European Commission

MEMBER STATE DATA

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

Year 2018

Health Connect Partners
supporting trust in data

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Health and Food Safety

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Executive summary

Directive 2011/24/EU codifies patients' rights to reimbursement for healthcare received in another EU Member State (MS). In accordance with the Directive MS are asked to complete a questionnaire each summer to report on the use of the Directive in the preceding year.

The data collected address treatment provided with Prior Authorisation (PA) from the MS 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 2018, collected between June and October 2019. Filled or partially filled questionnaires were received from twenty-nine of the thirty countries contacted (being the EU-28 plus the EFTA countries Norway and Iceland), with only Iceland unable to reply. As several Member States had difficulties in providing data on all the questions asked, many provided only partially filled questionnaires, as a result 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 on the Coordination of Social Security Systems and various regional and bi-lateral agreements tools. Sections one to five of the report discuss the data returned by the Member States and Norway, following the format of the questionnaire and provide the raw data submitted by the Member States and Norway at the end of each section. The concluding chapter reviews the data reported for 2018 in comparison to the data provided on mobility in 2017. The concluding chapter then also provides an overview of the data on patient mobility under the Regulations as reported for 2017 by De Wispelaere et al and includes an example of a bi-lateral cross-border care agreement between France and Germany.

Information requests received by National Contact Points (NCPs)

The NCPs reported that a total of 95,565 requests for information about access to healthcare were received, with most NCPs receiving fewer than 2,000 requests in 2018. Estonia and Poland were the outliers receiving 27,242 and 24,233 requests respectively. The data show that almost three quarters of the requests for information were made by telephone, with the remainder either made in writing (email) or made in person. The number of requests reported for 2018 represents an increase on the number reported for 2017 which is attributable primarily to a change in data collection methods by Estonia.

Limitations for patient in-flow

Article 4(3) of the Directive provides that MS may adopt mechanisms to limit access to healthcare by a citizen coming from another MS, however only four MS (Denmark, Estonia, Romania, UK) reported that they had put in place such measures. Only Denmark reported having used these measures, with the ten reported cases being the first reports of limitation being imposed since data collection began in 2015.

Healthcare subject to Prior Authorisation (PA)

Twenty-three Member States reported that they had adopted Prior Authorisation systems, and nineteen returned data on patient mobility based on PA. In total 7,279 requests for patient mobility with PA were reported, however the majority of MS reported fewer than 100 requests for PA. The most common reason for authorisation being granted was that the medical intervention required an overnight stay (92% of all authorised 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 (80% of all refused cases). The total reported spend across the fourteen MS who provided this information was 16,806,793€ ranging from highs of 11,622,453€ and 4,501,759€ in Ireland and the UK respectively, all other countries reported total spends on care with Prior Authorisation under 300,000€. These numbers represent a rise of approximately 22% in the number of requests for PA since the previous year, with the rate of grant of authorisation staying stable (approximately 70% of requests granted). The data provided on where patients travelled to when PA had been granted show that 70% of all such mobility is between groups of neighbouring countries, notably UK and Ireland,

Luxembourg and Germany and France with its neighbours.

Healthcare not requiring Prior Authorisation (PA)

The Directive also provides for citizens to travel to another MS for care without PA and then to seek reimbursement upon return. In 2018 twenty MS and Norway reported that they had received 271,565 requests for such reimbursement, of which 84% were accepted for reimbursement. The total reported spend across the seventeen MS who reported was just over 56M€. This ranged from a high of almost 13 M€ in France to 6,740€ in Spain. These figures show an increase of approximately 15% in requests since 2017. As with mobility based on Prior Authorisation, here too most patient mobility was between neighbouring countries

Total amount of patient mobility in the European Union in 2018

The grand total of cases of patient mobility, both with and without PA reported for the year 2018 was 278,844, a slight increase from 2017 which saw 205,417 cases of mobility being reported, coupled with the rise in requests for information this shows a slow but steady increase in the awareness of European citizens of the potential to access cross border health care.

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') codifies and clarifies the jurisprudence of the Court of Justice of the European Union with regard to 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 a number of significant flanking measures to support patients in using these rights in practice. As a result, there is now a minimum set of 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. 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.

Although the Directive applies generally to care provided without any form of prior agreement from the insurance funding body in the country of affiliation, the Directive 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 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. Furthermore, 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.

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.

In addition, Article 4(3) of the Directive also provides the opportunity to Member States to adopt 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. In practice however only one Member State has reported making use of this provision since the Directive has been in force.

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, e.g. information about healthcare providers, quality and safety standards, complaints and redress procedures, etc.

The healthcare 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 individual covered by the Directive are nationals of a Member State, stateless persons and refugees residing in a Member State who are or have been subject to the legislation of one or more Member States, as well as to the members of their families and to their survivors. Such individuals must also be insured, which means that they must satisfy the conditions required under the legislation of the Member State competent to have the right to benefits, taking into account the provisions of Regulation (EC) No 883/2004 on the coordination of social security systems.

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 (Member State of insurance);
- Healthcare in the Member State of residence, other than the competent Member State (Member State of insurance) – 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.
- The Directive requires up-front payment by patients to the foreign healthcare provider, while under the Regulations reimbursement is made between competent institutions (except the co-payment that may exist 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 conclusion 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 provisions in national or in (bilateral) agreements, and in some Member States account for a much more significant patient flows 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. Accordingly, 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. Norway transposed in 2015 and Iceland in late 2016. 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, Norway and Iceland each year since 2015; 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 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 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.

The body of this report discusses the aggregated data in four sections relating to sections one to four 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

The five-part questionnaire was sent in June 2019 to the EU 28 plus Iceland and Norway, who also participate in the cross-border care regime. All but one country responded to the request for information (Iceland did not reply). It should be noted however that many countries were able to provide only very limited information.

Of particular note are Sweden and Germany. Sweden reported that the information collection systems are currently being updated and that as a result the authorities were not able to provide any data for 2018; while Germany was able to provide data only on information requests but not on authorisation requests or reimbursements, this arose because the data is collected by over one hundred Health Insurance funds and collation of the data at a national level was not possible. Other Member States were able to supply some but not all data on patient mobility

In Section Three the data on patient mobility subject to Prior Authorisation are discussed. These data cover 19 Member States since the Czech Republic, Estonia, Finland, the Netherlands, and Norway have not implemented a system of prior authorization and accordingly had not data to report in Section Three. Although Germany, Hungary, Latvia, and Lithuania reported having a system for prior authorization in place, they nevertheless reported '0' requests for Prior Authorisation. Furthermore, the number of requests for Prior Authorisation reported for Luxembourg includes requests made under the Directive and Regulation, since at the request stage not distinction is made between the two different routes for reimbursement, accordingly these data are not as accurate as they might be.

In Section Four the data on mobility not subject to Prior Authorisation are discussed, using reports from 22 Member States. France noted that data provided under this section include all the reimbursements made in 2018 directly to insured persons for treatment abroad without prior Authorisation, whether under the Directive or the Regulation, the number of cases of mobility not requiring Prior Authorisation in France is therefore high compared to other Member States. Belgium,

noted that the various insurance funds used in Belgium were not all able to provide data on the outcomes of requests for reimbursement or where patients travelled, this meant no aggregate national number was available on the details of outcomes, although the national aggregate expenditure was available. Furthermore, Cyprus was unable to provide any data on mobility requiring not PA but did not provide any reason as to why. Several Member States noted that replied on the time taken to make reimbursements was not available.

Fuller details of the number reported by the Member States are given in the following sections of this report, but here it should be noted that due to a variety of reasons 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 no data were returned on patient mobility for just over 16% of the potential total patient mobility population. This is because the sum of the populations of those countries who were unable to return any patient mobility data (as opposed to information on request for information) amounts to roughly 84.34 million, that is 16.3% of the total population of all countries asked to participate (517.39 Million total population in EU plus Iceland and Norway).

Comments regarding the quality of the data provided by each country can be found in section 5 of the questionnaire. These answers can be found copied in full in Annex 1 of this report so as to provide a useful background and explanation of the reported data.

5. Data from the EFTA countries

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 it has 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 since then the Icelandic Health Insurance system has been developing processes regarding the Directive, however, as these processes are not yet complete Iceland was not able to provide data on patient mobility to date, and has accordingly not featured in the reports on patient mobility in 2016, 2017, or 2018. 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. However, any data reported by other EU countries to do with Liechtenstein has been included in this report. In Switzerland, the Directive is not applicable (as it is not an EFTA country). Where Member States reported data on patient mobility to Liechtenstein or Switzerland the data were excluded.

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 by InforEuro for the month of September 2019[1].

[1] [1] Exchange Rate (InforEuro) viewed on 04/09.19, https://ec.europa.eu/budget/graphs/inforeuro.html

Table 1: Exchange Rates

Country	Currency	Exchange Rate 1 EUR =
Bulgaria	Bulgarian Lev	1.95
Croatia	Croatian Kuna	7.41
Czech Republic	Czech Koruna	25.8
Denmark	Danish Krona	7.45
Hungary	Hungarian Florin	328.53
Poland	Polish Zloty	4.33
Romania	Romanian Leu	4.72
UK	Pound Sterling	0.91
Norway	Norwegian Krone	9.98

Section One
Information requests received by National Contact Points

National Contact Points (NCPs) are vital for information to be provided for patients and the public. The Directive requires for each Member State to provide at least one NCP however each Member may choose to create more than one and each can decide and how information is provided.

