.

3. Data collection methodology

The Directive was due to be transposed by the Member States by 25 October 2013, although the actual transposition in all Member States was not complete until late 2015. In order to gain an understanding of the impact of the Directive a questionnaire on its usage was developed and sent to all Member States in 2015, 2016 and 2017, in each case asking for reports of patient care provided under the Directive in the preceding year.

The questionnaire contained 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

[1] The list of countries noted above was those which were reported as having bi-lateral scheme in 2014 by PACOLET, J. and DE WISPELAERE, F., Planned cross-border healthcare – PD S2 Questionnaire, Network Statistics FMSSFE, European Commission, June 2014. For more details of certain border agreements see entitled "Patients without Borders – Cross-border patient flows in the Benelux" (http://www.benelux.int/files/5814/5829/0001/rapport_DEF_FR.pdf).

the countries to which patients had travelled.

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

In addition, the questionnaire contained a collection of definitions based on the terminology used in Article 3 of the Directive.

The body of this report discusses the aggregated data in four sections relating to sections 1 to 4 of the questionnaire. However, 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.

4. Data Quality

In 2017 the five-part questionnaire was sent in mid-July to the EU 28 plus Iceland and Norway, who participate also in the cross-border care regime. The initial deadline for responses was set in mid-September, however, as some Member States struggled to collect data from their regions, the deadline was extended to early November. Further revisions to the data were provided by some countries in early 2018.

While all countries responded to the request for data on patient mobility, it should be noted that the questionnaires returned were not always complete, as several Member States had difficulties in collecting all the requested data and that a significant number of Member States provided only partial information. Belgium, Germany, Estonia, France, Iceland, Luxemburg, the Netherlands and Romania explained that data are not available to answer specific sections of the questionnaire due to the way data are collected and processed by public health insurance or private health funds on which they depend to get accurate data.

Another group of Member States encountered difficulties dividing their data between data pertaining to the Directive and those pertaining to the Regulations. As an example, the way in which patient mobility data are collected in Luxembourg, does not allow the extraction of reimbursement data with a clear distinction between the Directive and the Regulations. One should therefore keep in mind the close relationship between the Directive and the two Regulations when analysing the information provided for.

The fact that Member States were not all able to report in the same way on each of the questions in the questionnaire means that the comparisons offered in this report are not always as meaningful as they might be. This is particularly true for the analysis of patient mobility flows. As some Member States were not able to provide data on the countries to which patients travel, but others were able to do so, a mismatch in the data between sending countries and receiving countries exist. For example, Germany was not able to provide data on patient mobility from their country since such data is not collected at a national level. However, the data provided by other Member States show that Germany was a major recipient of patients from other countries. The data maps presented in this report therefore need to be treated with caution.

The specific comments made by the responding countries (in section 5 of the questionnaire concerning the quality of their data), are presented in the Annex 1 to this report. The comments have been copied directly from the replies provided by the responding countries and provide useful background information to explain some of the number reported.

5. Data from the EFTA countries

With respect to the EFTA countries (Iceland, Liechtenstein and Norway), the Directive was due to be transposed no later than 1st of August 2015. However, in reality, not only the transposition date was relevant.

Norway has reimbursed healthcare provided in another EEA country since 1st of January 2011 (with the exception of hospital care), and since 1st of March 2015 has implemented the Directive (including hospital care). The figures provided for this report concern a period from 1 January to 31 December 2016.

Iceland implemented the Directive on 1st of July 2016, and since then the Icelandic Health Insurance system has been developing processes regarding the Directive. The Icelandic Health Insurance will continue their work on making everything regarding the procedures adequate and set up according to this questionnaire for gathering proper data. For this reason the data returned for the present data collection were somewhat limited.

Liechtenstein and Switzerland were 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. On this basis where Member States reported data on patient mobility to these countries, the data were excluded. This is the case in the data returned by France.

6. Comparisons with 2015

A full data collection was conducted 2015, and a detailed analysis of those data was presented in 2016. Comparisons will be drawn wherever possible with data from 2015. Some data were also collected on the use of the Directive in 2014. Some comparisons are highlighted in this report, but a more detailed comparison across the years of data collection will be made to be published in 2018 by the European Commission.

It should be noted also that some comparisons are made only after data for France have been excluded. This is because France was not able to provide data for 2015 and as the data from France represent such a significant proportion of the 2016 data, it would be misleading to compare 2015 data excluding France with 2016 data including France.

7. Exchange rates

The tables in Sections 3 and 4 show the amount of money spent in each country on reimbursing care provided under the Directive in another country. The tables show all data in Euros, using the conversion rate given in the Official Journal of the European Union on 31 December 2016[2]. Please note that the rate used for Iceland referenced was obtained from www.xe.com because the Official Journal did not list an exchange rate for the Icelandic Krona.

[2] Official Journal of the European Union, C 491, 31 December 2016.

Table 1 Exchange rates

Country	Currency	Exchange rate 1 euro =
Bulgaria	Bulgarian Lev	19,558
Croatia	Croatian Kuna	75,597
Czech republic	Czech Koruna	27,021
Denmark	Danish Krone	74,344
Hungary	Hungarian Forint	309,83
Poland	Polish Zloty	4,410
Romania	Romanian Leu	4,539
Sweden	Swedish Krona	95,525
UK	Pound Sterling	0,85618
Iceland	Iceland Króna	122,550
Norway	Norwegian Krone	90,863

Section One

Information requests received by National Contact Points

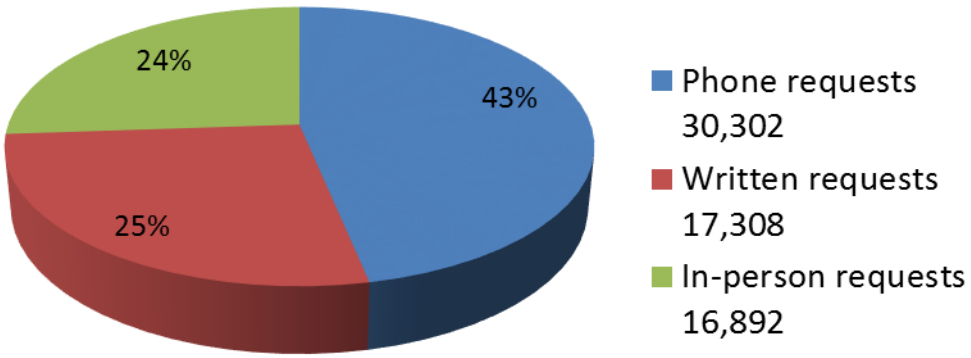
A key provision of the Directive is the creation of National Contact Points (NCPs) for information to patients and the public, although each Member States will decide how many NCPs they will create and what form they will take.

Question 1.2 of the questionnaire asked Member States to provide the total number of information requests they received in 2016 broken down by media (in written, by phone or in person). They were requested to aggregate requests to National Contact Points as well as Regional Contact Points. It proved difficult for some Member States to provide data concerning information requests, this especially relates to National Contact Points that are located within organisations which deal with more issues than cross-border healthcare provided in accordance with the Directive. In such cases it was not always possible to label an enquiry as concerning the Directive, the Regulations or a parallel method when responding to a patient enquiry. Most Member States provided reports on all potential methods of seeking healthcare in another country.

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

In total 69,723 enquires were made in 2016 across the 29 NCPs providing data. However, most Member States received fewer than 1,000 requests.

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



Note: the total number represented in the chart is 64,502 rather than 69,723 as not all countries were able to show the division of requests between written, phone and in-person requests.

The outliers were Poland, Lithuania and Austria with 16,139, 15,053 and 9,826 requests respectively. The 2016 data show a decrease in requests for information since 2015, when a total of 83,245 requests were received in 21 Member States. Given that the 2016 data represent the total number of requests for information across 29 States, rather than 21 States reporting on requests

made in 2015, the 2016 data show that the relative decline between 2015 and 2016 is almost 38%.

Without further discussion with the Member States, it is difficult to explain this drop in the number of information requests. One might suggest that the increase of information available on websites has reduced the number of requests patients make to NCPs, similarly as doctors have become more knowledgeable about the scheme they too will be able to provide information to patients and reduce the number seeking information from a NCP.

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

NCP information requests	Total Number of Requests	written	phone	in person
Austria	9826	9826	0	0
Belgium	253	174	79	0
Bulgaria	no data	no data	no data	no data
Croatia	968	437	531	NA
Cyprus	17	0	12	5
Czech Republic	100	50	50	0
Denmark	3130	475	2625	30
Estonia	754	no data	no data	754
Finland	2134	no data	2134	no data
France	432	432	no data	no data
Germany	2290	545	1745	0
Greece	630	180	300	150
Hungary	169	77	90	2
Ireland	5565	1136	4424	5
Italy	446	446	0	0
Latvia	34	no data	34	no data
Lithuania	15053	453	2185	12415
Luxembourg	18	10	5	3
Malta	10	3	5	2
Netherlands	165	165	N/A	N/A
Poland	16139	1085	11648	3406
Portugal	14	14	no data	no data
Romania	2500	1200	1300	no data
Slovakia	74	44	30	no data
Slovenia	1181	224	952	5
Spain	334	66	258	10
Sweden	5	0	0	0
UK	5495	109	66	104
Norway	1982	155	1827	no data
Iceland	5	2	2	1
Totals	69723	17308	30302	16892

Section Two
Limitation of patient inflow

Question 2a) to 2d) of the questionnaire asked Member States to provide information relating to mechanisms put in place to limit access to healthcare according to Article 4(3) of the Directive.

