Evaluative study on the cross-border healthcare Directive (2011/24/EU)

Final report

21 March 2015

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This document does not represent the position of the European Commission and does not represent European Commission's Recommendations. The interpretations and opinions contained in it are solely those of the authors.

Contract number: SI2.684413

SANCO/2012/02/011 – Lot 1

Written by KPMG Advisory Spa, Technopolis group; empirica GmbH
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Directorate-General for Health and Food Safety
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Directorate-General for Health and Food Safety
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GLOSSARY

ATM	Automated Teller Machine
CABG	Coronary artery bypass graft
CBHC	Cross-border healthcare
DcR team	Data collection and research team
DRG	Diagnosis-related group
EC	European Commission
ECJ	European Court of Justice
EQ	Evaluative question
EP	European Parliament
EU	European Union
GDP	Gross Domestic Product
GP	General practitioner
HCP	Healthcare provider
HIP	Health insurance provider
HoNCAB project	Support creation of a pilot network of hospitals related to payment of care for cross border patients
JCI	Joint Commission International
ISO	International Organization for Standardization
MRI	Magnetic resonance imaging
MS	Member State
NCP	National contact point
NHI	National health insurance
NHO	National healthcare organisations
NHS	National Health Service
PG	Patient groups
PO	Patient ombudsman
PTCA	National Health Service
SAI	Specific analytical items
SWOT	Strengths, weaknesses, opportunities and threats
TOR	Terms of Reference
TFEU	Treaty on the Functioning of the European Union
WHO	World Health Organisation

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The contents of this report solely represent the view of the consortium.

The consortium does not take any responsibility for the accuracy of the statements of the stakeholders involved in the study.

EXECUTIVE SUMMARY

Background, approach and validity

The deadline for transposition into Member States legislation of the Directive 2011/24/EU on the application of patients' rights in cross-border healthcare was 25 October 2013. Article 20 of the Directive requests a report to be submitted by 25 October 2015 to the European Parliament and to the Council including information on related processes in place and the overall operation of the Directive in the first years of its implementation.

The present study therefore aimed at analysing the functioning of the Directive by means of a number of evaluative questions, which may be grouped according to three main areas:

- Reimbursement of cross-border healthcare;
- Quality and safety of cross-border healthcare;
- Undue delay.

The study was carried out at EU-28 level with the aim of gathering reliable and comparable information from all Member States on the implementation of the Directive.

In order to perform an in-depth assessment, the study sampled 12 focus countries in which the analysis was broadened. In this sample, countries with a certain level of existing cross-border activity were preferred as well as those likely to represent the different structural, organisational and economic features of all Member States with respect to health care organisation.

The assessment addressed 28 evaluative questions set out in the Tender Specifications. The study applied a mixed-method approach, developing analytical tools with a high level of detail so as to triangulate the information but also to address the complexity of the Directive's implementation.

The main stakeholders involved were the National Contact Points, healthcare provider organisations, individual health insurance providers, patient groups, trade unions, ombudspersons and healthcare inspectorate /audit bodies. These categories were defined in the Terms of Reference and were extended in order to assure a wider involvement of interested parties with the aim to obtain as much information and data as possible. We selected more than 120 contacts, at both country and European levels, of which 50% were interviewed or completed the online survey.

The study included a pseudo patient investigation exercise on the Directive's implementation. This was instrumental in understanding the operational functioning of the Directive as well as the critical role of National Contact Points. The pseudo patient investigation was pursued due to its extensive use in research on the pharmacy/customer interface relationship - the statutory quality assurance scheme of the German Chamber of Pharmacists is a good example of its use.

The indications are clear that cross-border healthcare is moving at a fast pace with yet still immense potential to grow in the years ahead. The Directive's implementation also coincides well with the upcoming launch of the European Reference Network, an innovative platform for knowledge and best practice sharing.