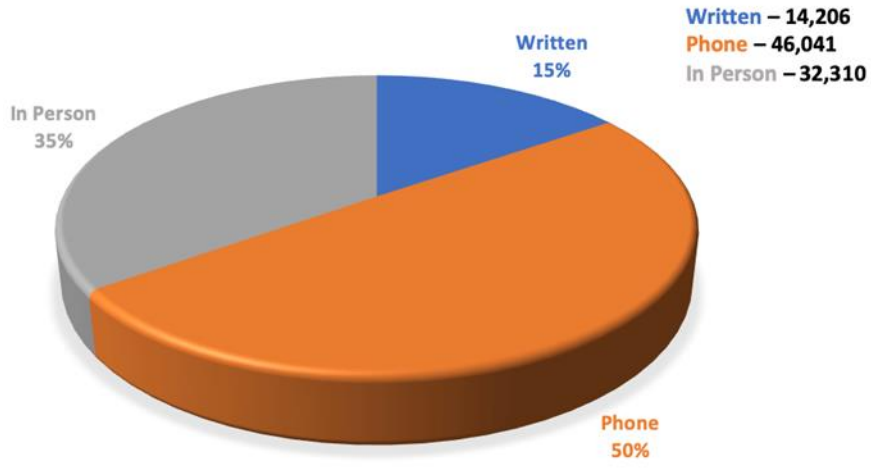
Each Member State was requested to present data regarding the number of information requests received from the public through both National and Regional Contact points. These data were provided in question 1.2 of the questionnaire and Member States were asked, where possible, to break these requests 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 2018, a total of 95,565 enquiries were made across the 28 NCPs providing data. Luxemburg provided contact details of two NCPs, but data was only available for the second. Finland noted that they have only one NCP which no longer has a phone line. They 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 2018.

While most Member States received fewer than 1,000 requests, Estonia, Poland, and Lithuania stand out in receiving 27,242; 24,233, and 15,532 respectively. Bulgaria, Portugal, and Norway provided NCP contact point information yet noted 0 requests for information during the year 2018, but did not give a reason for this.

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



The 2018 data show an increase in requests for information since 2017, when a total of 71,396 requests were received in 24 Member States. The increase is due in large part Estonia, whose number of requests increased almost 10-fold from 2,243 in 2017 to 27,242 in 2018. Estonia commented that in 2018 they were able to collect data in much greater detail due to new information system and reported that the 2017 data was only for requests made in the fourth quarter of the year. It would seem therefore that although the number show 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

	Total Number of Requests	Written	Phone	In-person
Austria	187	187	0	0
Belgium	303	191	112	0
Bulgaria	0	0	0	0
Croatia	1025	522	503	0
Cyprus	114	47	55	12
Czech Republic	105	50	50	5
Denmark	3008	0	0	0
Estonia	27242	1280	11148	14814
Finland	273	273	0	0
France	577	577	n/a	0
Germany	3526	551	2975	0
Greece	1344	294	940	110
Hungary	252	247	5	0
Ireland	4539	1512	3025	2
Italy	669	669	0	0
Latvia	2852	2386	466	n/a
Lithuania	15532	410	3697	11425
Luxembourg	62	15	41	6
Malta	27	12	12	3
Netherlands	279	279	0	0
Poland	24233	805	17548	5880
Portugal	0	0	0	0
Romania	4100	2400	1700	0
Slovakia	46	35	11	0
Slovenia	2440	619	1815	6
Spain	544	169	328	47
Sweden	no data			
UK	2286	676	1610	0
Norway	0	0	0	0
Iceland	no data			
Totals	95,565	14,206	46,041	32,310

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 according to Article 4(3) of the Directive, which provides that Member States limit access to treatment for visitors from another EU Member State where this is justified by overriding reasons of general interest, such as planning requirements.

Of the twenty-five countries who replied, four (Denmark, Estonia, Romania, UK) 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, barely been used. In 2018, Denmark reported 10 cases of patients whose access to treatment had been limited on the grounds of overriding reasons of general interest.

Table 3 Raw Data: Limitation of patient inflow

	Limitations adopted Y/N	Limitations imposed	New measurece since 2016
Austria	N	n/a	N
Belgium	N	0	N
Bulgaria	N	0	N
Croatia	N	0	N
Cyprus	N	0	N
Czechia	N	0	N
Denmark	Y	10	N
Estonia	Y	0	N
Finland	N	0	N
France	N	0	N
Germany	N	n/a	N
Greece	N	0	N
Hungary	N	0	N
Ireland	N	0	N
Italy	N	0	N
Latvia	N	0	N
Lithuania	N	0	N
Luxembourg	N	0	N
Malta	N	0	N
Netherlands	N	n/a	N
Poland	N	0	N
Portugal	N	0	N
Romania	Y	0	N
Slovakia	N	0	N
Slovenia	N	0	N
Spain	N	0	N
Sweden	no data		
UK	Y	0	N
Norway	Y	0	N
Iceland	no data		

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 if those which2. may be subject to a system of Prior Authorisation and those to which for which Prior Authorisation is not applicable. Within section four a Member State 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 receives 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 can expect to have reimbursed. This system may apply for any type of care or treatment, where as Prior Authorisation, discussed in section four of this report, can be applied to only certain types of care.

Of those who replied in 2018, nine Member States reported having such a system in place (Austria, Denmark, Estonia, Greece, Italy, Latvia, Malta, Poland, Portugal,) and Norway. Since the 2017 report, Austria and Latvia note that they have implemented a system of notification, although Latvia's has only been in place since September 2018. Slovenia noted that while they had not formally adopted a system of prior notification, patients are able to receive an informative calculation of costs.

Section Three

Healthcare subject to Prior Authorisation

Section Three of the questionnaire asked respondents 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 reported that in 2018 that they had not introduced a Prior Authorisation system: Czech Republic, Estonia, Finland, Netherlands, Norway, accordingly they did not complete Section 3 of the questionnaire. In September 2018 the legislation in Latvia changed, from which date Latvia no longer implemented a system of Prior Authorisation. Despite this change Latvia reported '0' cases in section three, as no applications has been made. Since 2017, France and Lithuania have both adopted a system of Prior Authorisation.

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 Regulation 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 Regulation route may be favourable to the patient because they will not have to make a payment up front and then claim a reimbursement. Furthermore the reimbursement under the terms of the Regulation is generally be more favourable to the patient, as the Regulation provides for reimbursement at the rate provided in the country of treatment, whereas the Directive provides for reimbursement at the rate that would apply 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)[2].

In 2018, twenty-three Member states reported that they had implemented a system of prior Authorisation and has provided data on their use of these systems. The number of requests for Prior Authorisation under the Directive made in 2018 remains low but has gone up since the previous report last year. In total 7,279 requests for Prior Authorisation were received, up from the 5,902 requests received in 2017[3]. Of the twenty-three Member States who reported having a system in place, thirteen of these Member States reported a receipt of fewer than 100 requests.

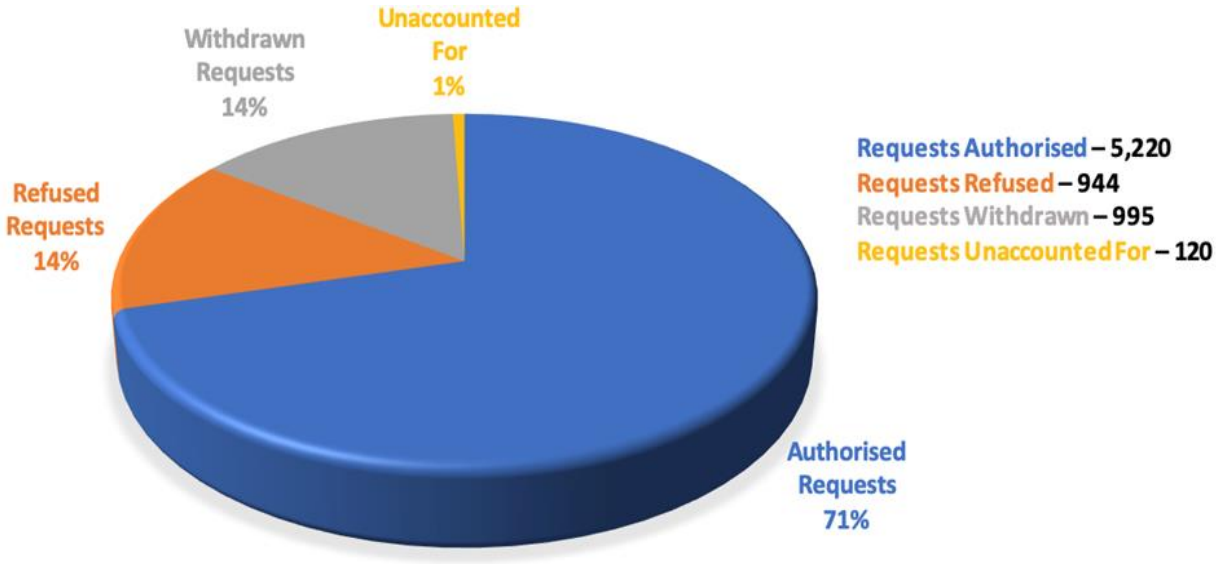
[2] Planned cross-border healthcare: report on S2 portable documents issued in 2013, available on http://ec.europa.eu/social/contentAdmin/BlobServlet?docId=13738&langId=en

[3] Note that this number is not the same as the one in the published report on Patient Mobility in 2017 as found at https://ec.europa.eu/health/sites/health/files/cross_border_care/docs/2017_msdata_en.pdf this is because France provided updated figures on Patient Mobility with Prior Authorisaion bin 2017 at the time of reporting on mobility in 2018.

Of those Member States reporting data on Prior Athorisations, France reported a considerably higher number of requests than any other Member State, with 3,076 requests. This can be explained by their note saying that the data provided under this section of the questionnaire also included all the S2 requests delivered in 2018. Luxembourg reported only the number of requests, and not outcome of requests or reimbursements made, noting that the authorisation procedure in Luxembourg treats requests concerning the Regulation and the Directive equally in a first step, only later establishing if the reimbursement is to be made under S2 or the Directive.