Of the twenty-four Member States who replied, three Member States (Denmark, Estonia, and Romania) have implemented mechanisms that can be used to limit access to cross-border healthcare according to Article 4(3) of the Directive. However, these mechanisms have, as far as data are available, not been used in practice.

Of those Member States reporting having used the possibility of putting a restriction in place, only Romania reported having done so since the last reporting period in 2015.

Although these numbers are small, they show a small reduction from 2014 when the number of Member States adopting limitations was seven.

However, some caution should be used in interpreting these numbers, since the comments supplied in 2014 suggest that Member States were referring to national rules which indicate their interpretation of the Directive, rather than limitation in the true sense of Article 4(3) of the Directive.

In the final analysis it is worth noting also that the general numbers of patient flows indicated in the next two sections suggest that such limiting mechanisms are unlikely to be needed by most Member States.

Section Three
Healthcare subject to Prior Authorisation

In section 3 of the questionnaire Member States were asked to provide information relating to healthcare subject to prior authorisation. 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 as well as highly specialised and cost intensive medical infrastructure or medical equipment. The following countries did not choose to introduce a prior authorisation system: Czech Republic, Estonia, Finland, Lithuania, Netherlands, Norway and Sweden. The questions in Section 3 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, patients will often choose to receive care in another Member State under the provisions of the Regulations rather than the Directive, because doing so means they will not have to make a payment up front and then claim a reimbursement. Furthermore, reimbursement under the terms of the Regulation would be more favourable to the patient, as the Regulation provides for reimbursement at the rate normally provided in the country of treatment, whereas the Directive provides for reimbursement at the rate that would apply in the home state.
Twenty Member States provided data on their use of the prior authorisation system. 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).[3]

The number of requests for prior authorisation under the Directive made in 2016 remains low. In total 5,538 requests for prior authorisation were received in the twenty Member States reporting on this question, with fourteen of these Member States reporting receipt of fewer than 100 requests, and five between 100 and 500. The outlier was France with 3,886 requests.

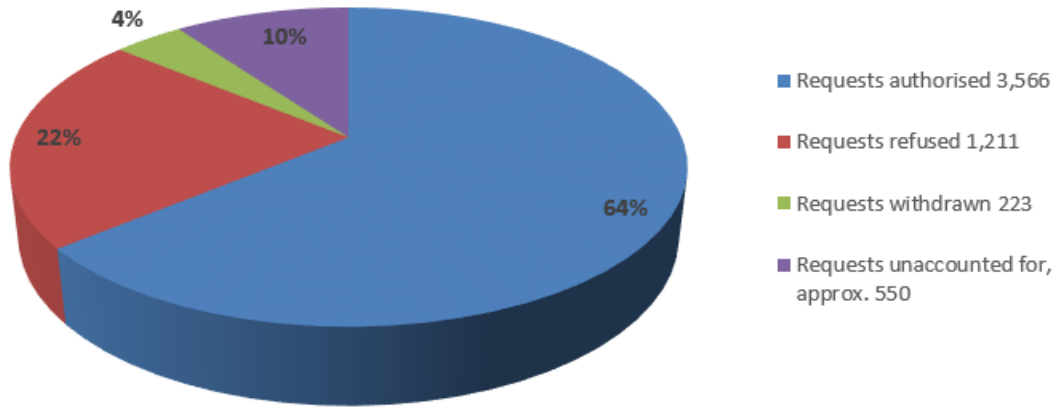
Member States were also asked to indicate if the requests were accepted, withdrawn or refused. No significant pattern was discernable, with the acceptance ratio ranging from 0% in some cases up to 77%. It should be noted however that the countries reporting a high level of rejection of requests for prior authorisation had generally received a very low number of such requests. Figure 2 below, shows that almost two-thirds of all requests were accepted, and only 4% withdrawn, which indicates a good level of information provided to patients prior to authorisation requests.

It should be noted however that the 2016 data are dominated by France, which represent over 70% of all the requests for prior authorisation. However, as France was not able to provide data in 2015, it is difficult to make comparisons between 2015 and 2016 - accordingly the comparisons below are made on the basis of excluding the French data from the 2016 figures.

[3] Planned cross-border healthcare: report on S2 portable documents issued in 2013, available on http://ec.europa.eu/social/contentAdmin/BlobServlet?docId=13738&langId=en.

With exclusion of the French data, the reports from the remaining countries show no significant statistical change in the number of requests made in 2015 and 2016. However, there was a good increase in granted authorisations (22% more), and the number of withdrawn or inadmissible requests fell by 50%. Refused requests were at roughly the same rate in 2015 and 2016, at approximately one in four. Again, however, these numbers have to be treated with caution, as the prior authorisation base line numbers are small and the variation between Member States significant. For example, Denmark received 75 requests and refused 68%, while Slovakia had 232 requests and refused 11%.

Figure 2 Prior Authorisation Requests (authorised, refused or withdrawn) in 2016 (including FR)



2. Basis of request for Prior Authorisation where authorisation was granted

Member States were asked to indicate the basis on which authorisation had been requested in those cases where authorisation was granted, based on three groups of reasons as follows:

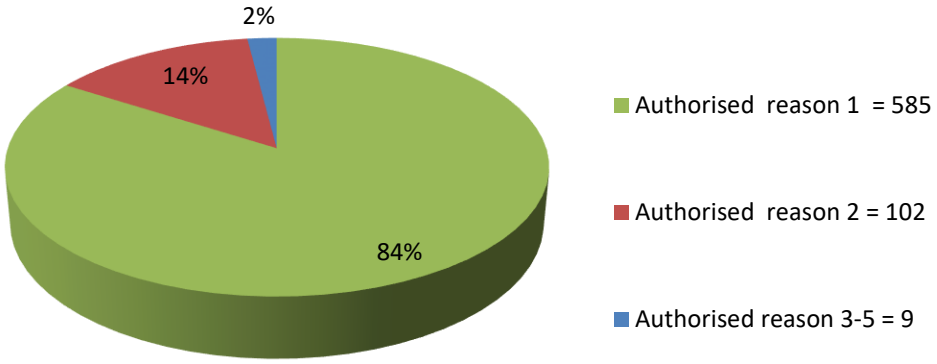
1. Healthcare which is made subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical 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.

Looking at request for prior authorisation that were granted, 84% of all the granted requests were granted when the request had been made on the basis that the treatment required at least one night hospital stay in the other Member State - these data are shown graphically in Figure 3 below. Note here that the data discussed pertain to the number of authorised requests for which data on the grounds for authorisation were provided. France and Luxembourg, which authorised 2,579 and 280 requests respectively, did not supply data on why the authorisations were made, accordingly the base line number for the discussion of reasons for acceptance of requests is 499 across all Member States, rather than 3,942 as shown in Figure 2 above.

Figure 3 Reasons for granting prior authorisation of requests



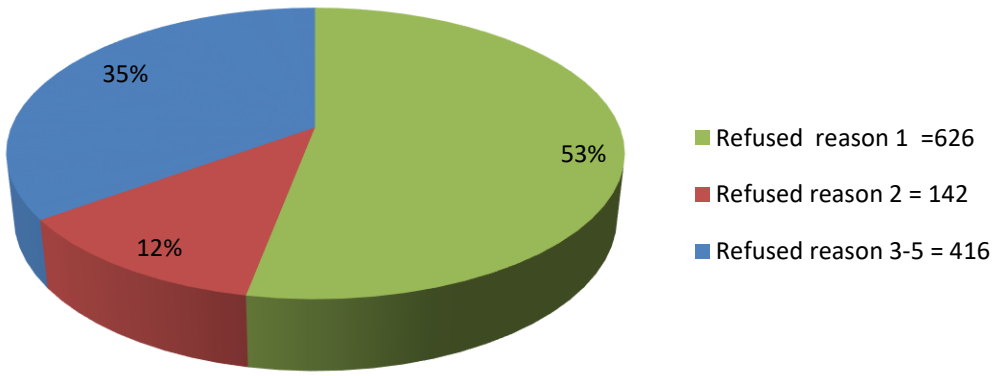
3. Reasons for refusal of Prior Authorisation

Member States were asked to indicate the basis on which authorisation was refused, based on 3 groups of reasons as follows:

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.

Looking at the requests for which prior authorisation was refused, a significant majority (approx. 53%) were refused because the requested treatment was assessed as available in the Member State of origin within a reasonable time frame. It should be noted that some Member States show a higher number of refusals than those listed under the three groups of reasons for refusal, this was accounted for in most cases by the fact that some requests were refused because the national procedure for requesting prior authorisation had not been properly followed. It is important to note here that not all refusals are accounted for under the three groups of reasons for refusal provided in the questionnaire. This has been explained by the respondents as arising from the fact that some requests were refused on administrative grounds not covered by the three groups of reasons provided. Note in Figure 4 data for France are included, as France supplied data on grounds given for refusal of prior authorization.

Figure 4 Reasons for refusal of prior authorization requests



In drawing comparisons with 2015, the data from France were again removed as comparison with 2015 was not possible for French data. With this exclusion, the figures for 2016 are very similar to those for 2015, when 89% of the authorised requests were made on the basis of an overnight stay. Only 16% were authorised on the basis of highly specialized care and only 2% for high risk care.

4. Processing times relating to requests for Prior Authorisation

The time (in days) taken to process a request for prior authorisation varied significantly across the Member States. Seventeen Member States reported that they had set a maximum time for giving a response to a PA request, ranging from 5 to 60 days, with the most common being 30 days. In practice the average time taken to process a request was 18 days.