The study was hampered by a lack of quantative data available – analysis of patient mobility and preferred medical destinations was therefore not performed. In addition the broad array of topics (eHealth, health technology assessments, European reference networks, rare diseases etc.), the absence of Member State data, and the impact of time lag in decision-making in addition to the limited size of the evaluation presented numerous challenges. The study was therefore unable to measure at least in quantative terms the full effects of the Directive's implementation in its initial years. In this vein it remains uncertain whether the findings deduced are relevant to the entirety of the National Contact Points or to a reprensentative subset of them. Nevertheless the study succeeded in providing substantial insights into the implementation of the Directive through broad sampling and by identifying the main trends and obstacles.

In this report, preference has been given to a non-nominal use of the stakeholder interviews and survey materials. As a general finding, all the stakeholders involved confirmed that the number of patients that made use of cross-border healthcare under this Directive is still very low.

Overview of the main findings of the study

The main findings of the study are set out below, according to the three aspects subject to analysis: Reimbursement, Quality and Safety, and Undue Delay.

Reimbursement

The study analysed the dissemination of information concerning the Directive and the central role of the National Contact Points. Overall, meaningful steps have been taken to implement the provisions of the Directive across the European Union, but in most cases further progress is still possible and indeed desirable. The stakeholders interviewed state that citizens are not adequately informed about the new opportunities available under the Directive and in a similar vein not aware of the existence of National Contact Points.

The small number of information requests received by National Contact Points and the small number of reimbursement requests forwarded to health insurance providers could be seen as a consequence of this lack of awareness.

Nevertheless, it was demonstrated through both, the pseudo patient investigation exercise and interviews with National Contact Points and health insurance providers, that most National Contact Points provide information with a satisfactory level of detail when they are requested to do so.

National Contact Points inform citizens about the categories of treatments subject to prior authorisation and, in some cases, make available detailed lists on their websites.

There are differing practices in Europe regarding prior authorisation. On the one hand, some countries, such as Sweden, do not require prior authorisation for any service; while countries, such as Italy, have created a procedure for an advanced prior authorisation request consisting of an additional document verification step to decide whether the authorisation is needed.

According to the results of the present evaluative study, no specific problems have been identified with the reimbursement procedure. The relationship between the different reimbursement procedures in Member States and their relative merits were found to be important. Regarding prior authorisation and corresponding reimbursement, each cross-border healthcare claim requires an individual assessment on a case-by-case basis by

health insurers. In certain cases, health insurance claims for cross-border healthcare can result in undue administrative workload. The main sources of this administrative burden on insurers include translation costs (where not covered by patients) and the review and processing of medical documentation.

Leading on from this, a number of disparities exist with the information provided by the National Contact Points and health insurance providers regarding procedures and documentations to be submitted. This could be overcome by better co-ordination between the National Contact Points and health insurance providers. Language differences are not considered as a significant problem, as long as the health insurance providers, and not the citizens, are in charge of translations.

Interviews with health insurance providers reveal that working with cross-border referrals and documentation under the Directive does not present particular burden for them in terms of administrative workflow and that they are able to process those without any difficulties. For such cases, the necessary time period for reimbursement is slightly higher than in case of national reimbursements.

As far as the applied tariffs are concerned, stakeholders reported that they are in accordance with the Directive, namely that patients seeking cross-border treatment are subject to the same rates as local citizens – these prices being available on a public list, often published online.

Results point out that the responsibility for choosing the treatment provider stays with the patients. Research tools available on Member States' websites often help them in making their choices. However, patients are often more influenced by the advice of other patients or acquaintances. Patients are then responsible for proving that the treatment was carried out, and for submitting the relevant documentation.

In summary, with reference to the reimbursement process, there are no apparent problems or particular administrative burden at this stage of the Directive's implementation process. However, it should be kept in mind that an increase in patient numbers seeking cross-border care may reveal unforeseen concerns.

Quality and safety

Information on quality and safety is available on most National Contact Point websites, but it is often not comprehensive. In some cases, links are only provided to the general description of hospital evaluation systems featuring safety parameters, such as mortality rate, number of cases treated with complications, renewed operations due to complications, infection after the surgery.