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.

Figure 2 Prior Authorisation Requests (authorised, refused or withdrawn)



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

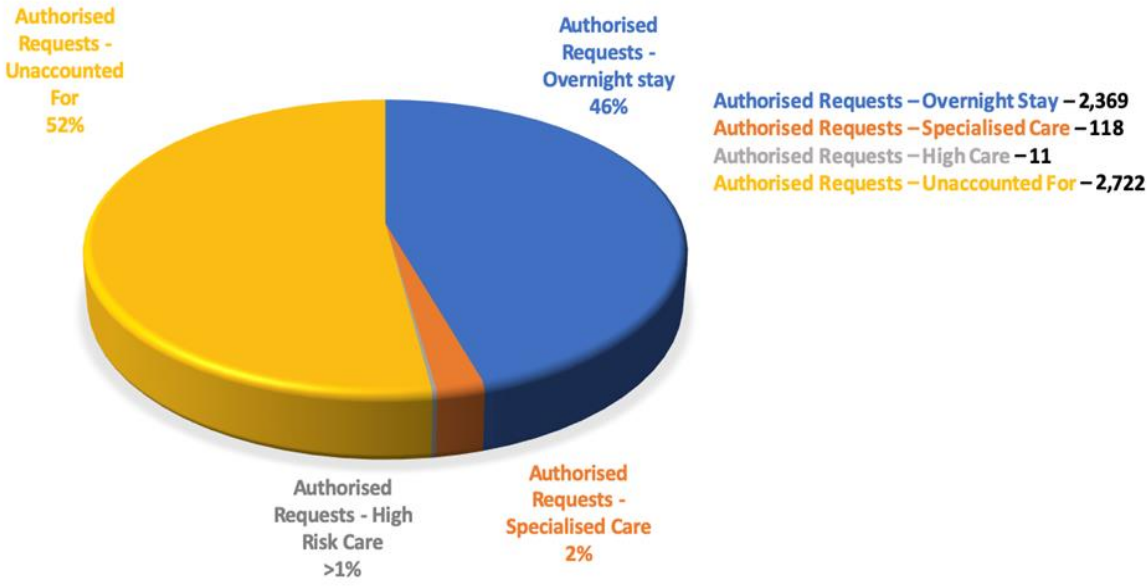
Member States were asked to indicate the basis on which authorisation had been authorised, based on three groups of reasons as follows:

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 2,498 of the 5,220 authorisations being assigned to one of the three reasons for authorisation. France notably did not assign its authorisation to one of the requests yet reported 2,067 of the 5,215 authorised requests.

Amongst those Member States who were able to provide this data, 95% 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. These data for the reporting year of 2018 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, not all refusals are accounted for under the three groups of reasons for refusal provided in the questionnaire. While some countries did not provide details on why grounds for refusal were not detailed, two countries also provided further information in this section. Denmark noted that the total number of cases where Prior Authorisation had been refused

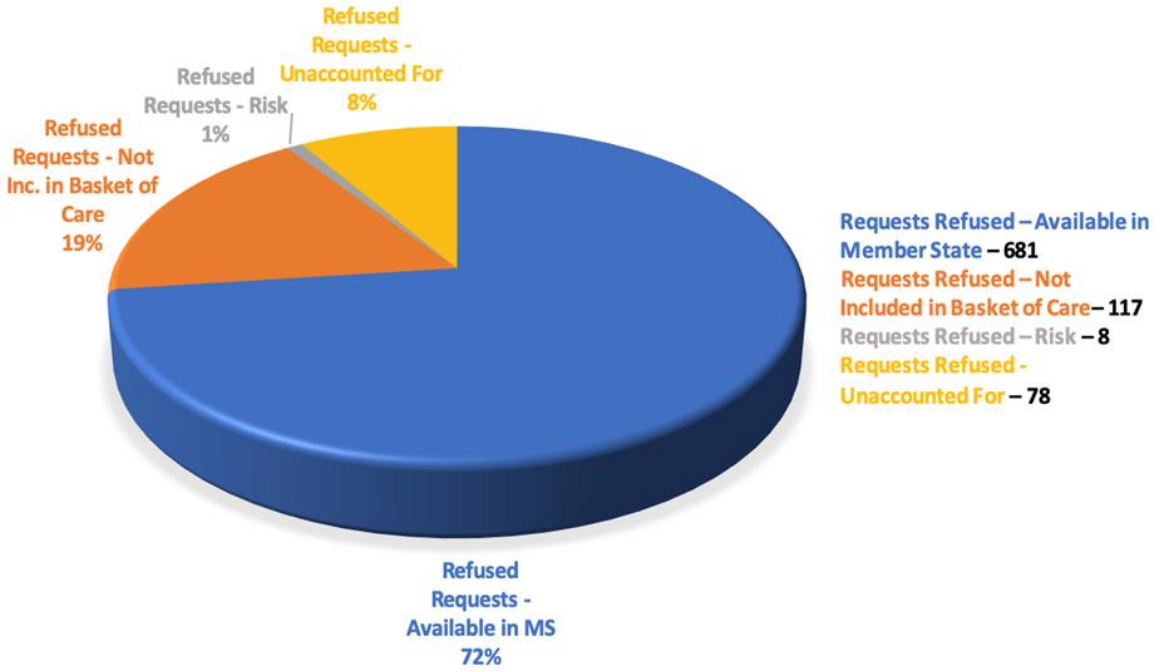
is higher than the sum of the three reasons for refusal. This is because in Demark Prior Authorisation may be refused for other reasons than those mentioned in Article 8.6. of the directive, for example if the patient did not have a referral in cases where it is required according to the Danish legislation. Denmark reported one such case of refusal in 2018. Ireland also provided a further breakdown on refusals, noting that the 15 applications refused Prior Authorisation were for the following reasons:

- 9 applicants did not provide a valid referral pathway in line with the member state.
- 4 applicants accessed private consultations in Ireland and therefore were not eligible under Cross Border Directive.
- 1 applicant did not have eligibility for their treatment in Ireland.
- 1 applicant did not attend an initial consultation abroad prior to their treatment and therefore did not follow the public pathway in Ireland

The data received for 2018 shows that the most common ground for refusal of Prior Authorisation was that the treatment requested could be provided on the Member State's territory within a medically justifiable time. Of the twenty-six Member States who provided data, 944 requests received were refused, and of these, 72% were refused because of the afore mentioned reason.

Note that Figure 4 below shows only the refused requests that fall within the three groups mentioned in the questionnaire.

Figure 4 Reasons for refusal of Prior Authorization 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 eleven of the eighteen Member States 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 7 (Malta) to 90 days (Portugal and Spain), with the most common being between 30 and 60 days.

Fifteen Member States 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, a 5 day increase from the data collected last year. However, this indicates that Member States are broadly still within their self-imposed targets

Full details are given in Table 4.4 hereunder.

5. Amounts reimbursed for treatment requiring Prior Authorisation

In comparison to 2017, the total amount of aggregated reimbursements for this year has gone up considerably in line with the general number of requests for Prior Authorisation being approved going up. The reported spend across fourteen Member States who provided data for this part of the questionnaire ranged from a high of 11,6M€ and 4,5M€ in Ireland and the UK respectively, to 1,735€ in Poland. Of the other eleven Member States reporting, six reported spending under 7,000€; two between 15,000 and 22,000€ and three spent over 200,000€. Full details are given in Table 4.4. The total reported spend across fourteen Member States who provided data for this part of the questionnaire was 16,881,884€, representing a 300% increase from the total spend in 2017 which was just over 5 million€. This increase is accounted for almost entirely by a significant increase in spend in Ireland and UK, up from 3M€ to 11M€ in Ireland and up from 1M€ to 4,6M€ in UK.

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.

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 is across borders with neighbouring countries. The data are represented in a flow map (Figure 5), which shows clearly that 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:

- France to Germany (670), to Spain (581), and Belgium (306) (total
- Ireland to UK (1244)
- UK to Ireland (476)

- Luxembourg to Germany (402)
- Slovakia to Czech Republic (280)

These five country groupings represent over 70% 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.