The picture is not as positive in the case of time taken to process a reimbursement claim.
Fifteen Member States provided data on the time taken to make a reimbursement for a treatment with prior authorisation, with the length of time ranging from 19 to 255 days. However, if the outlier at 255 days is removed, the average time taken was 42 days, which brings Member States broadly within their targets. These data vary very little to those reported for 2015. Full details are given in Table 3.4 hereunder.

5. Amounts reimbursed for treatment requiring Prior Authorisation

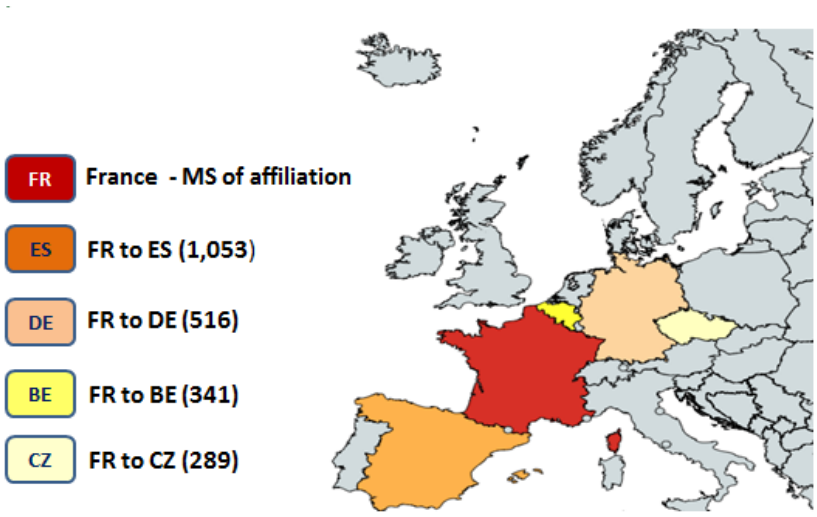
With respect to the aggregated reimbursement amounts for 2016, the numbers were low, as is to be expected in line with a relatively small number of authorised requests for prior authorisation. The total reported spend across thirteen Member States was 24,654,929 €. Of the Member States who returned data on costs this ranged from a high of 21.75M€ in France, to just under 400€ in Croatia. Of the other eleven Member States reporting, three reported spending under 5,000€; six spent between approximately 5,000€ to 500,000€; and two approximately between 1,500,000€. Full details are given in Table 3.4.

6. Where do patients travel when Prior Authorisation is required?

One of the most interesting data 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 when prior authorisation is required. Table 3.5 gives the full data set, but a graphic representation allows one to see easily that the biggest trend for patient mobility is across-borders with neighbouring countries.

The data are represented in two maps (Figure 5 and Figure 6), one showing patient movement from France to neighbouring countries, since this patient flow accounts for 72% of all patient mobility based on prior authorisation in Europe.

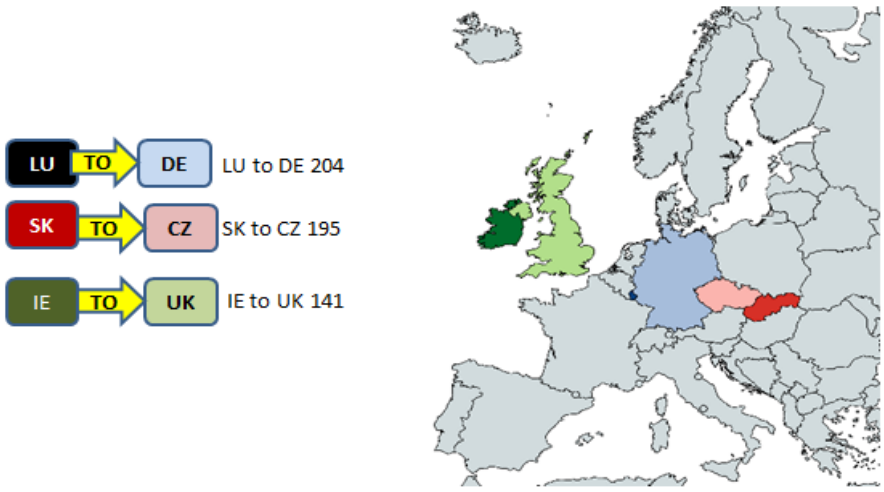
Figure 5 Mobility from France with Prior Authorisation



Of the remaining 987 cases of patient mobility wit prior authorisation in Europe in 2016, the three biggest 'senders' of patients were:

- Luxembourg to Germany (204 episodes of patient mobility)
- Slovakia to Czech Republic (195 episodes of patient mobility)
- Ireland to UK (141 episodes of patient mobility)

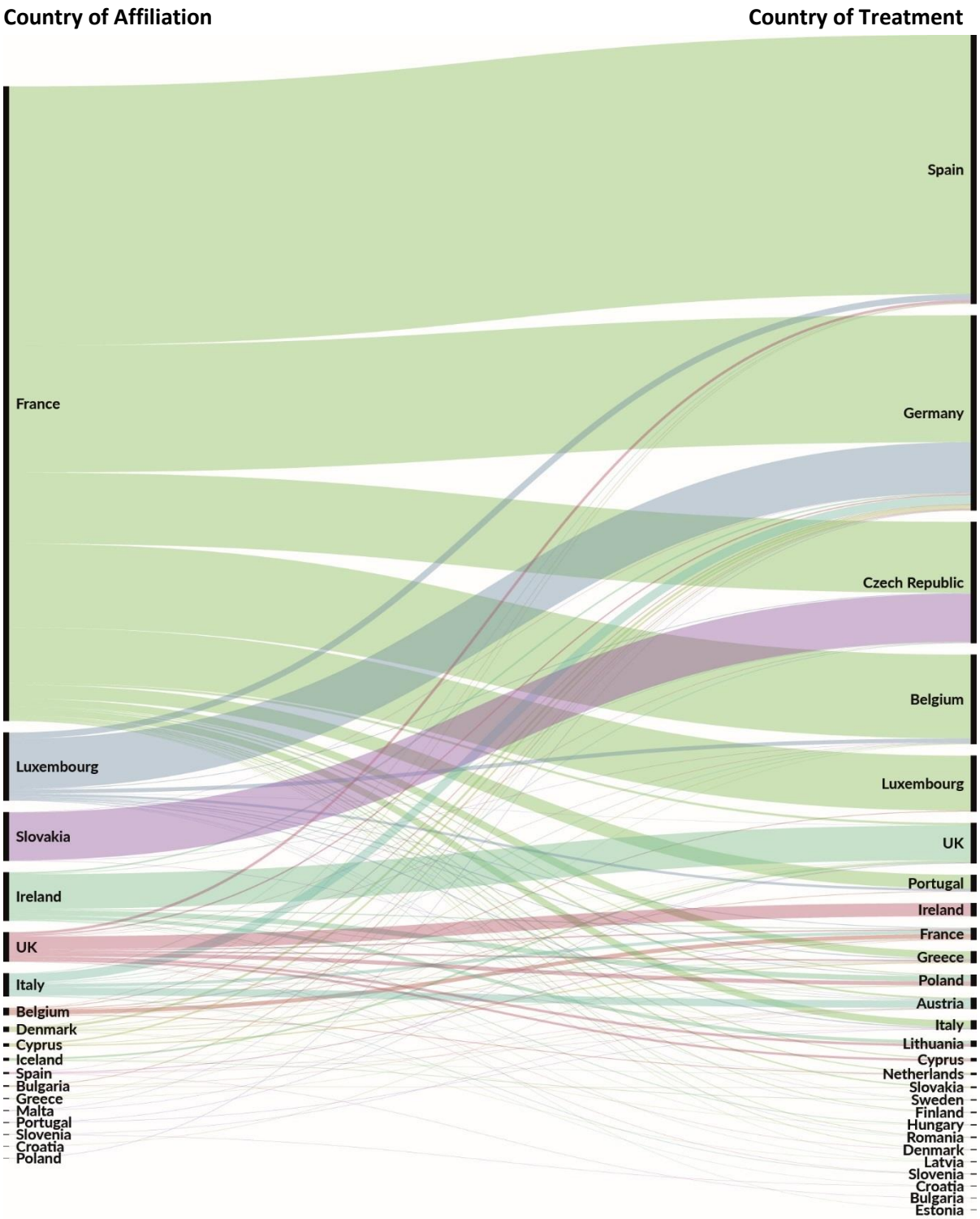
Figure 6 Patient Mobility with Prior Authorisation (excluding France)



It is important to note that the maps show only the data on patient mobility from their state of affiliation to another state. It is also important to note that the three receiving countries in the pairs shown in the map in Figure 6 either were not able to provide data on their own patient mobility with prior authorisation, or did not do so because they had not introduced a system of prior authorisation (as in the case of Czech Republic). The picture presented is therefore not as complete as it could have been if all Member States had been able to report on all of the questions in the questionnaire. However, an image of the density of flow can be obtained by converting the data of all patient mobility with prior authorisation in 2016 to a flow map:

Figure 7: Flow Map of all patient mobility with Prior Authorisation in Europe in 2016

(The flows are based on the data reported by Member States - Table 3.5)



In looking back at the mobility in 2015, we need to remove the data for France, since we do not have data for patient mobility with prior authorization from France in 2015. Without the French data, the picture of mobility in previous years is remarkably similar to that in 2016. In 2015 the top three outflows were from Luxembourg to Germany (185); Slovakia to Czech Republic (140) and Ireland to UK (72).