The interviews show that quality of care is not considered a key driver in patients' choices. Patients often request necessary information subsequent to their choice, which is in many cases guided by the experience of other patients and acquaintances.

Patient groups stated that administrative burden concerning prior authorisation and procedures rather than quality and safety are the main reasons that prevent patients from using the Directive.

The pseudo patient investigation exercise indicated that National Contact Points do not directly disclose information on quality and safety relating to healthcare providers outside their country or region. Nevertheless, they provide information on whether a specific provider is authorised, under the given national rules, to provide a specific treatment.

National Contact Points actively co-operate with government organisations, insurers and healthcare providers. Cooperation with patient organisations varies significantly across Member States. Interviews with frontline prescribers and healthcare providers show that the right to follow-up care is always guaranteed to patients who undergo treatment abroad. The issue of aftercare has therefore not been flagged up as a complication by the present evaluation.

Since the number of cases under the Directive is still limited, no administrative problems appear to exist linked to quality and safety. However, the interviews showed that in cases where prior authorisations are necessary, health insurance providers often obtain information on healthcare providers by directly contacting the National Contact Points, or the relevant provider, and verify whether such providers comply with local quality and safety requirements.

Undue delay

The study revealed that there is a general concept well shared among different entities regarding the definition of waiting times. Websites of governments or health insurance providers often disclose information on the average waiting times for different treatments. Using this data, the study compared the average waiting times for certain countries.

There are large differences in Member State practices in terms of undue delay. From interviews with patient groups, it appeared that patients are aware of their waiting time when requesting treatment. Furthermore, undue delay is most often evaluated on an individual basis.

There are only two countries among those analysed (The Netherlands and Denmark) where specific rules determine the maximum waiting times for all treatments. In these cases, the most frequent option is to leave the citizen free to choose a private national provider and have the services reimbursed accordingly. The procedure in Denmark has given patients the right to seek assistance abroad since 2008, a right now granted to all European citizens with the introduction of the Directive.

Outlook

The Directive is at an early stage of implementation. Due to the small number of related cross-border healthcare referrals, some of the Directive's fields of application are not mature enough to be evaluated. This study represents a starting point to evaluate the evolution of the Directive in the future. Further evaluative efforts require a stronger focus, for example, on not only identifying good practices, but also addressing barriers to their implementation across Europe.

A major outcome of this study is that the Directive's implementation could benefit from more targeted and regular publicity and communication activities. Evidence indicates that demand for cross-border healthcare would be larger should the patients be made aware of the possibilities offered. This could be achieved by facilitating provision of additional information not only on citizens' rights, but also on the specific steps that need to be followedfor each individual request on procedures and other administrative aspects. Moreover this could be further assisted by enhancing the usefulness of the information provided on the websites of the National Contact Points through cross-referencing and by involving patient organisations in defining standard requirements:

- provide additional information not only on citizens' rights, but also on the specific steps that need to be followed at individually concerning procedures and any related administrative aspects;

- enhance the usefulness of the information provided on the websites of the National Contact Points through cross referencing and by involving patient organisations in defining standards' requirements.

RAPPORT EXECUTIF RESUME

Base rationnelle, contexte et approche

Les Etats Membres ont eu l'obligation de transposer dans leur législation la Directive UE 24/2011 relative à l'application des droits des patients en matière de soins de santé transfrontaliers avant le 25 octobre 2015. Conformément à l'article 20 de cette Directive, un rapport doit être soumis au Parlement européen et au Conseil avant le 25 Octobre 2015, incluant des informations sur les processus en place et l'application générale de la Directive dans les premières années de sa mise en œuvre.

La présente étude vise ainsi à analyser le fonctionnement de la Directive au moyen d'un certain nombre de questions d'évaluation pouvant être regroupées en trois groupes principaux :

- Le remboursement des soins de santé transfrontaliers.
- La qualité et la sécurité des soins de santé transfrontaliers.
- Le temps d'attente pour l'accès aux soins.