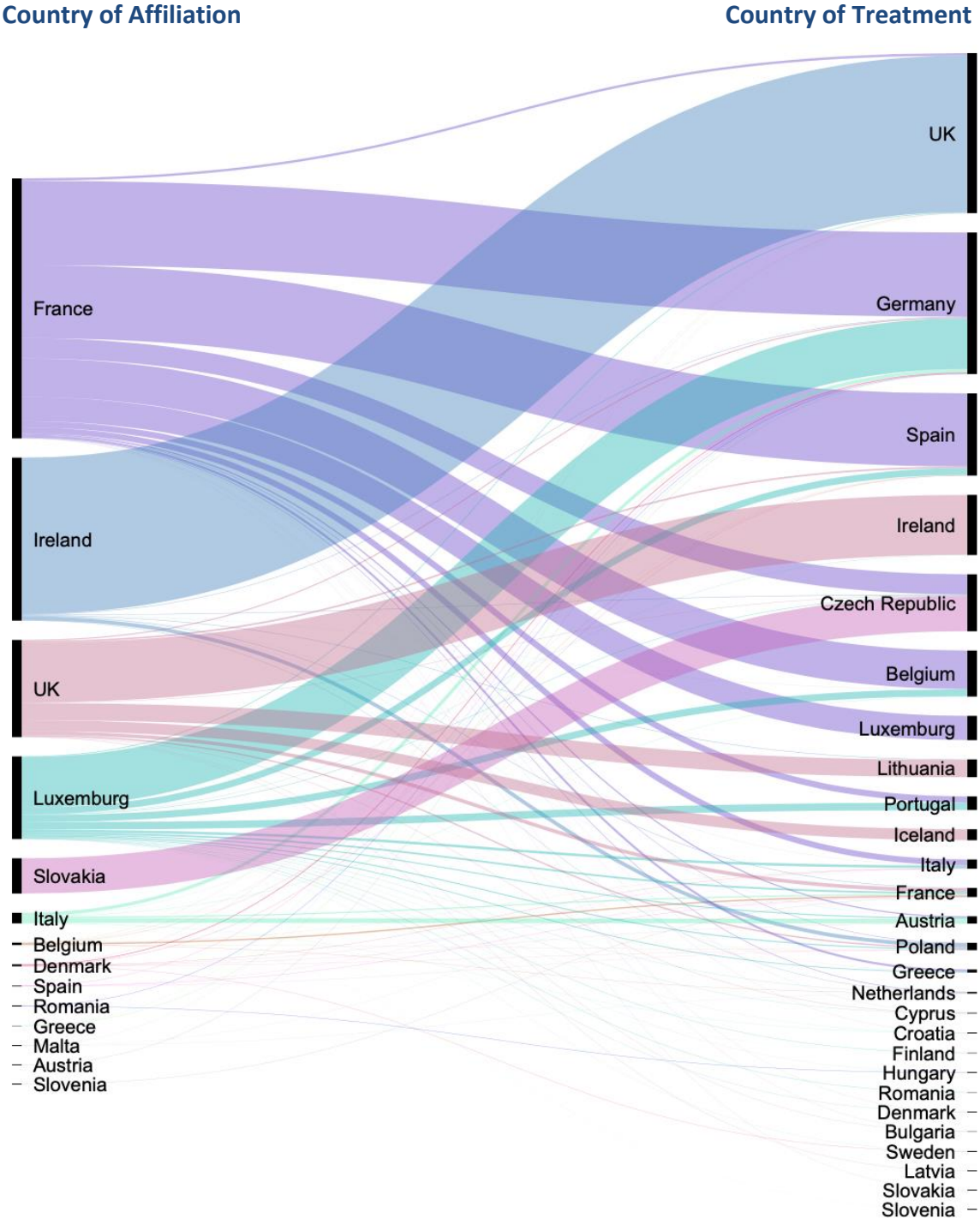
The flow chart in Figure 5 shows these data.

7. Comparison between 2018 and 2017

When broadly comparing the data from 2018 and 2017, we can see that despite there being an overall rise in spend on reimbursements for treatments requiring Prior Authorisation, many countries have seen a decrease in spending. Indeed, of the eleven Member States who provided data in both 2017 and 2018, five have seen the cost of reimbursement go down over the last year. However, it should be noted that this data does not depict an accurate picture of the amounts spent on Prior Authorisation as overall very few countries provided data and, of those who did, some expressed uncertainty over the quality of their data from previous years.

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 authorisation	Number of received requests	Number of authorised requests
Austria	Y	1	1
Belgium	Y	44	19
Bulgaria	Y	9	2
Croatia	Y	3	1
Cyprus	Y	4	3
Czechia	N	0	0
Denmark	Y	75	17
Estonia	N	0	0
Finland	N	0	0
France	Y	3076	2,067
Germany	Y	0	0
Greece	Y	5	3
Hungary	Y	0	0
Ireland	Y	1854	1,296
Italy	Y	139	84
Latvia	Y	0	0
Lithuania	Y	0	0
Luxembourg	Y	719	657
Malta	Y	9	3
Netherlands	N	0	0
Poland	Y	21	1
Portugal	Y	5	0
Romania	Y	7	6
Slovakia	Y	302	280
Slovenia	Y	18	1
Spain	Y	10	6
Sweden	no data		
UK	Y	978	773
Norway	N	0	0
Iceland	no data		
totals		7,279	5,220

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	1	0	0
Belgium	7	12	0
Bulgaria	2	0	0
Croatia	0	1	0
Cyprus	3	0	0
Czech Republic	0	0	0
Denmark	13	4	0
Estonia	0	0	0
Finland	0	0	0
France	n/a	n/a	n/a
Germany	n/a	n/a	n/a
Greece	3	0	0
Hungary	0	0	0
Ireland	1296	0	0
Italy	48	32	6
Latvia	0	0	0
Lithuania	0	0	0
Luxembourg	n/a	n/a	n/a
Malta	3	0	0
Netherlands	0	0	0
Poland	1	0	0
Portugal	0	0	0
Romania	1	0	5
Slovakia	214	66	0
Slovenia	1	0	0
Spain	5	1	0
Sweden	no data		
UK	771	2	0
Norway	0	0	0
Iceland	no data		
totals	2,369	118	11

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	0	0	0
Belgium	17	2	6
Bulgaria	4	0	0
Croatia	1	0	0
Cyprus	0	0	0
Czech Republic	0	0	0
Denmark	21	15	0
Estonia	0	0	0
Finland	0	0	0
France	562	134	0
Germany	n/a	n/a	n/a
Greece	1	0	0
Hungary	0	0	0
Ireland	0	0	0
Italy	47	7	1
Latvia	0	0	0
Lithuania	0	0	0
Luxembourg	n/a	n/a	n/a
Malta	0	0	0
Netherlands	0	0	0
Poland	1	0	0
Portugal	0	0	0
Romania	0	0	1
Slovakia	3	1	0
Slovenia	8	0	0
Spain	1	0	0
Sweden	no data		
UK	15	18	0
Norway	0	0	0
Iceland	no data		
totals	681	177	8

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	0	14	6,091.20	6,091.20
Belgium	N	0	0	25,398.42	25,398.42
Bulgaria	Y	30	72	n/a	-
Croatia	Y	60	46	33,727.33	4,551.59
Cyprus	Y	90	150	63,770.00	66,770.00
Czech Republic	-	0	0	-	-
Denmark	N	0	33.4	159,156.85	21,363.33
Estonia	-	0	0	-	-
Finland	-	0	0	-	-
France	N	0	29	-	-
Germany	N	0	n/a	n/a	-
Greece	Y	40	40	4,486.60	4,486.60
Hungary	Y	14	n/a	-	-
Ireland	Y	30	32	11,622,452.86	11,622,452.86
Italy	Y	60	16.2	226,621.08	226,621.08
Latvia	-	0	0	-	-
Lithuania	-	0	0	-	-
Luxembourg	N	0	14	n/a	-
Malta	Y	7	5	6,979.11	6,979.11
Netherlands	-	0	0	-	-
Poland	Y	-	45	7,513.26	1,735.16
Portugal	-	90	n/a	-	-
Romania	N	0	69.5	26,230.75	5,557.36
Slovakia	Y	30	30	289,819.78	289,819.78
Slovenia	Y	60	21	3,549.53	3,549.53
Spain	Y	90	46	19,658.37	19,658.37
Sweden	no data				
UK	Y	22.5	14.6	4,096,601.24	4,501,759.60
Norway	-	0	0	-	-
Iceland	no data				
TOTAL		23.98	27.65		16,806,793.99

Table 4.5 Raw Data: Patient Mobility with Prior Authorisation – where patients travel

(Those countries not providing data are left blank).

Country of Treatment

Country of Affiliation	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	TOTALS SENT
Austria	0	0	0	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	1
Belgium	0	0	0	0	0	0	0	0	0	11	1	0	0	0	1	0	0	0	0	0	0	2	1	0	0	0	0	2	0	1	0	19
Bulgaria	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	0	2
Croatia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Cyprus	0	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	1	0	3
Czech republic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Denmark	1	0	0	0	0	0	0	0	0	1	6	1	0	0	2	0	0	0	0	0	0	0	1	0	0	0	2	2	2	1	0	17
Estonia	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	0	0	0	0	0
Finland	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	0	0	0	0	0
France	10	306	1	1	1	161	1	0	0	0	670	17	0	0	47	0	0	0	193	0	5	4	49	0	1	0	581	0	19	0	0	2067
Germany	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Greece	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	1	0	3
Hungary	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	0	0	0	0	0
Ireland	1	1	0	0	0	4	0	0	0	4	4	0	0	0	1	0	0	0	4	0	0	3	30	0	0	0	0	0	0	1244	0	1296
Italy	37	3	0	2	0	1	0	0	1	10	26	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	2	0	0	0	84
Latvia	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	0	0	0	0	0
Lithuania	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	0	0	0	0	0
Luxembourg	9	56	0	1	2	4	2	0	3	14	402	7	1	2	20	0	0	0	0	0	2	9	59	3	0	0	54	1	6	0	0	657
Malta	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	3
Netherlands	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	0	0	0	0	0
Poland	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	0	0	0	0	0
Portugal	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	0	0	0	0	0
Romania	0	0	0	0	0	0	0	0	0	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Slovakia	0	0	0	0	0	280	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	280
Slovenia	0	0	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	1
Spain	0	0	0	0	0	0	0	0	0	2	2	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	6
Sweden	no data																															
UK	0	0	2	0	3	3	0	0	0	29	9	0	1	476	0	2	0	137	0	0	0	11	0	0	0	0	13	0	0	0	87	773
Norway	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	0	0	0	0	0
Iceland	no data																															
TOTALS RECEIVED	58	366	3	4	6	453	3	0	4	74	1126	27	5	478	74	2	0	141	193	0	12	59	108	3	1	1	654	3	1274	0	87	5219