Raw data tables for questions in Section 3

Table 3.1 Request for Prior Authorisation

Country of affiliation	Prior authori-sation Y/N	Number of received requests	Number of authorised requests	Number of refused requests	Number of withdrawn / inadmissible requests
Austria	y	10	0	10	0
Belgium	Y	47	30	17	0
Bulgaria	Y	16	5	3	8
Croatia	Y	8	1	6	1
Cyprus	Y	24	13	2	9
Czech Republic	N	N/A	N/A	N/A	N/A
Denmark	Y	75	21	40	11
Estonia	N	N/A	N/A	N/A	N/A
Finland	N	N/A	N/A	N/A	N/A
France	Y	3886	2579	931	0
Germany	Y	no data	no data	no data	no data
Greece	y	5	3	0	2
Hungary	Y	0	0	0	0
Ireland	Y	316	197	7	88
Italy	Y	208	94	108	0
Latvia	Y	0	0	0	0
Lithuania	N	N/A	N/A	N/A	N/A
Luxembourg	Y	375	280	0	0
Malta	Y	10	2	2	5
Netherlands	N	N/A	N/A	N/A	N/A
Poland	y	38	1	1	25
Portugal	Y	4	2	0	0
Romania	Y	1	0	1	0
Slovakia	Y	232	198	27	24
Slovenia	Y	26	2	16	8
Spain	Y	17	7	7	3
Sweden	no data	no data	no data	no data	no data
UK	Y	227	120	32	48
Norway	N	N/A	N/A	N/A	N/A
Iceland	Y	13	11	1	1
totals	Y=23 N=5	5538	3566	1211	233

Table 3.2 Requests for Prior Authorisation – Accepted

Country of affiliation	Authorised requests - overnight stay Reason 1	Authorised requests - specialised care reason 2	Authorised requests - high risk care reasons 3-5
Austria	0	0	0
Belgium	19	11	0
Bulgaria	5	0	0
Croatia	0	1	0
Cyprus	13	0	0
Czech Republic	N/A	N/A	N/A
Denmark	10	11	0
Estonia	N/A	N/A	N/A
Finland	N/A	N/A	N/A
France	no data	no data	no data
Germany	no data	no data	no data
Greece	3	0	0
Hungary	0	0	0
Ireland	197	0	0
Italy	66	19	9
Latvia	0	0	0
Lithuania	N/A	N/a	N/A
Luxembourg	no data	no data	no data
Malta	2	0	0
Netherlands	N/A	N/A	N/A
Poland	1	0	0
Portugal	1	1	0
Romania	0	0	0
Slovakia	156	42	0
Slovenia	0	2	0
Spain	4	3	0
Sweden	no data	no data	no data
UK	108	12	0
Norway	N/A	N/A	N/A
Iceland	0	0	0
totals	585	102	9

Table 3.3 Requests for Prior Authorisation – refused

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	10	0	0
Belgium	11		1
Bulgaria	3	0	0
Croatia	6	0	0
Cyprus	1	1	0
Czech Republic	N/A	N/A	N/A
Denmark	32	4	0
Estonia	N/A	N/A	N/A
Finland	N/A	N/A	N/A
France	474	67	390
Germany	no data	no data	no data
Greece	0	0	0
Hungary	0	0	0
Ireland	no data	no data	no data
Italy	52	34	22
Latvia	0	0	0
Lithuania	N/A	N/A	N/A
Luxembourg	N/A	N/A	N/A
Malta	1	1	0
Netherlands	N/A	N/A	N/A
Poland	1	0	0
Portugal	0	0	0
Romania	0	0	1
Slovakia	13	14	0
Slovenia	15	1	0
Spain	3	4	0
Sweden	no data	no data	no data
UK	4	15	2
Norway	N/A	N/A	N/A
Iceland	0	1	0
totals	626	142	416

Table 3.4 Patient Mobility with Prior Authorisation – time taken & reimbursement made

Country of affiliation	Maximum time for processing (Y/N)	Maximum time	Average Processing time (days)	aggregated amount reimbursed	in Euro
Austria	Y	5	3	no data	no data
Belgium	Y	45	No data	14,962.75	14,962.75
Bulgaria	Y	63	255	4,032.00	2,062.00
Croatia	Y	60	30	3,000.00	396.00
Cyprus	Y	60	35	21,513.44	62,712.00
Czech Republic	N/A	N/A	N/A	N/A	N/A
Denmark	Y	10	19.4	446,735.25	59.983.17
Estonia	N/A	N/A	N/A	N/A	N/A
Finland	y	14	No data	no data	no data
France	no data	no data	No data	21,750,698.70	21,750,698.70
Germany	no data	no data	No data	no data	no data
Greece	N/A	N/A	60	no data	no data
Hungary	no data	no data	No data	no data	no data
Ireland	y	30	24.9	1,752,132.01	1,752,132.01
Italy	Y	30	11.2	383,369.64	383,369.64
Latvia	Y	30	No data	no data	no data
Lithuania	N/A	N/A	N/A	N/A	N/A
Luxembourg	N	N/A	40	no data	no data
Malta	N	N/A	4	4,951.47	4,951.47
Netherlands	N	N/A	N/A	N/A	N/A
Poland	y	30	No data	0.00	0.00
Portugal	Y	35	No data	no data	no data
Romania	Y	5	3	no data	no data
Slovakia	Y	15	56	375,549.96	375,549.96
Slovenia	Y	60	34	796.23	796.23
Spain	Y	45	17	37,859.32	37,859.32
Sweden	no data	no data	No data	no data	no data
UK	Y	20	11,375	240,401.00	269,439.00
Norway	N/A	N/A	N/A	N/A	N/A
Iceland	no data	no data	No data	no data	no data
TOTAL					24,654,929.08

Table 3.5 Patient Mobility with Prior Authorisation – where patients travel

(Those countries not providing data are shown in grey).

Country of Affiliation	Country of Treatment																														TOTALS SENT
	AT	BE	BG	HR	CY	CZ	DK	EE	FI	FR	DE	EL	HU	IE	IT	LT	LI	LU	MT	NL	PL	PT	RO	SK	SL	ES	SE	UK	NO	IC	
Austria	x																														
Belgium		x								17	3	1						3		3		2				1					30
Bulgaria	1		x								3													1							5
Croatia				x						1																					1
Cyprus					x						6	5																2			13
Czech Republic																															
Denmark		2					x			3	9		1			1					2					2					20
Estonia																															
Finland																															
France	7	341			4	289	2		3	x	516	30			28	1		224		4	4	56	2	5		1053	1	9			2579
Germany											x																				
Greece	1	1									1	x																			3
Hungary													x																		
Ireland	2					2		1		4	6		3		1	1	14				21		1					141			197
Italy	31	2		1		3				13	36	2			x					1					2	2		1			94
Latvia																x															
Lithuania																															
Luxembourg	1	16				3			1	3	204	4			4			x			3	10	1			25	1	1			277
Malta											1								x									1			2
Netherlands																															
Poland											1										x										1
Portugal															1							x						1			2
Romania																							x								
Slovakia	1	1				195					1													x							198
Slovenia	1			1																					x						2
Spain	1		1							3	1				1											x					7
Sweden																											x				
UK		1			9	1	1			5	5	6		54	1		10				16				1	10					120
Norway																													x		
Iceland																				1	1						2	7		x	11
TOTALS RECEIVED	**46**	**364**	**1**	**2**	**13**	**493**	**3**	**1**	**4**	**49**	**793**	**48**	**4**	**54**	**36**	**3**	**24**	**227**	**0**	**9**	**47**	**68**	**4**	**6**	**3**	**1093**	**4**	**163**		**3562**	**3562**

Section Four
Healthcare not subject to Prior Authorisation

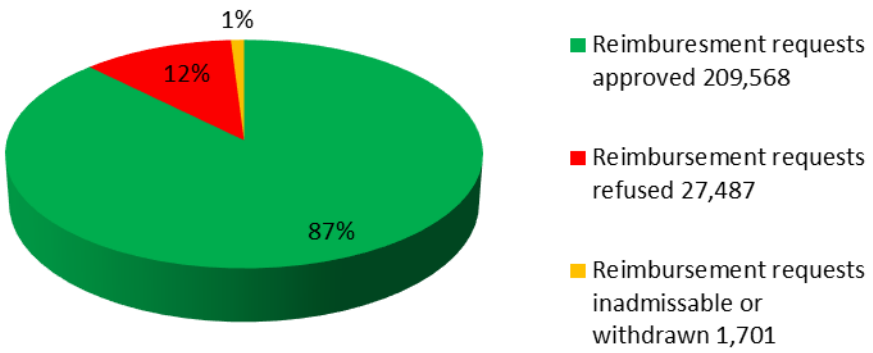
The Directive also provides for citizens to travel to another Member State to receive treatment and seek reimbursement upon return. It should be noted however that even in this category Member States may implement a system for prior notification according to Article 9(5). This article provides for a voluntary system of prior notification whereby the patient receives a written confirmation of the amount to be reimbursed on the basis of an estimate. This estimate shall take into account the patient's clinical case, specifying the medical procedures likely to apply. Accordingly although the directive does not require such a prior authorisation system, it may be implemented.

Of those who replied, a total of ten countries (Denmark, Estonia, Greece, Italy, Malta, Poland, Sweden, UK, Norway and Iceland), reported that they had adopted such procedures. This list represents very little change from 2015. However in 2015 when in addition to the ten countries mentioned above, Spain, Hungary and Slovenia also reported having a prior notification system in place, but they no longer report having it in place in 2016. Malta and Iceland were newcomers to the list in 2016.