L'étude a été menée à l'échelle des 28 Etats membres avec comme objectif la collecte d'informations fiables et comparables sur la mise en oeuvre de la Directive dans toute l'Union européenne.

Afin d'effectuer une évaluation approfondie, l'étude s'est penchée sur un échantillon de 12 pays qui ont fait l'objet d'une analyse plus détaillée. Ces pays ont été choisis ou bien pour leur niveau élevé d'activité transfrontalière, ou bien pour leurs systèmes de santé représentant au mieux dans leur ensemble la diversité européenne en termes de structure, organisation et économie.

L'étude s'adresse aux 28 questions d'évaluation formulées dans le cahier de charges. Une méthode basée sur approche mixte a été mis en œuvre s'attachant à développer des outils analytiques très détaillés afin non seulement de trianguler l'information, mais aussi de répondre à la complexité de la mise en œuvre de la Directive.

Les principales parties prenantes impliquées dans l'étude furent les points de contact nationaux, des organismes prestataires de soins de santé, des prestataires d'assurance maladie individuelle, des groupes de patients, des syndicats, des médiateurs et des organismes d'inspection de santé/organismes d'audit de santé. Ces catégories avaient été définies dans le cahier de charges et ont été élargies afin d'assurer une implication plus large des parties intéressées et d'obtenir ainsi le plus d'informations et de données possible. Ont été pris en compte plus de 120 contacts, dont 50% ont été interviewés ou ont rempli une enquête en ligne.

L'emploi d'une méthode d'enquête basée sur l'utilisation de pseudo patients sur la mise en œuvre de la Directive a fortement contribué à la bonne compréhension du fonctionnement opérationnel de la Directive ainsi que du rôle critique des points de contacts nationaux. L'enquête au moyen de pseudo-patients a été menée en référence avec son utilisation étendue dans les recherches sur l'interface pharmacie/utilisateur, l'assurance qualité officielle de l'ordre des pharmaciens allemand étant un bon exemple de son utilisation.

Il apparaît clairement que les soins transfrontaliers sont en train d'évoluer rapidement avec un important potentiel de croissance dans les années à venir. La mise en oeuvre

de la Directive coïncide également opportunément avec le prochain lancement des Réseaux de Référence Européens, une plateforme innovante pour le partage des savoirs et des bonnes pratiques.

L'étude est limitée par la faible disponibilité de données quantitatives - une analyse de la mobilité des patients et des points de destination médicales préférées n'a donc pas été effectuée. De plus, la diversité des sujets (e-santé, évaluation des technologies de la santé, Réseaux de référence européens, maladies rares etc.), le manque d'indicateurs au niveau des États membres, les délais nécessaires dans les processus décisionnels et la taille limitée de l'évaluation ont présenté parmi les nombreux défis. L'étude d'évaluation n'a pas été ainsi en mesure d'estimer en termes quantitatifs l'entièreté de l'impact de l'application de la Directive au niveau des 28 États membres dans les premières années de sa mise en œuvre. Dans cet ordre d'idées, il n'est pas non plus possible de mettre suffisamment en évidence dans quelle mesure les généralisations faites seraient applicables à l'intégralité des points de contact nationaux ou seulement à une partie représentative de ceux-ci. En dépit de cela, des informations importantes ont pu être obtenues sur la Directive en utilisant un large échantillonnage et par l'identification des principales tendances et obstacles.

Dans ce rapport, la préférence a été donnée à une utilisation non-nominale des entretiens et des documents d'enquête. Le constat général, confirmé par tous les acteurs impliqués, est que le nombre de patients ayant fait usage de soins de santé transfrontaliers en vertu de cette Directive reste très faible.

Aperçu des principaux résultats de l'étude

Les principaux résultats de l'étude sont présentés ci-dessous, selon les trois aspects soumis à l'analyse: le remboursement, la qualité et sécurité, le temps d'attente excessif.

Remboursements

L'étude a analysé la diffusion des informations sur la Directive et le rôle vital des points de contact nationaux. Dans l'ensemble, des mesures significatives ont été prises pour mettre en œuvre les dispositions de la Directive dans toute l'Union européenne, cependant que dans la plupart des cas, des progrès sont encore possibles.