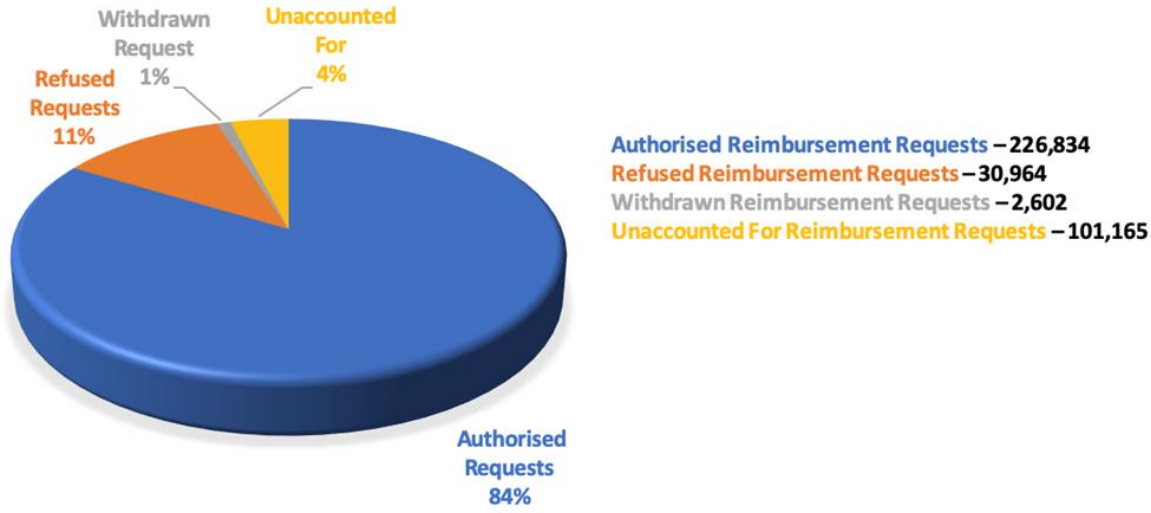
Section Four

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

During this year's survey, twenty-two Member States reported having received a total of 271,565 requests for reimbursement. Of these, 84% were authorised, with 30,964 being refused and less than 1% were withdrawn. There are however discrepancies between the total number of requests received and those for which data on grounds for acceptance or refusal are provided, indeed, certain Member States reported fewer outcomes than requests received. Though this discrepancy is not all that significant (around 10,000 fewer outcomes reported than requests received), it nevertheless shows that there are still some issues present with the recording of data on cross-border care.

Figure 6 Reimbursement Requests (grounds for reimbursement or refusal)



The average number of reimbursements made across the Member States was low, with three notable exceptions in France, Denmark, and Poland. Of the three outliers, France is by far the most significant with 157,585 reimbursements made. This number has remained roughly the same over the last few years with 130,070 and 143,475 requests granted in 2017 and 2016 respectively. This figure should, however, be treated with caution when compared with other Member States because, as France stated in their notes in all three years that data provided under section on treatment not requiring Prior Authorisation include all the reimbursements made to directly to insured persons for treatment abroad whether made under the Directive or the Regulation.

As in previous years, Denmark is again an outlier in 2018 with 26,715 reimbursements, which is a slight increase from 2017. Over the last three years we have seen that this is a constant for Denmark, for whom cross border dental care accounts for over 88% of the reimbursements made (29,155 requests concerned dental treatment in 2018). Poland likewise was an outlier in 2017 and 2018, but with no significant change in numbers between the two reporting periods.

2. Processing times relating to requests for reimbursement

In 2018, nineteen Member States and Norway provided data on the time taken to process a request for reimbursement for treatment. The average amount of time was 32 days with length of time ranging from 14 to 81 days. This is shows that there has, overall, been an improvement since 2017 when the average was 40 days (and 57 in 2016).

3. Amount reimbursed

The total amount reimbursed across the nineteen countries who reported in 2018, amounted to 56,413,782€, this ranged from a high of almost 13M€ in France to 6,740€ in Spain.

However, this figure does not paint an entirely accurate picture as the accuracy to which countries provided data varied greatly. Belgium, for example, was not able to report the number of requests for reimbursement, but was able to give a total spend on reimbursements, commenting that this was because not all health insurance funds have provided data on the number of requests received/granted/refused/withdrawn or inadmissible and they therefore preferred not to provide partial data that do not reflect the actual situation. Finland also reported only on the total costs, as 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.

Comparing the number of requests received and reimbursements made between 2018 and 2017, we see a small increase, as shown in figures 8 and 9 in the conclusion chapter of this report.

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 63% of all patient mobility where Prior Authorisation was not required.

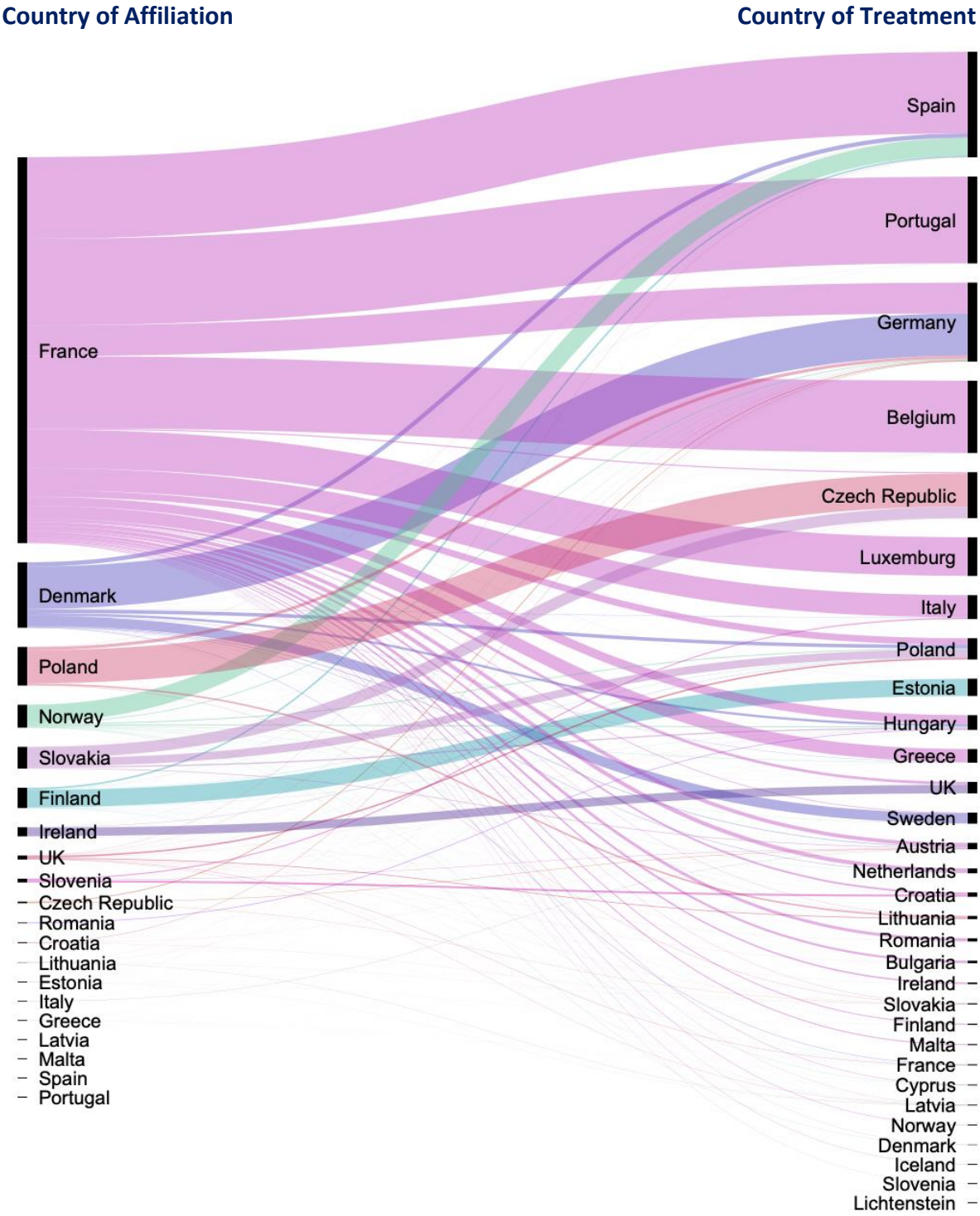
Setting aside the movement from France, the biggest flow being from Denmark to Germany, Poland to Czech Republic and Norway to Spain. It is notable that, as with care delivered on the basis of a Prior Authorisation, Germany and Czech Republic again feature among the biggest recipients of patients, and again from their neighbouring Member States.

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 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 trend towards greater patient mobility.

The Flow Map in Figure 7 below depicts the trends in Europe in which, we see the trend of higher patient mobility from a few Member States, while a majority of countries reported very limited patient mobility. As in the case of patient mobility based on Prior Authorisation, mobility in 2018, is very similar to that reported for 2017, with mobility being dominated by France with a further clustered in the Nordic countries as well as a considerable outflow from Norway to Spain.