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

In 2016 twenty-one Member States reported they had received in total 239,684 requests for reimbursement. It should be noted that there are some discrepancies between the total number of reported requests and those for which data on grounds for acceptance or refusal are provided. In some cases the discrepancy was negative (fewer outcomes than requests reported) and in some cases positive (a higher number of outcomes than requests). These discrepancies, though not very significant, indicate that there are still some issues with the recording of cross-border care, as well as a time-lag between request and outcome which will not always be covered within the reporting period (i.e. some requests will still be pending a reimbursement decisions).

Figure 8 Reimbursement Requests (grounds for reimbursement authorisation or refusal)



The average number of reimbursements made across the Member States was low, with a three notable of exceptions in France, Denmark, and Norway. Denmark is an interesting outlier, with over 30,000 requests for reimbursement and some 25,000 authorisations. This is very similar to 2015 and was driven heavily by cross-border dental care, which accounted for more than 90% of Denmark's reimbursements in both 2015 and 2016[4]. Finland also reported a high number of requests (over 11,000), but was not able to provide data on if the requests were granted or not as Finland compiles statistics on provided services, not on persons or applications, thus when a person has several treatments on one visit each will be listed as one event.

With respect to changes between 2015 data and 2016 data it is worth noting that in 2015 Belgium had more than 30,000 requests for reimbursement, while in 2016 no data was returned on the number of claims in Belgium, although the total spend was reported as 5,184,627€, which is broadly in line with the amount spent in 2015. This discrepancy is accounted for in the comments, where Belgium notes that not all health insurance funds were able to provide data on the number of requests received/granted/refused/withdrawn or inadmissible. Accordingly Belgium preferred not to provide partial data that do not reflect the actual situation.

2. Processing times relating to requests for reimbursement

Nineteen Member States provided data on the time taken to process a request for reimbursement for treatment. The length of time ranged from 14 to 255 days. If the outlier at 255 days is removed, the average was 57 days.

3. Amount reimbursed

The total reported spend across the twenty-one MS who reported on the reimbursements they had made was 41,142,966 €. This ranged from a high of 20M€ in France to 2,657€ in Spain. Of the other twenty MS reporting, eight reported spending of under 100,000€; six 100,000€ to 1M€; and six 1M€ to just over 6.3M€.

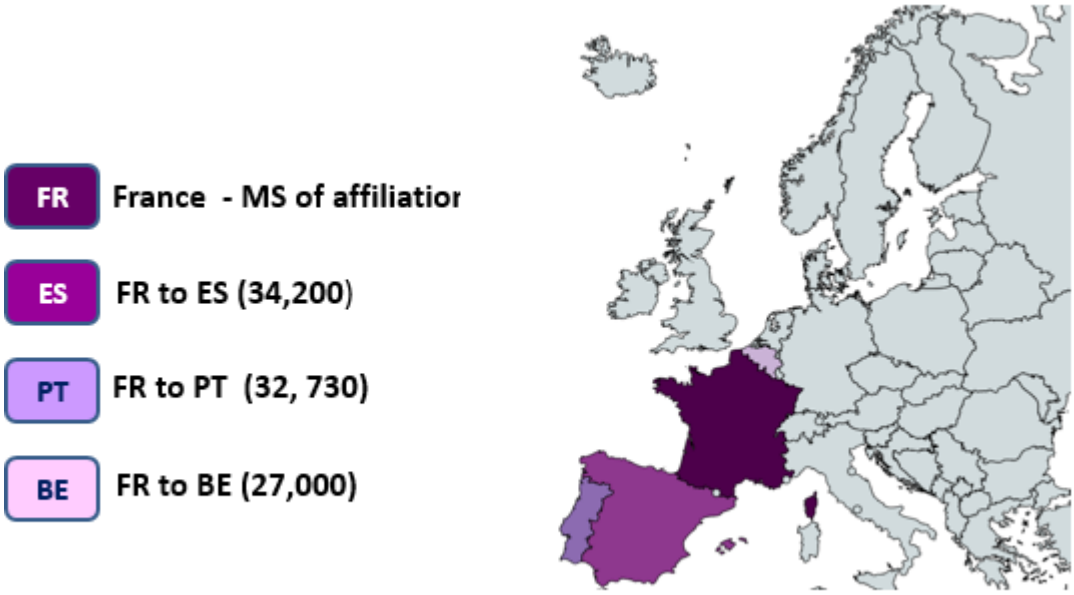
It should be noted that the figures described above do not present a perfect picture of the reality, because not all Member States were able to present their data to the same level of detail. Important factors to note are that Belgium provided data that they had spent just over 5M€, but they were not able to provide the number of cases to which the spend was related. Finland was in the same situation, while Portugal could report the number of approved requests, but not the spend.

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 56% of all patient mobility where prior authorisation was not required. The map in Figure 9 therefore shows the outflows of patients from France when prior authorization had been granted.

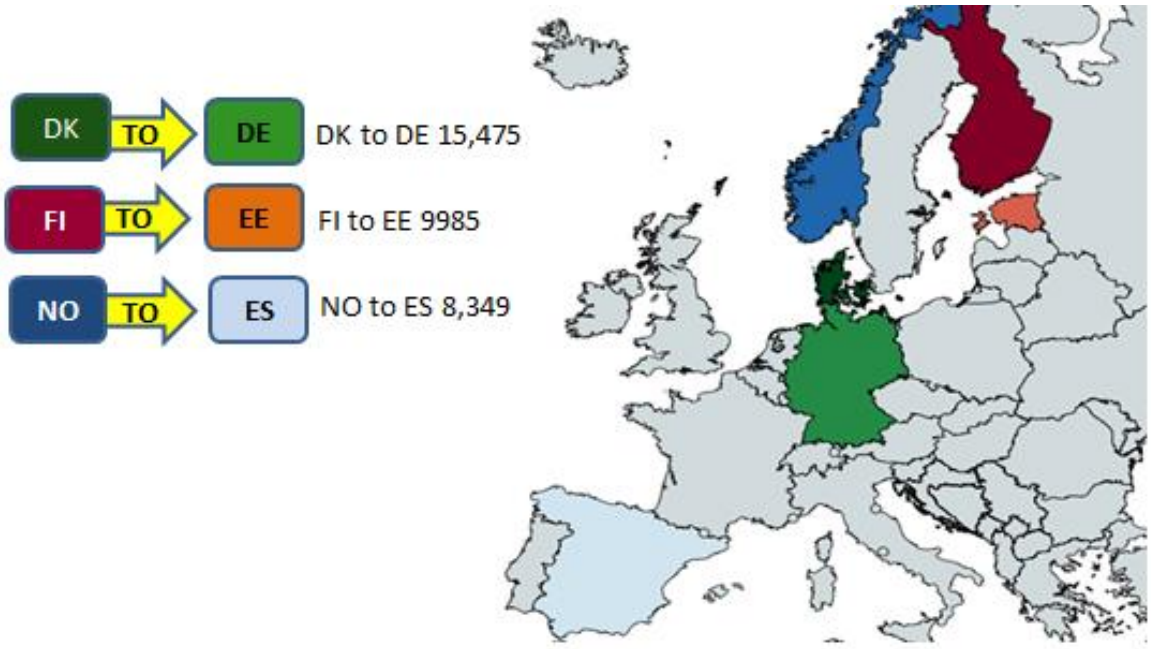
[4] For further information see Appendix 1 country specific comments.

Figure 9 Patient mobility from France not requiring Prior Authorisation



Setting aside the movement from France, Figure 10 depicts the three pairs of counties between which the largest number of cases of patient mobility occurred. Accordingly we see the biggest flow being from, Denmark to Germany; Finland to Estonia; and Norway 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.

Figure 10 Patient mobility not requiring prior authorisation (excluding France)