Les acteurs interrogés considèrent que les citoyens ne sont pas suffisamment informés sur les nouvelles possibilités offertes par la Directive et ne sont ainsi pas au courant de l'existence de points de contact nationaux.

Le faible nombre de demandes d'information reçues par les points de contact nationaux et le faible nombre de demandes de remboursement transmises à des prestataires d'assurance maladie pourraient être la conséquence de ce manque de sensibilisation.

Néanmoins, il a été démontré à la fois à travers l'enquête pseudo patients ainsi que par les entretiens avec les points de contact nationaux et les prestataires d'assurance maladie, que la plupart des points de contact nationaux, lorsqu'on le leur demande, fournissent des informations avec un niveau de détail très satisfaisant.

Les points de contact nationaux informent les citoyens sur les catégories de traitements soumis à une autorisation préalable et, dans certains cas, mettent à disposition des listes détaillées sur leurs sites web.

Les pratiques en Europe varient sensiblement en ce qui concerne l'autorisation préalable. D'une part, certains pays comme la Suède n'exigent d'autorisation préalable

pour aucun service, alors que d'autre part, des pays comme l'Italie ont créé une procédure de demande d'autorisation préalable avancée, sous la forme d'un document additionnel destiné à vérifier si l'autorisation est nécessaire.

En général, dans l'état actuel des choses, aucun problème particulier lié à la procédure de remboursement n'a été identifié à travers la présente étude d'évaluation. Une relation importante entre les différentes procédures de remboursement dans les différents États membres et leurs mérites respectifs a été constatée. En ce qui concerne l'autorisation préalable et son remboursement, chaque demande de soins de santé transfrontaliers nécessite une évaluation individuelle au cas par cas par l'assurance maladie. Cela peut provoquer par conséquent une certaine charge de travail administrative pour chaque demande pour les assureurs. Les principaux éléments de cette charge administrative pour les assureurs comprennent les coûts de traduction (lorsqu'ils ne sont pas couverts par les patients) ainsi que l'examen et le traitement de la documentation médicale.

Un certain nombre de disparités existent d'ailleurs entre les informations fournies par les points de contact nationaux et les prestataires d'assurance maladie concernant les procédures et les documentations à soumettre. Ceci pourrait être surmonté par une meilleure coordination entre les points de contact nationaux et les prestataires d'assurance maladie. Les différentes de langues ne sont pas considérées comme un problème important, tant que les prestataires d'assurance maladie, et non les citoyens, restent en charge des traductions.

Les entretiens avec les prestataires d'assurance maladie indiquent que travailler avec des prescriptions transfrontalières et des documentations en relation avec la Directive ne présente pas de complications particulières en terme de travail administratif et que les prestataires sont en mesure de les traiter sans aucune difficulté. Pour de tels cas, la période de temps nécessaire pour le remboursement est très légèrement plus élevée que pour les remboursements nationaux.

En ce qui concerne les tarifs appliqués, les acteurs ont signalé qu'ils sont conformes à la Directive, et sont les mêmes que ceux qui sont appliqués aux citoyens locaux. Ils figurent dans la liste de prix, souvent publiée sur les sites internet.

Les résultats indiquent que la responsabilité du choix du prestataire de traitement repose sur les patients. Les outils de recherche disponibles sur les sites internet des États membres les aident souvent à faire leurs choix, mais ils sont généralement plus influencés par l'avis d'autres patients ou par des connaissances. Le patient est également celui qui doit prouver que le traitement a bien été effectué, et soumettre la documentation appropriée.

Pour ce qui est du processus de remboursement, il n'y a pas de problèmes apparents ou de complications administratives particulières à ce stade du processus de mise en œuvre de la Directive. Cependant, il faut garder à l'esprit qu'une augmentation du nombre de patients en quête de soins transfrontaliers pourrait relever des problèmes passés inaperçus jusqu'à présent.