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 – 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	Y	1	0	0	0
Belgium	N	0	0	0	0
Bulgaria	N	16	n/a	2	0
Croatia	N	375	270	99	6
Cyprus	N	0	0	0	0
Czech Republic	N	681	655	26	0
Denmark	Y	33,118	26,715	5,948	234
Estonia	Y	99	97	2	0
Finland	N	8,280	n/a	n/a	n/a
France	N	177,863	157,585	20,278	n/a
Germany	N	n/a	n/a	n/a	n/a
Greece	Y	59	50	2	3
Hungary	N	0	0	0	0
Ireland	N	5,413	3,703	63	1,617
Italy	Y	100	84	14	0
Latvia	Y	17	19	5	0
Lithuania	N	136	128	8	0
Luxembourg	N	n/a	n/a	n/a	n/a
Malta	Y	13	13	0	0
Netherlands	N	n/a	n/a	n/a	n/a
Poland	Y	18,666	15,751	808	446
Portugal	Y	13	1	0	12
Romania	N	1,102	331	91	26
Slovakia	N	9,782	8,878	621	116
Slovenia	N	1,604	1,523	37	44
Spain	N	18	10	1	4
Sweden	no data				
UK	N	2,559	1,648	309	94
Norway	Y	11,650	9,373	2,650	0
Iceland	no data				
TOTALS		271,565	226,834	30,964	2,602

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	30	N	0	-
Belgium	0	N	0	8,398,465
Bulgaria	n/a	Y	30	-
Croatia	81	Y	60	34,618
Cyprus	-	-	-	-
Czech Republic	15	Y	30	218,386
Denmark	13.3	N	0	1,662,199
Estonia	18.3	Y	30	97,000
Finland	60.9	N	0	468,285
France	29	N	0	12,944,780
Germany	n/a	N	n/a	n/a
Greece	40	Y	40	10,510
Hungary	n/a	n/a	n/a	-
Ireland	32	Y	30	11,622,453
Italy	13.8	Y	60	25,619
Latvia	40	Y	20	15,631
Lithuania	18	Y	30	113,587
Luxembourg	14	N	0	n/a
Malta	30	N	0	-
Netherlands	n/a	N	n/a	-
Poland	-	Y	-	7,769,345
Portugal	n/a	Y	90	-
Romania	69.5	N	0	448,991
Slovakia	30	Y	120	1,415,163
Slovenia	25	Y	60	309,541
Spain	58	Y	90	6,740
Sweden	no data			
UK	24.5	Y	22.5	3,106,052
Norway	35	Y	60	7,746,418
Iceland	no data			
TOTALS	32.37		772.5	56,413,782

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

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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Belgium	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	0	0	0	**0**
Bulgaria	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	0	0	0	**0**
Croatia	28	8	2		0	0	5	0	0	5	11	132	1	3	2	20	0	0	0	1	0	9	0	1	0	0	33	3	5	1	0	**270**
Cyprus	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	0	0	0	**0**
Czech Rep	187	0	1	0	0		0	0	0	3	0	344	1	0	0	0	1	0	0	0	1	1	12	0	1	96	0	3	0	4	0	**655**
Denmark	242	21	23	30	11	23		0	4	9	174	17266	121	959	2	126	20	0	55	14	12	187	1428	46	16	8	0	1756	4100	31	22	9	**26715**
Estonia	1	1	7	0	3	1	0		0	13	2	18	1	0	0	4	21	0	8	2	0	0	0	0	1	0	2	14	0	0	0	0	**99**
Finland	4	29	23	7	7	16	7	6963		0	37	83	15	74	1	15	46	0	21	0	3	24	116	15	19	10	1	687	33	5	11	0	**8272**
France	1522	29398	912	801	199	488	86	49	394		0	12561	5254	3629	635	9038	101	4	135	15740	425	1637	2720	35357	1206	135	78	33309	296	1122	208	146	**157585**
Germany	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**0**
Greece	2	13	2	0	8	0	0	0	0	0	10	4	0	0	0	7	0	0	6	0	2	0	0	0	0	0	0	1	0	4	0	0	**59**
Hungary	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	0	0	0	0	0	**0**
Ireland	2	3	0	0	0	17	0	5	0	6	6	34	1	5	0	2	5	0	35	0	0	3	114	0	0	4	1	7	0	3459	0	0	**3703**
Italy	66	2	0	1	0	0	0	0	0	2	2	10	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0	0	**84**
Latvia	0	0	1	0	0	0	0	6	0	0	0	6	1	0	0	0	0	0	2	0	0	0	0	0	0	0	0	3	0	0	0	0	**19**
Lithuania	1	0	0	0	0	1	0	5	0	2	2	23	0	0	0	0	48	0	0	0	0	0	21	0	0	19	1	1	1	5	0	0	**128**
Luxembourg	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**0**
Malta	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	0	**13**
Netherlands	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	0	0	0	0	0	**0**
Poland	20	0	0	4	1	13499	0	0	0	1	5	1281	0	2	0	20	0	0	694	0	0	0	0	0	0	139	0	78	0	7	0	0	**15751**
Portugal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Romania	17	0	0	0	0	0	0	0	0	0	10	12	0	276	0	7	0	0	0	1	0	1	1	0	0	0	0	5	0	1	0	0	**331**
Slovakia	310	9	8	11	0	4634	0	2	0	3	3	48	2	559	0	20	0	0	0	1	0	9	3249	3	5	0	0	3	0	2	0	0	**8878**
Slovenia	150	1	0	837	0	11	1	12	0	3	3	18	0	38	1	441	0	0	0	1	0	0	0	0	0	1	0	3	0	5	0	0	**1523**
Spain	1	1	0	0	0	0	0	0	0	0	4	0	0	0	0	1	0	0	0	1	0	0	0	0	0	1	0	0	0	1	0	0	**10**
Sweden	no data																																
UK	13	15	39	4	17	34	0	2	0	125	74	21	49	26	29	90	0	0	297	0	0	6	645	8	35	33	1	81	1	0	1	0	**1646**
Norway	41	14	35	54	108	24	104	14	48	48	343	165	396	2	21	22	0	54	1	8	90	395	46	9	8	0	7173	96	38	0	16	**9373**
Iceland	no data																															
TOTALS RECEIVED	**2608**	**29515**	**1053**	**1749**	**354**	**18753**	**198**	**7062**	**474**	**442**	**32257**	**5583**	**5990**	**669**	**9755**	**354**	**4**	**1301**	**15768**	**449**	**1969**	**8701**	**35476**	**1292**	**455**	**117**	**43128**	**4532**	**4694**	**242**	**171**	**235115**

Country of Affiliation

Section Five
Comments from Member States

The final section of the report provided free text space for the National Contact Points to provide additional information to report pints which would clarify the numbers they had, or had not, been able to report. Nineteen Member States 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 ask 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, Estonia, 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 neighbourhood and the morphology (mainland and hundreds 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

1. Cross-Border Healthcare in the EU under the Directive in 2018 compared to 2017

The data collected on patient mobility in 2018 demonstrate that 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 Authorisation. The grand total of cases of patient mobility, both with and without Prior Authorisation reported for the year 2018 was 232,054 a slight increase from 2017 which saw 205,417 cases of pre-authorised and reimbursed mobility under the Directive.

The total spends on all reimbursements reported by the Member States also rose in 2018 was approximated 73.2M€, while in 2017 it was approximately 49.9M€. The most significant rise in numbers between the two years was in the number of requests for information on treatment abroad which more than doubled in 2018, rising from 69,723 to 95,565 with a major share in both years being made by phone.

Figures 8, 9 and 10 below demonstrate these rises.