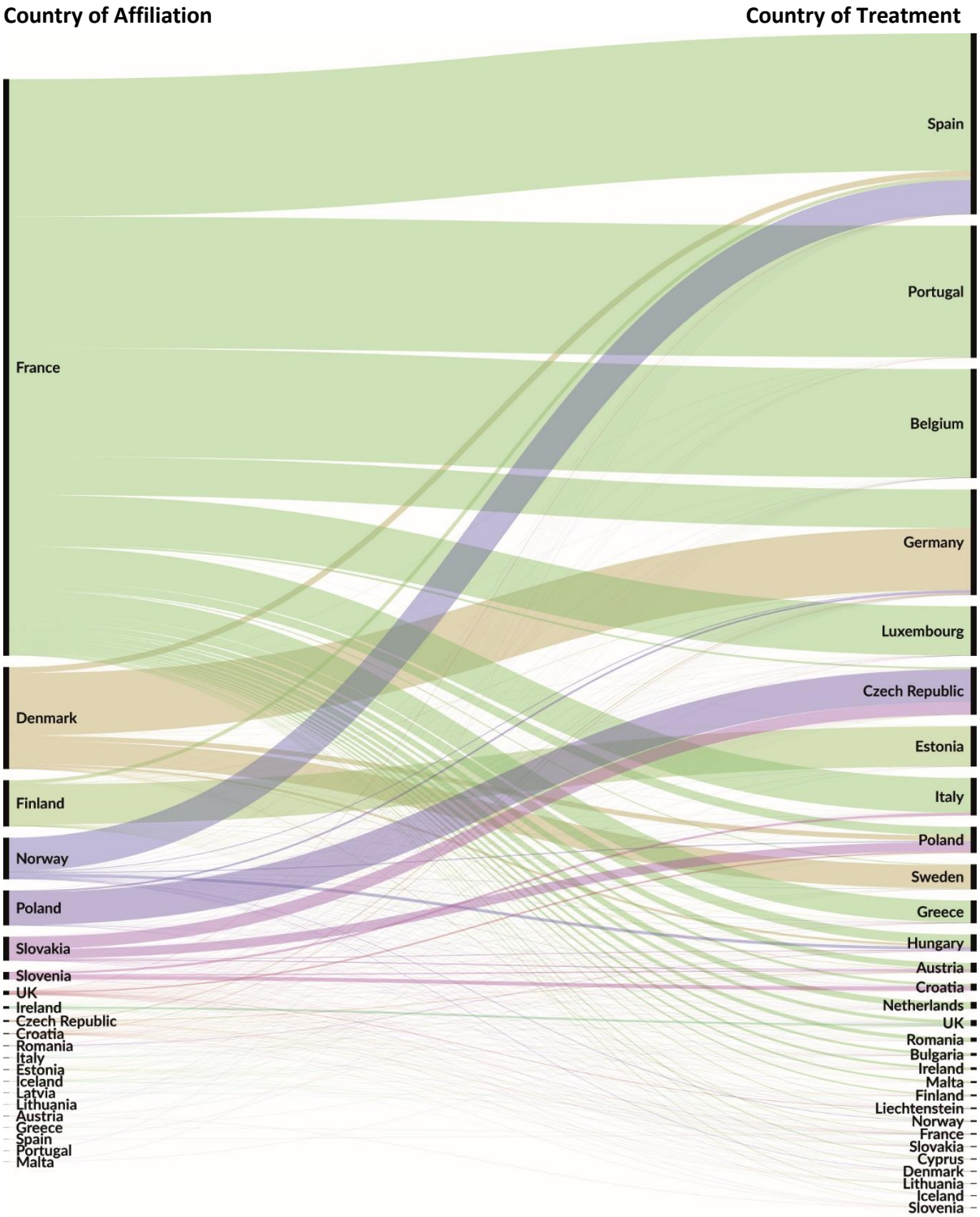
As in the case of care delivered on the basis of a prior authorisation, the map shows only the data on patient mobility from their state of affiliation to another state. The full detail mobility, shown in Table 4.3 at the end of this section, shows that a significant number of countries reported episodes of patient mobility in single figures. However, despite the fact that 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 start towards greater patient mobility.

The Flow Map in Figure 11 below depicts the trends in Europe which, as in the case of mobility where prior authorisation is required, we again see the trend of a few major 'senders', and a majority of countries reporting very limited patient mobility.

As in the case of patient mobility based on prior authorisation, in looking back at the mobility in 2015, we need to remove the data for France, since we do not have data for patient mobility from France in 2015. With the French data removed, the pattern in 2016 is very similar to that in 2015, being clustered in the Nordic countries as well as a considerable outflow from Norway to Spain.

Figure 11: Flow Maps of all patient mobility not requiring Prior Authorisation

(The flows are based on data received from Member States shown in Table 4.3).



Section 4 Raw data

Table 4.1 Mobility not requiring prior authorisation – request, authorisation, refusals, withdrawals

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	9	9	0	0
Belgium	N	no data	no data	no data	no data
Bulgaria	N	18	0	3	8
Croatia	N	283	199	81	3
Cyprus	N	no data	no data	no data	no data
Czech Republic	N	447	401	46	0
Denmark	Y	31753	25323	5849	444
Estonia	Y	88	80	4	0
Finland	N	11431	11427	no data	no data
France	N	162137	143475	18658	0
Germany	N	no data	no data	no data	no data
Greece	Y	9	7	0	1
Hungary	N	no data	no data	no data	no data
Ireland	N	742	594	10	100
Italy	Y	138	107	25	0
Latvia	N	28	27	3	5
Lithuania	N	53	53	0	0
Luxembourg	N	no data	no data	no data	no data
Malta	Y	10	2	3	6
Netherlands	no data	no data	no data	no data	no data
Poland	Y	10637	8646	45	404
Portugal	N	10	3	0	6
Romania	N	429	130	54	23
Slovakia	N	6479	5912	557	96
Slovenia	N	1931	1833	54	44
Spain	N	10	4	6	0
Sweden	Y	no data	no data	no data	no data
UK	Y	1763	993	241	257
Norway	Y	11232	10301	1845	302
Iceland	Y	47	42	3	2
TOTALS		239,684	209,568	27,487	1,701

Table 4.2 Mobility not requiring Prior Authorisation – reimbursement processing time and amount

Country of Affiliation	Average time for processing requests for reimbursement	Max days for processing requests Y/N for reimbursement	If yes # of days	Total reimbursed in euro
Austria	30	no data	no data	39,116
Belgium	no data	no data	no data	5,184,628
Bulgaria	255	Y	63	no data
Croatia	80	Y	60	17,723
Cyprus	0	no data	no data	no data
Czech Republic	14	Y	30	11,171
Denmark	18.3	N	N/A	1,353,718
Estonia	29	Y	90	117,000
Finland	107.6	N		751,593
France	no data	N	NA	20,982,368
Germany	no data	no data	no data	no data
Greece	150	N	NA	4,267
Hungary	no data	no data	no data	no data
Ireland	21.2	Y	30	429,440
Italy	40.7	Y	60	83,641
Latvia	40	Y	31	10,438
Lithuania	16	Y	30	32,468
Luxembourg	40	N	N/A	no data
Malta	NA	N	N/A	4,951
Netherlands	no data	no data	no data	no data
Poland	no data	Y	no data	4,003,844
Portugal	no data	Y	90	no data
Romania	69.5	N	N/A	115,748
Slovakia	56	Y	64	1,024,003
Slovenia	19	Y	60	442,209
Spain	85	Y	90	2,657
Sweden	no data	Y	90	no data
UK	16	Y	23	73,676
Norway	85.5	Y	60	6,350,782
Iceland	0	N	N/A	107,526
TOTALS				41,142,966

Table 4.3 Mobility not requiring Prior Authorisation – patient flows

(Those countries not providing data are shown in grey)

Country of Affiliation

Country of Treatment

	AT	BE	BG	HR	CY	CZ	DK	EE	FI	FR	DE	EL	HU	IE	IT	LT	LI	LU	MT	NL	PL	PT	RO	SK	SL	ES	SE	UK	NO	IC	SENT
Austria	x											1													1	7					9
Belgium		x																													
Bulgaria			x																												
Croatia	22	1	1	x			2	1	0	1	4	108	2	2	3	9	1		1		4		1		30	2	2	1	1		199
Cyprus					x																										
Czech Republic	121	1	1	1	2	x			3	3	187					1						6	73		1		1				401
Denmark	143	20	28	30	4	36	x	7	7	140	1545	71	577	5	40	6	41	6	7	38	1273	42	7	4	3	1474	5786	29	34	8	25323
Estonia	1	11		3	1	1	x	9	0	25	3		1		1	9	1				3					11	1		1		80
Finland	6	32	17	5	2	11	1	9985	x	37	93	10	83	1	14	30	23	1	3	6	81	15	21	4	0	878	58	6	4		11427
France	1472	2700	570	604	195	495	86	37	345	x	9542	5416	2405	589	8659	70	93	12282	451	1532	2161	32730	955	119	76	34200	234	872	158	127	149475
Germany										x																					
Greece						1				1	3	x																2			7
Hungary													x																		
Ireland		2	1			7				9	11		2	x	1	4	8				24		5		3		517			594
Italy	61	5		2						11	21	1			x					1					5					107
Latvia	1		6					1	1		3					x	9				1				5					27
Lithuania		2			2			5			10					x														19
Luxembourg																	x													
Malta											1							x										1		2
Netherlands																			x											
Poland	6			1		8120			3	460	1				4	8	1			1	x			8		29		4		8646
Portugal																						x				3				3
Romania	19		1						2	9	1	97					1						x							130
Slovakia	246	2	4	2	1	3089	1			38	2	176	1	3		1	2		3		2331		2	x	1			7		5912
Slovenia	259	3		954		2			1	30		43		535										1	x	3		2		1833
Spain									3					1												x				4
Sweden																											x			
UK	9	16	21	1	7	36	1	5	1	79	50	26	26	18	14	29	133	8	2	11	392	14	11	27	3	52	1				993
Norway	26	8	24	77	27	5	105	3	32	28	192	57	754	2	18	14	26	1		47	230	19	3	12		8349	75	33	128	6	10301
Iceland				1					1	1	1				1	2				1	2					23	1	8	1	x	42
Received	2391	27093	685	1678	241	11807	195	10043	399	322	26241	5591	4165	620	9299	164	345	12303	463	1644	6498	32827	999	253	114	45045	6158	1483	327	141	209534

Section Five
Comments from Member States

Most of the information given by the countries in their specific comments relates to the fact that data are not available to answer to one or more specific questions.

Belgium, Germany, Estonia, Iceland, Luxemburg, the Netherlands and Romania explained in depth why data were not available to answer the questions on authorisation and reimbursement processing times. Belgium explains 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 is 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 is not identical within 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 underlines that the data collected are not complete as there is no data available about requests made at the desk or by phone, while Iceland has just implemented the Directive.

Another group of countries, Austria, Greece and Latvia, set out reasons explaining why only a small number of patients use the opportunity to go to another Member State to receive healthcare services. In Austria for example, the small number of such patients is misleading as patients often rely on national cost reimbursement regulations which often do not explicitly refer to the Directive.

Greece and Latvia explained that patients often opt for planned healthcare in their home countries for reasons that concern the extent of the coverage of healthcare costs, the high healthcare rates abroad as opposed to the low reimbursement rates domestically.

For Greece these issues are further complicated by the European geographical neighborhood and the morphology (mainland and tens of islands), the fact that traveling and accommodation expenses are not reimbursed under the Directive, as well as the language barrier.