Qualité et sécurité

Des informations sur la qualité et la sécurité sont disponibles sur la plupart des sites web des points de contact nationaux, mais sont souvent peu exhaustives. Dans certains cas, on peut trouver des liens vers des systèmes d'évaluation des hôpitaux qui mentionnent certains indicateurs (taux de mortalité, nombre de cas traités avec complications etc.)

Les entretiens avec les parties prenantes montrent que la qualité des soins n'est pas considérée comme un facteur déterminant dans le choix des patients. Les patients demandent souvent des informations dont ils ont besoin après avoir fait leur choix, qui est dans de nombreux cas guidé par l'expérience d'autres patients voire de connaissances proches.

Les groupes de patients ont affirmé que la qualité et la sécurité ne sont pas parmi les raisons qui empêchent les patients d'utiliser cette Directive, contrairement aux raisons administratives liées aux procédures d'autorisation préalable ou aux procédures en général.

L'enquête pseudo-patients a indiqué que les points de contact nationaux ne donnent pas d'informations directes sur des données de qualité et de sécurité relatives aux prestataires de soins de santé en dehors de leur pays ou région. Ils fournissent par contre des informations sur le fait qu'un prestataire spécifique soit oui ou non autorisé, en vertu des règles nationales données, à fournir un traitement spécifique.

Les points de contact nationaux coopèrent activement avec les organisations gouvernementales, les assureurs et les prestataires de soins de santé. La coopération avec les organisations de patients varie sensiblement d'un Etat membre à un autre. Les entretiens avec les prescripteurs de première ligne et les prestataires de soins de santé montrent que le droit aux soins de suivi est toujours garanti aux patients bénéficiant d' un traitement à l'étranger. Le problème du suivi des soins n'a par conséquent pas été signalé comme un problème dans le cadre de la présente évaluation.

Etant donné que le nombre de cas à traiter en vertu de cette Directive est encore limité, aucun problème administratif lié à la qualité et à la sécurité ne semble exister. Cependant, les interviews ont montré que dans les cas où les autorisations préalables sont nécessaires, les prestataires d'assurance maladie obtiennent souvent des informations sur les prestataires de soins de santé en contactant directement les points de contact nationaux ou le prestataire concerné, et vérifient si de tels prestataires se conforment aux exigences de qualité et de sécurité locales.

Temps d'attente excessif

L'étude a révélé qu'il existe un concept notion générale bien partagé entre les différentes entités concernant la définition du temps d'attente. Les sites web des gouvernements ou des prestataires d'assurance maladie donnent souvent des informations sur les temps d'attente moyen pour les différents traitements. Grâce à ces données, l'étude a pu comparer la moyenne des temps d'attente pour certains pays.

On observe de grandes différences dans les pratiques des États membres en termes de retard excessif. Au cours des interviews avec les groupes de patients, il est apparu que les patients sont bien au courant de leur temps d'attente lorsqu'ils demandent un traitement. De plus, un délai excessif est le plus souvent évalué sur une base individuelle.

Deux pays seulement parmi ceux analysés (le Pays-Bas et le Danemark) ont des règles spécifiques qui déterminent le temps d'attente maximum pour tous les traitements. Dans ces cas-là, l'option la plus fréquente est de laisser le citoyen libre de choisir un prestataire national privé et de se faire rembourser les services en conséquence. La procédure au Danemark donne le droit aux patients depuis 2008 de demander une assistance à l'étranger, un droit aujourd'hui accordé à tous les citoyens européens suite à l'introduction de la Directive.

Perspectives

La Directive se trouve à un stade précoce de sa mise en œuvre. En raison du faible nombre de prescriptions de soins de santé transfrontaliers, certains champs d'application de la Directive ne disposent pas d'une maturité suffisante pour être évalués en profondeur. Cette étude représente un point de départ pour en étudier l'évolution future de la Directive. Des efforts d'évaluation supplémentaires exigent, par exemple, de mettre plus d'accent non seulement sur l'identification des meilleurs pratiques, mais aussi sur les obstacles à surmonter pour leur mise en œuvre à travers l'Europe.