Figure 8 Patient Mobility with Prior Authorisation 2017-2018

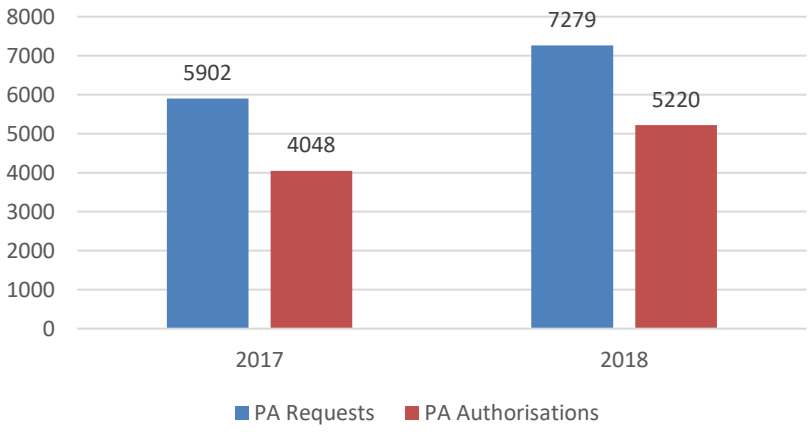


Figure 9 Patient Mobility not requiring Prior Authorisation 2017-2018

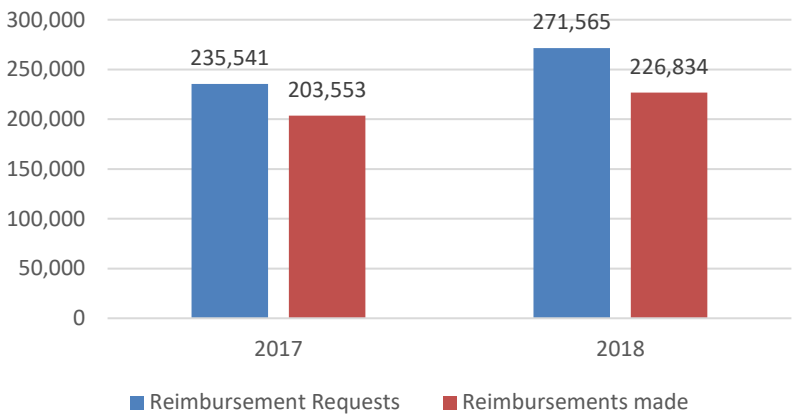


Figure 10 Requests for Information 2017-2018

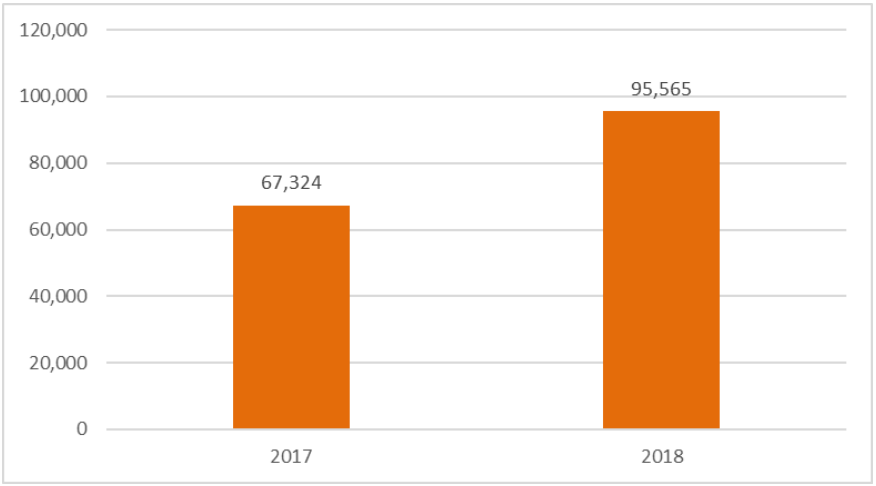
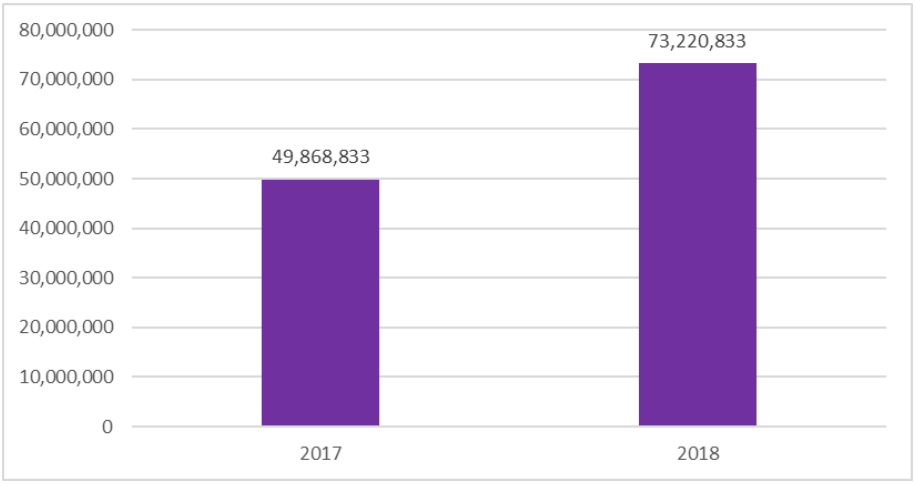


Figure 11 Total Reported Spend on Reimbursements 2017-2018 (with and without PA)



The data depicted in the Flow Charts for 2018 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.

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 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

It is interesting to consider the reports on patient mobility under the Directive in the context of all patient mobility for care, given that such healthcare in another EU country may be reimbursed under the Directive, the Regulations and a number of parallel schemes. While the data on reimbursement under the Regulations for 2018 are not yet available, the data published in the 2017 Statistical Report on the Coordination of Social Security Systems allow us to build up a bigger picture of all cross-border planned and unplanned care. The Report also provides some data on parallel schemes, allowing some comments to be made also on the impact of these schemes of cross-border care generally.

2.1 Unplanned Care reimbursed under the Regulations

Unplanned care, or treatment that becomes necessary when a citizen is in a country other than their own Member State, are covered by the Regulations and usually administered through the European Health Insurance Card (EHIC). The claims are handled either through the E125 form, where the claims are made from one country to another, or through the E126 form, where a patient pays at the point of care and then seeks reimbursement when returning home. The 2017 Statistical Report indicates that the EHIC scheme is working well, as more than nine out of ten of reimbursement claims for unplanned necessary treatment abroad are settled between the Member State of stay and the competent Member State, and not between the insured person and the competent Member State (i.e. by E125 rather than E126). In 2017, some 2 million E125 forms were issued by the reporting Member States with claims amounting to more than €1 billion.

The biggest flows of payment for unplanned care under the EHIC scheme were from France to Italy and Belgium, Germany to Austria and UK to Spain; the patterns of patient mobility are therefore very similar to those under the Directive.

In terms of total budgetary impact, the 2017 Statistical Report shows that unplanned care reimbursed under the Regulations amounts, on average, to 0.12% of total healthcare spending related to benefits in kind of a Member State; only Bulgaria, Romania, Slovenia and Lithuania showed a cross-border expenditure of more than 0.5% of total healthcare spending, and of those only Bulgaria was significant in reporting that 1.56% of total health care expenditure was on cross-border care.

The coming into force of the Directive has had very limited impact on the number of claims made under the Regulations for unplanned care, because reimbursement made under the Regulations

covers the actual treatment costs incurred, rather than the tariffs for the same treatment in the home country. However, the 2017 Statistical Report noted that a small minority of patients receiving unplanned care elected to seek reimbursement through the Directive rather than the Regulations. This seems however to be limited to rare cases where the patient could not use the EHIC and found that claiming through the Directive route was quicker or easier than the E126 route

2.2 Planned Care reimbursed under the Regulations

In the case of planned care, the patient will apply for a certificate of coverage, referred to as Portable Document S2 (PD S2). In 2017 about 9 out of 100,000 insured persons received a PD S2, with only Luxembourg showing a significantly high volume of patient mobility to receive planned healthcare in another Member State (some 15 out of 1,000 insured persons received a PD S2). As in the case of the reported figures on patient mobility using the Directive, the reported mobility under the PD S2 route shows a very concentrated use of planned cross-border healthcare within a limited number of Member States, the 2017 data show five main flows of planned cross-border healthcare by a PD S2:

- France to Belgium (17,733 PDs S2)
- Luxembourg to Germany (7,156 PDs S2)
- Germany to Austria (4,610 PDs S2)
- Germany to Switzerland (4,477 PDs S2)
- Luxembourg to Belgium (3,374 PDs S2)

However, as in the case of reporting on patient mobility under the Directive, the figures reported in the 2017 Statistical Report are not as robust as they might be. The report showed that 30, 456 PD S2s were issued, but noted that Germany, Estonia, Ireland, and Sweden were not able to provide data on PD S2 forms issued, however as other countries reported the number of forms received from these countries, some figures for non-reporting countries exist, thus we know that Germany gave permission for at least 4,610 patients to travel to Austria, because Austria reported treatment of these patients.

Despite the lack of a full report from all counties, the 2017 Statistical Report indicates that roughly nine out of every ten PD S2s were issued for treatment in an EU 15 MS, and eight of those ten were for treatment in a neighbouring country.

The patterns of patient mobility under the Regulations are therefore very similar to those under the Directive, even if the numbers are more significant under the Regulations. It is interesting to note also a significant similarity in cases where an application for a PD S2 was refused. Under the Directive, 13% of requests for Prior Authorisation were refused, while under the Directive the average refusal rate 14%, and just as in the case of the Directive, the most common reason for refusal was that the care was available in the home State in a reasonable timeframe.

In terms of budgetary impact, planned cross-border healthcare under the Regulations provided on the basis of a PD S2 in 2017 amounted to 0.02% of total healthcare spending related to benefits in kind.

As in the case of unplanned care, Member States were invited to comment if they believed the Directive had had any impact on numbers of patients seeking cross-border care using the Regulations route. Only Belgium and Poland reported that they believed that the Directive had had an impact

on the number of PDs S2 issued. According to Belgium this could be explained by a stricter application of the rules under the Regulations than under the Directive; while Poland noted that they believed the entry into force of the Directive had raised general awareness of the possibility of receiving medical treatment abroad.

2.3 Parallel schemes for funding cross-border patient mobility

While the Regulations bring clarity to the way in which the fundamental freedom of movement of workers enshrined in the Treaties applies to the right to access healthcare in another country, and the Directive codifies the landmark judgements of the European Court of Justice between 1998 and 2010 on the freedom to provide services in the field of healthcare; they are not the only legal tools that shape cross-border care.

Alongside the procedures determined by the Regulations and the Directive, several Member States reported the existence of parallel procedures adopted under national legislation. The 2017 Statistical Report includes some comment on such parallel procedures, noting that they exist in Austria, Belgium, Czech Republic, Denmark, Greece, Croatia, France Finland, Hungary Italy, Malta, Poland, Portugal, and Sweden.

While the volume of these parallel schemes in terms of number of treatments provided abroad is only available for certain schemes, the 2018 Statistical Report notes that where figures are available, the patient flows under these parallel schemes are often much larger than under the Regulations and Directive. In Belgium, for example, a total of 13,678 permissions were issued under parallel procedures, of which 8,383 came within the IZOM[4]-agreement between Germany, The Netherlands and Belgium, yet Belgium reported issuing only 280 PD S2s under the strict rules of the Regulations. Similarly, Portugal reported that its medical assistance abroad programme covered 436 authorizations for the treatment or the performance diagnostic tests not available in Portugal, but reported only 60 PD S2s in 2017.

The exact number of parallel schemes in operation is not known, however Cross Border.CARE, a study funded by the European Commission to map EU funded cross-border healthcare initiatives, identified 426 initiatives undertaken between 2008 and 2018 which all addressed some element of cross-border care. The initiatives described in the study are wide ranging and include many focussed on training, knowledge sharing and resource development as well as several developed to provide direct patient care.

The study also identified a number of key factors that lead to the success in cross-border care initiatives, including that cross-border healthcare initiatives are more effective in regions where ease of cooperation is already established. Based on the findings of Cross Border. CARE study, as well as the case studies reported in the publication European Cross-Border Cooperation on Health: Theory and Practice which was developed to mark the 25th Anniversary of European Territorial Cooperation (better known as Interreg), one example of a successful bi-lateral scheme is described in more detail overleaf.

The various parallel schemes that exist are important as they have grown out of real, practical needs in specific regions and serve patients populations who may reasonably be predicted as wanting to avail of cross-border care, often because the hospital nearest to them geographically is located

[4] Integratie Zorg Op Maat (Integration of Tailored Care)

across a national border, as demonstrated by the list of six agreements currently in force in the Alsace Franco-German Region provide an example of specific agreements and healthcare treatment provided[5]:

Major Burns Agreement (Signed 10/2/2009)
Between the BG Unfallklinik of Ludwigshafen to be used when French hospitals in the region cannot meet demand.