Finally it is worth mentioning that some questionnaires are very thoroughly completed and provide a wealth of information. This is the case for Demark and for Finland which also included references to national legislation in order to reimburse planned treatment given in Switzerland which has not implemented the Directive.

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

Conclusion

The data collected in 2016 demonstrate that uptake of patient rights to cross-border care as provided for under the Directive is growing, albeit slowly. While 2016 saw a decrease in requests for information of almost 40% since the previous year, it also saw an increase in granted authorisations of over 20% and a fall in the number of withdrawn or inadmissible requests of 50%. There is no specific explanation offered in the free text section of the questionnaire, but the decrease in requests for information coupled with an increase in granted prior authorisations, as well as reimbursements for treatments in cases which did not require prior authorisations, could suggest that NCPs and other advisors are becoming more knowledgeable about the system and are better able to advise patients.

In the case of patient mobility for treatment requiring prior authorisation, the most common reason for requesting authorisation in 2016, and in the previous year, was the need for at least one night of hospital accommodation. It should be noted however that the flow of patients traveling to receive pre-authorised care in another country remained low in 2016.

In total number of episodes of care in another country reimbursed under the Directive in 2016, whether with or without prior authorization in 2015 was 213,134. This number is so small in comparison to all the episodes of care across the EU (where the average in 2015 was between 10,000 and 20,000 per 100,000 inhabitants[5]), that it is financially insignificant. However, the small financial impact on a health system should not undermine the huge personal importance to a patient who is enabled to travel to receive care that he or she would not have been able to receive at home.

Looking at the direction of patient flows, one significant trend that emerges is that most mobility is across shared borders. There is however one significant exception, which is the number of patients travelling from Norway to Spain. This is true both for treatment requiring prior authorisation and treatment which does not require such authorization.

A key final point remains however that 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 Member States were able to provide full information. It is hoped that as Member States become more accustomed to processing these requests, more robust data will be available.

Appendix 1

[5] See Eurostat http://ec.europa.eu/eurostat/statisticsexplained/index.php/Hospital_discharges_and_length_of_stay_statistics

Specific Comments from the respondents

Country of affiliation	Comment
AT	The reasons for the low numbers are that most cases can be settled according to the coordination regulations (VO 883/2004) or due to the preexisting national cost reimbursement regulations which often do not explicitly refer the directive 2011/24.
BE	Section 3.1.b) -Authorisation/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. 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.e) - Reasons for refusal: the total number of refusals does not correspond to the figure provided under section 3.1.a) because in 5 cases the refusal was based on another reason than the ones mentioned in this section, e.g. the request was insufficiently motivated/documented (2) and other reasons (3). 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. 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.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.
BG	/
CY	Based on the provision of Directive 2011/24/EU, Cyprus has introduced a system of prior authorisation. With regard to request for prior authorisation made by an insured person for receiving cross-border healthcare, Cyprus Competent Authority ascertains whether the conditions laid down in Regulation EC 883/2004 have been met. If so the prior authorisation is granted in accordance with the Regulation unless the patient requests otherwise. According to the relevant national law any kind/category of cross-border healthcare needs prior authorisation except from the visit/consultation to a specialist doctor once a year. The Cyprus Competent Authority is in the process of developing a new system of prior authorisation. This new system will involve a list of specific healthcare services which will be subject to prior authorisation. There are cases that patients can be reimbursed without being applied for a prior authorisation in advance. These cases are usually urgent cases or with short notice (not enough time to get prior authorisation) that can be authorized afterwards in order to be reimbursed.
CZ	Entries about information requests (section 1.2) are estimated. Questions related to Patients' rights directive usually arise as a part of complex request related to Social security coordination.
DE	The reason for not filling out most of the figures above is that the data requested in this data collection exercise is not available in Germany (in terms of Article 20(2) of the Directive 2011/24/EU). The data we have available for Germany do not fit within this Questionnaire. In Germany the way Health Insurance Funds collect and provide information for statistical purposes, i.e. the "annual account", is determined on the basis of national law. Not least for reason of reducing bureaucracy all data concerning "cross-border healthcare" is summarized. The respective information and data comprise more than the legal entitlements deriving from the Directive 2011/24/EU (e.g. reimbursements on the basis of Regulation (EC) 883/2004, treatments in non-EU / non-EEA countries,...). Although these data are comprised in one area "cross-border healthcare" the overall share of expenses for benefits provided outside Germany (EU and Non-EU, based on all relevant legal grounds/entitlements) is every year only a small percentage of the total of the Statutory Health Insurances` expenses for health care benefits (well below 1 %).

DK	Re point 1.2 - Unfortunately, not all contact points are able to specify the information requests by media and the submitted figures are based on estimates. Re point 3.1a - In 2016 the Danish Patient Safety Authority processed 19 complaints from patients regarding prior authorisation. In 9 of the cases the Danish Patient Safety authority changed the regional decision with the result that the patients were entitled to prior authorisation. Re point 3.1.a/3.1.e - Refused requests: Four cases have been refused because the patient did not have a referral from a doctor which was required according to the Danish legislation. Re point 3.2.b - Regarding the aggregated reimbursement amount not all authorities in Denmark have been able to submit data for this point. One of the reasons is that the patient never received the requested treatment or did not apply for reimbursement. Re point 4.1.a - According to the reported data from the five regions in Denmark they had in 2016 received 31.753 requests for reimbursement and 29.411 of the requests were for dental treatments.
EE	Unfortunately, at the moment we are only able to give statistics about written information requests. Requests made via desk or telephone are not separately categorized as NCP ones. We are in the process of developing our information system in the way that we would be able to differentiate the requests by certain topics. Hopefully we are able to give you more detailed information next year.
EL	Low mobility of patients under the Directive General reasons * The national Healthcare Benefits Regulation (Greek acronym EKPY), which is presently under revision, provides for a number of benefits/services concerning healthcare abroad further to the provisions of the Regulations (EC) [e.g. unplanned and planned healthcare in non-EU or non-European countries, reimbursement of prosthetics purchased through the internet, rare diseases, medicines that are not marketed in Greece but are imported through the Institute of Pharmaceutical Research & Technology (Greek acronym IFET) etc.], for which the public paying authority (EOPYY) pays fully directly or indirectly. Such benefits/services have not been categorized as services that fall under the umbrella of the Directive. * Patients opt for the provisions of the Regulations (EC) concerning planned healthcare or their rights pursuant to the Healthcare Benefits Regulation (EKPY) and not the Directive, for reasons that concern the extend of the coverage of healthcare costs, the high healthcare rates abroad as opposed to the low reimbursement rates domestically, the particularity of the European geographical neighbourhood and the morphology (mainland and tenths of islands) of Greece, the traveling and accommodation expenses that are not reimbursed under the Directive as well as the language barriers. * Supplementary insurance, which would contribute to the rise of demand for healthcare abroad, is not the norm in Greece. Finally, the third in five years reform of the national health system, in particular the primary healthcare sector as well as the aftermath of the unification of the health insurance funds (which operated on different benefits baskets) in one (EOPYY) in 2012 are also crucial factors that potentially contribute to the low mobility rates of outgoing patients under the Directive.
ES	SECTION 4 Following this questionnaire, an error has been detected in the questionnaire for 2015 data. In section 4, the answer to the question about if Spain has implemented a system for prior notification according to Article 9.5 of Directive 2011/24/EU is No. In order to record the number of requests in this questionnaire, the criteria established last year have been respected.
FR	/
FI	Finland reimburses acute illnesses based on Regulation (not Directive) if a person has to pay all the costs by himself. Justification: the reimbursement is thus bigger. 4.1.A. Finland compiles statistics on solutions, not on persons or applications. A solution means operation and treatment given, thus a person can have several operations and solutions per visit. 4.1.D. Even if Switzerland has not implemented the Directive, Finland according to national law reimburse planned treatment given in Switzerland. To make the overview of the Finnish statistic complete Switzerland is also mentioned in the table.

HR	An explanation for point 4.1.b.: The average time for dealing with requests for reimbursement is longer than a maximum time limit for dealing with mentioned requests according to the Croatian legislation because in each case we have to check whether health care was used in private health care provider or in provider which is covered by the basic health insurance of some EU Member State. The reason for such procedure is insisting of our insured persons that their requests will be solved according to EU Regulations (883/04 and 987/09).
HU	/
ICE	On the 1st of July 2016 Iceland implemented directive 2011/24/EU. Since then the Icelandic Health Insurance have been in constant revision and development of processes regarding those matters. The Icelandic Health Insurance will continue their work on making everything regarding the procedures adequate and set up according to this questionnaire for gathering proper data.
IE	/
IT	- the categorisation "withdrawn/inadmissible requests" is not used by the Italian administration. - there is a further maximum time limit of 15 "Days" for urgent prior authorisation requests. - the "Number of requests still being processed" in 2016 has been calculated as [Number of request received in 2015 - Number of request whose processing ended in 2015 + Number of request received in 2016 - Number of request whose processing ended in 2016]. - the number indicated as “Maximum time, if set as a limit by the MS” for healthcare not subject to prior authorisation corresponds to the limit set by the Legislative Decree 38/2014 which transposes the Directive in the Italian law; since this Decree entered into force on 5 April 2014, claims for reimbursement of treatments requested before this date are subject to a maximum time of 90 days: this is the time limit for the provision of answers to citizens by the all Italian Public Administrations, unless differently set by the specific legislation. -with regard to the question concerning “whether the MS has implemented a system of prior notification”, Italy has implemented a procedure by which a patient can ask in advance their local health authorities to check their specific right to be reimbursed amount included; this procedure was introduced in order to check in advance whether a prior authorisation is necessary and, if so, terms for processing prior authorisation request start from the presentation of the checking request.
LU	In section 1, the details concerning information requests for the NCP1 (CNS) are not 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. -In section 3, please note that the authorisation 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 authorisation under the scheme of the Directive is established. -Concerning the reimbursement, the Luxembourg system does not enable to extract figures with a clear distinction between the Directive 2011/24 and the EC-Regulation 883/04. Thus there are no figures indicated under section 4 concerning the reimbursement. Some pieces of information may be extractable but no global figure or precise number can be indicated.
LV	Assessing the statistical data from the moment of the transposition of the Directive 2011/24/EC, it can be concluded that patients rarely use the opportunity to go to another MS to receive health care services. Provisionally this is due to the following reasons: 1) the payment for health care services should be made in full amount; 2) health care costs will be reimbursed in accordance with Latvian health care tariffs (mostly, health care tariffs in Latvia are significantly lower than in other MS); 3) the patient has additional costs (for example - travel and accommodation expenses), which will not be reimbursed; 4) the patient may experience difficulties in communication with health care provider (not familiar with the language of another MS); 5) patient don`t know the procedure how he/she may receive health care services in another MS.