Urgent Care Agreement (signed 10/02/2009)
Between the regions of Alsace in France and Bade-Wurtemberg in Germany to provide urgent care in the nearest hospital regardless of the origin of the patient

Urgent Care Agreement (signed 10/02/2009)
Between the regions of Alsace in France and Rheinland-Palatinat in Germany to provide urgent care in the nearest hospital regardless of the origin of the patient.

Child and Adolscent care Ageement (Signed 21/12/2011)
Between the CPAM of the Bas-Rhin in France and the Oberlin School in Kork in Germany.

Transborder Cardiology Agreement (signed 19/03/2013)
Between the Unisanté hospital in Forbach, France the SHG Kliniken Völklingen, Germany for all cardiac care.

Transborder Epilepsy Care Agreement (signed 14/09/2014)
Between the University Hospital of Strasbourg, France and the Epilepsiezentrum in Kork, Germany to provide care for all epilepsy patient in the border at optimal speed.

[5] https://www.cleiss.fr/docs/cooperation/cc-france-allemagne.html

The Franco-German inter-hospital Cardiology Agreement

- The Lorraine coalfield area in France has alarming mortality statistics for cardiovascular diseases, and in addition faces a shortage of doctors.
- The re-organisation of healthcare in the Lorraine coalfield area in designated the hospital at Forbach (France) as a cardiac intensive care unit.
- Forbach ran into difficulties in meeting the necessary conditions for commissioning, however, just a dozen kilometres away, the HerzZentrum Saar - the German cardiology centre Völklingen - had substantial resources for treating cardiac problems.
- Forming a partnership project with Völklingen was the obvious thing to do.

Objective: The aim of the inter-hospital partnership is the joint organisation and development of cardiac care in a sustainable manner.

The cardiology partnership has a threefold aim:

- optimisation of patient care for heart attack victims within the sector covered by the mobile emergency and intensive care services (SMUR) in Forbach;
- despite the medical problems of demography, the maintenance of high quality cardiac care at the Centre Hospitalier Marie-Madeleine in Forbach and strengthening the medical team in the care unit;
- organisation of the sharing of good practices between health professionals and encouragement of bilingualism among medical and non-medical staff.

Functioning The agreement between Forbach and Völklingen has been operational since 2 April 2013, to the great satisfaction of health professionals, patients, hospital managers, the ARS and the health ministry in Saarland.

- Since the project was set up, a growing number of staff at the two hospitals are becoming bilingual.
- More specifically, since the project came into force, the hospital in Völklingen has been recruiting bilingual doctors.
- Overall, the inter-hospital partnership provides high quality cardiac care in Forbach through strengthening the medical team with bilingual cardiologists from Völklingen.
- In practice, this care is initially provided in Völklingen; after three days on average, patients can be transferred to Forbach.
- Although the project is a success, it remains relatively limited, at the geographical level, it only applies to certain border municipalities,
- and thus to a restricted area, while at a medical level it only concerns diagnoses of acute ST+ infarction.

Appendix 1
Specific Comments from the respondents

Country of affiliation	Comment
Austria	Have you introduced measures regarding facilitating access to treatment according to Article 4.3 of Directive 2011/24/EU - Provide patients with relevant information on treatment options and quality and safety; - Apply professional treatment - in a non-discriminatory manner; - Respect privacy in processing personal information; - Supply patients with a copy of the record of their medical treatment.
Belgium	Section 3.1.b) - authorisation/processing times : 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: 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 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 2018, we granted 1 prior Authorisation (hospital treatment requiring a stay of at least one night) ; amount of reimbursement not yet known 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 € 18.554,88 for health care provided in Switzerland not requiring a prior Authorisation.
Bulgaria	/
Cyprus	/

Croatia	An explanation for point 4.1.b.: The average time for dealing with requests for reimbursement is longer than a maximum time limit according to Croatian legislation because in each case we have to check whether health care was used in a private health care provider or in provider which is covered by the compulsory health insurance of some EU Member State. The reason for such procedure is insisting of our insured persons that their requests be solved according to EU Regulations (883/04 and 987/09). In some cases, correspondence with other EU Member State takes longer than 60 days (which is our maximum time limit).
Czech Republic	/
Denmark	RE. SECTION 1.2 - Unfortunately, we are not able to specify the number of NCP requests by media. Therefore, we have only provided the total number of requests for the year 2018. The submitted data is based on estimates. RE. SECTION 3.1.a - In some cases prior Authorisation have been refused for other reasons than those mentioned in article 8.6. of the directive, for example if the patient did not have a referral in cases where it is required according to the Danish legislation. Refusals of prior Authorisations in such cases are not reflected in the questionnaire. Therefore, the total number of refused requests under section 3.1.a does not correspond to the number in section 3.1.e. RE. SECTION 4.1.a - In 2018, Denmark received 33.118 requests for reimbursement of which 29.155 concerned dental treatment.

Estonia	Section 1.2 Our data regarding information requests have become more detailed to do new information systems.
Finland	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.
France	Data from general scheme (CNSE): It's not possible for us to distinguish the care provided under the European Regulations CE n°883/2014 from those provided under the Directive 2011/24/EC. Therefore, data provided under section "treatment not requiring PA" include all the reimbursements made in 2018 for treatment abroad without PA whether it is under CE n°883/2014 or Directive 2011/24/EC.

Germany	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 %).
Greece	/
Hungary	/
Ireland	All figures provided are based on applications received from 01/01/2018 to 31/12/2018 and their status at 31/12/2018. Reimbursements figures are based on claims received from 01/01/2018 and paid by 31/12/2018. Applications that were received in late 2017 and reimbursed in 2018 are included in the reimbursement figures. Claims received in late 2018 are included in the applications received. Where reimbursement for such claims was processed in 2019 such figures will be included in the 2019 report. All information provided is specific to applications both received and actioned or reimbursed in 2018 solely. Prior Authorisations deemed withdrawn/inadmissible are mainly applications where the patient did not apply for prior approval before their proposed treatment but would however have been eligible for prior approval had they applied. 3.1 e) Refused requests for prior Authorisation by reason for refusal. - The 15 applications refused prior Authorisation were for the following reasons: - 9 applicants did not provide a valid referral pathway in line with the member state. - 4 applicants accessed private consultations in Ireland and therefore were not eligible under Cross Border Directive. - 1 applicant did not have eligibility for their treatment in Ireland. - 1 applicant did not attend an initial consultation abroad prior to their treatment and therefore did not follow the public pathway in Ireland.
Italy	/
Latvia	In 2018 our legislation concerning prior authorization changed and starting from September of 2018 there is no prior authorization required to receive treatment abroad. When counting NCP information requests by phone, they are limited to calls only to one single phone number, which was originally specifically designated for the NCP. However, our NCP receives questions about cross-border health care also to other phone numbers of the National Health Service, which are not counted. Therefore, in reality the number of requests is higher. We are still not collecting data about information requests in person.
Lithuania	Information Information requests (point 1.2.) indicate all requests concerning the reimbursement of expenses for the healthcare services abroad under European Union legislation in general. This information includes requests concerning the reimbursement under Regulations on the coordination of social security systems and Directive 2011/24/EU as well.

Luxembourg	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 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: Healthcare not subject to prior authorization 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.
Poland	Section 3.1 b) It is difficult to indicate precisely the average time of processing the requests 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 requests (because sometimes they do not indicate days which should not be included in the time limit). Section 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 should take maximum 30 (calendar) days from the date of initiation of proceedings. In a situation when the assessment of the request requires further investigation the deadline is 60 days from the date of initiation of proceedings. However in a situation where assessment of the request would require 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 of the request is extended to 6 months from the date of initiation of proceedings. Section 3.2 a): In respect of 'the average time (in working days) for dealing with requests for reimbursement in 2017' - the data are given in days, not in working days. Section 4.1 b): In respect of 'the average time (in working days) for dealing with requests for reimbursement in 2018' - 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.

Portugal	Under the national legislation, the national health system provides health care abroad, when cannot be given such treatment within a time-limit which is medically justifiable, taking into account his current state of health and the probable course of his illness, or there is no adequate treatment in the health system. The expenses related to medical treatment, travel and allocation, for the patient and accompanying person, will be assumed by the National Health System with no charge for the patient. Taking into account that the legislation, and coverage of the National Health System, the request for health care to be provided under the Directive are very low.
Romania	1) at pnt 3.1 let a), at the heading "Number of withdrawn/inadmissible requests": - reasons: no number of requests considered withdrawn/inadmissible. 2) 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. 4. In 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	3.1 b- time from receipt of the application for reimbursement of costs until the decision is issued (not just working days) 4. system for prior notification: patient can obtain an informative calculation before access cross-border healthcare 4.1 b- time from receipt of the application for reimbursement of costs until the decision is issued (not just working days)/
Spain	The difference between the total of received requests and the total of authorised, refused and withdrawn/inadmissible are due to the number of requests received at the end of 2017 and 2018 (solved in 2018 and 2019 respectively).
UK	Wales – 4.1(b) The All Wales Procedure includes a target of 20 working days for dealing with requests for reimbursement, however this is suspended when further information needs to be obtained. The average across LHBs in Wales in 2018 of 23.8 working days for requests for reimbursement for treatment not requiring PA includes an outlier from a single LHB of 57 days for a small cohort of cases. Excluding this LBH, the average processing time was 15.5 working days in 2018.
Iceland	/
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	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	EU 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	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

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

Lithuania

Name	Ministry of Health of the Republic of Lithuania
Affiliation/Organisation	/
Website	http://sam.lrv.lt
Telephone	+37052193308

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	Het CAK
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, Consumer Affairs and Social Welfare
Website	http://www.mscbs.gob.es/en/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