MT	Malta had one application where it was withdrawn. Three applications were inadmissible because treatment of high quality is available in Malta and with no undue delay in waiting lists. Two cases involved individuals who were enquiring about the best methods to obtain healthcare. One case involved an individual who requested reimbursement for private treatment in Malta.
NL	Section 4: Healthcare not subject to prior authorisation 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. It appears that the data recorded in their administration systems by these private health insurers is not identical with each insurer. In other words: administrations between health insurers vary widely. As a result, it is not possible to aggregate the data administered by the insurers. The questions in section 4 can for this reason not be answered.
NO	- Section 4.1 a: Number of received requests: The indicated number refers to both requests for reimbursement and requests for prior notification, as we are not able to separate these in the system used for statistics. Number of granted requests: The indicated number refers to number of cases where reimbursement has been granted and paid. Number of withdrawn/inadmissible requests: The indicated number refers to inadmissible requests, and does not include withdrawn requests. - Section 4.1 b: The number of days indicated correspond not to working days, but to all calendar days. - Section 4.1 d: Norway is indicated as country of treatment in 128 granted requests for reimbursement. This is due to incorrect registration in the claims handling system, and we have been unable to re-register the cases to indicate correct country. We believe this problem will be somewhat reduced in our next reporting.
PL	3.1a) In addition to the figures provided in the table: - in 6 cases the processing of the applications was not closed before the end of the year 2016, - in 2 cases the applications were re-categorized in accordance with Article 8 paragraph 3 of the Directive (i.e. processed as applications for prior authorisation under Article 20 of the Regulation No 883/2004/EU, - in 5 cases the proceedings were discontinued. 3.2 a) and 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 potential need of initiating investigation procedure during the assessment. In general, assessment of the request with no need for further investigation takes 30 days (no matter whether there are working days or not) from the date of initiation of proceedings. In a situation when the assessment of the request requires further investigation, the deadline is extended to 60 days. In a situation the assessment of the request requires an investigation with participation of the national contact point for cross-border healthcare situated in the other EU Member State, the deadline for the assessment is 6 months from the date of initiation of proceedings. In respect of 'the average time (in working days) for dealing with requests for reimbursement in 2016' - 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.
PT	/

RO	1. In section 1 at point 1.2, at the heading "Desk (in person)“: - reasons: given that this issue is not regulated at the EU level, we notified that such data are estimated; - steps taken to improve the available statistics: in case if these data will be required for 2017, we will begin the necessary measures in order to provide relevant data as you requested. 2. In section 2 at let b), at the heading "Number of patients": - reasons: there was no patient whose treatment access was limited in 2016. 3. In section 3: 1) at point 3.1 let a), at the heading "Number of withdrawn/inadmissible requests": - reasons: no number of requests considered withdrawn/inadmissible. 2) at point 3.2 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. 4. In section 4 at point 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.
SE	N.B. point 4. All persons insured in Sweden are able to get healthcare abroad without prior notification. The Swedish system of prior notification is purely voluntary. It was established in order to help the patient to make a rational choice before seeking healthcare abroad, so that patient knows if the cost for planned healthcare will reimbursed and to which extent. N.B. point 4. Sweden is unfortunately not able to provide any figures. This is due to that we do not distinguish between necessary and planned healthcare in the IT-system that is the base for statistical production. Sweden is working on necessary changes in the IT-system to be able to provide necessary figures in the future.
SK	/
SL	/
UK	Wales provided the following information: Reasons provided by Health Boards for refusing applications include; The local clinical team felt there was a risk to the patient if the requested intervention took place too soon and were therefore monitoring the patient locally to undertake the intervention at the clinically appropriate time. Entitlement to orthopaedic surgery - refused as the patient was unable to provide evidence that they would be entitled to/met access criteria relating to the requested treatment in the home (Wales) system. Residency - patient unable to provide evidence to confirm residency in the Wales. Patient was 'living' in Spain and using a relatives address as a reference. Therefore, the request would not be for NHS Wales to consider. Scotland provided the following information: Section 2.1 Information Requests - these are approximate figures based on average weekly activity.
I CE	/

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	Gesundheit Österreich GmbH
Affiliation/Organisation	Subsidiary of the Austrian Federal Government, represented by the Federal Minister of Health
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

Czech Republic

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

Denmark

Name	International Health Insurance
Affiliation/Organisation	Danish Patient Safety Authority
Website	www.stps.dk
Telephone	+45 72269490

Estonia

Name	Estonian National Contact Point (since 1st of June 2016)
Affiliation/Organisation	Estonian Health Insurance Fund
Website	www.haigekassa.ee/en/estonian-national-contact-point
Telephone	+372 669 6630

Finland

Name	Contact Point for Cross-Border Healthcare
Affiliation/Organisation	Kela (Social Insurance Institution)
Website	www.hoitopaikanvalinta.fi (fi) www.vårdenhetsval.fi (swe) www.choosehealthcare.fi (en) www.saame.hoitopaikanvalinta.fi (sami)
Telephone	/

France

Name	Cleiss (Centre des liaisons européennes et internationales de sécurité sociales)
Affiliation/Organisation	/
Website	www.cleiss.fr
Telephone	e-mail: soinstransfrontaliers@cleiss.fr

Germany

Name	EU-PATIENTEN.DE
Affiliation/Organisation	Teilorganisation des GKV-Spitzenverbandes, Deutsche Verbindungsstelle Krankenversicherung – Ausland (DVKA)
Website	www.eu-patienten.de
Telephone	+49 228 9530 800

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	www.eopyy.gov.gr
Telephone	+30 210 8110935, +30 210 8110936

Hungary

Name	Integrated Rights Protection Service, Hungarian National Contact Point
Affiliation/Organisation	Ministry of Human Capacities
Website	www.eubetegjog.hu
Telephone	Green (free of charge) number: +36/20/9990025

Iceland

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

Ireland

Name	HSE Cross-border Directive - National Contact Point
Affiliation/Organisation	Health Service Executive
Website	www.hse.ie/crossborderdirective
Telephone	+353 (0)56 778 4556

Italy

Name	National Contact Point
Affiliation/Organisation	Ministry of Health - Health Planning General Directorate
Website	www.salute.gov.it/portale/temi/p2_4.jsp?lingua=english&tema=International%20Health&area=healthcareUE
Telephone	/

Latvia

Name	The National Health Service (there is only one NPC)
Affiliation/Organisation	/
Website	www.vmnvd.gov.lv
Telephone	+371 67043700

Luxembourg

Name	Caisse nationale de santé / Service national d'information et de médiation dans le domaine de la santé
Affiliation/Organisation	Public Administration / Governmental entity
Website	www.cns.lu / www.mediateursante.lu
Telephone	+352 2757-1 / 352 24775515

Malta

Name	Anthony Gatt
Affiliation/Organisation	Office of the Chief Medical Officer, Ministry for Health
Website	https://deputyprimeminister.gov.mt/en/cbhc/Pages/Cross-Border.aspx
Telephone	+356 22992381

Netherlands

Name	Netherlands NCP Cross-Border Health Care
Affiliation/Organisation	Zorginstituut Nederland (National Health Care Institute)
Website	www.cbhc.nl
Telephone	/

Norway

Name	National Contact Point
Affiliation/Organisation	Helfo
Website	https://helsenorge.no/foreigners-in-norway/norwegian-national-contact- point-for-healthcare1
Telephone	800HELSE: (800 43 573) calling from Norway +47 23 32 70 30

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	www.nkm.sk
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	Citizens' Advice and Information Office
Affiliation/Organisation	Ministry of Health, Social Services and Equality
Website	www.msssi.gob.es/pnc/home.htm
Telephone	+34 90 140 01 00

Sweden

Name	Försäkringskassan, The Swedish Social Insurance Agency / Socialstyrelsen, The National Board of Health and Welfare
Affiliation/Organisation	Stockholm, Sweden
Website	www.forsakringskassan.se / www.socialstyrelsen.se
Telephone	+46 (0)771 524 524 /+46 (0)75 247 30 00
	+46 (0)75 247 30 00

UK

Name	NHS England
Affiliation/Organisation	England, Scotland, Wales and Northern Ireland each have a contact point, the details for each region are found on the NHS England website
Website	https://www.nhs.uk/nhsengland/healthcareabroad/national-contact-point/pages/uk-national-contact-point.aspx