Un résultat majeur de cette étude est que la mise en œuvre de la Directive pourrait bénéficier davantage d'activités de communication et de publicité plus ciblées et plus régulières. Les résultats indiquent que la demande de soins de santé transfrontaliers serait plus importante, si les patients étaient au courant des possibilités offertes. Ceci pourrait être réalisé par la mise à disposition d'informations supplémentaires, non seulement sur les droits des citoyens, mais aussi sur les démarches spécifiques qui doivent être suivies au niveau individuel concernant les procédures et autres aspects administratifs. De plus, l'utilité des informations fournies sur les points de contact nationaux sur les sites internet pourrait être davantage soutenue au moyen de références croisées, et l'implication d'organisations de patients dans la définition de critères standards d'exigences:

- Fournir des informations supplémentaires non seulement sur les droits des citoyens, mais aussi sur les étapes spécifiques à suivre pour chaque demande individuelle et pour les aspects administratifs relatifs à celle–ci.

- Renforcer l'utilité de l'information fournie sur les sites-web par les points de contacts nationaux au moyen de références croisées et en impliquant les organisations de patients dans la définition des critères standards.

1 INTRODUCTION

This is the Final Report for the study commissioned by DG SANTE entitled "Evaluative Study on the Cross-border Healthcare Directive (2011/24/EU)" (hereafter referred to as "the study"). The proposed framework for this work is based on the technical proposal submitted by the Consortium to the Commission and on the inception report, reflecting the outcomes of the kick-off meeting (held on 23 May 2014), the inception meeting (held on 12 September 2014) and the Inception Report (submitted on 26 September 2014).

In this report, in accordance with the Terms of Reference (ToR), it is provided full evidence on the implementation of the Directive after the first year, based on the findings related to the questions (the "EQs") formulated in the ToR.

1.1 Scope of the study

The European Commission (the "Commission") is required to monitor the timely, accurate and effective transposition of the Directive by Member States. According to article 20 of the Directive 2011/24/EU, the Commission shall draw up a report on the functioning of the Directive and submit it to the European Parliament and to the Council by 25 October 2015.

In order to provide evidence for the Commission's report, this study look at the current state of the functioning of the Directive, focusing on the following three aspects:

- Reimbursement of cross-border healthcare;
- Quality and safety of cross-border healthcare;
- Undue delay.

The study bases its findings on different data sources: key stakeholders, the National Contact Points, healthcare providers, healthcare insurance institutions, patient organisations and national authorities. The study explores and assesses good practices and potential barriers for patients in accessing cross-border healthcare, falling under the responsibilities of the Member States in the Directive. These include:

- Information provided on patient rights, standards applied on quality and safety of healthcare in other Member States, processes and procedures to be followed for the reimbursement, documentation required and existence of reliable sources of data;
- Timely dissemination and provision of the above information;
- Understanding the decision-making practices in relation to undue delay.

1.2 Study design and approach

Our approach to the study clustered the activities in three different stages:

Stage 1: Inception and structuring: The objectives of this phase were to develop a common understanding as to the scope of the study and of tasks to be performed together with an updated work plan based on the kick-off and inception meetings. During the inception meeting focus countries were selected in agreement with DG SANTE. The output of this phase was the inception report.

Stage 2: Data collection and analysis: Tools were developed to gather information from different sources and stakeholders and applied systematically to collect as much evidence as possible.

The analytical tools used in data gathering were:

- Desk research and literature review;
- Website analysis;
- Online survey;
- Pseudo patient investigation method;
- Stakeholder interviews.

Stages 3: Analysis, Triangulation and Final Report: Following the interim report and the interim meeting, the consortium continued the data collection activities with the stakeholders. This became indispensable because some stakeholders made themselves available only after the presentation of the interim report. The results were then consolidated and validated through triangulations with different sources and summarised in this report.

Validity and limitations

The information and data collection took place in the period October -December 2014. Evaluations of websites are thus referring to this period and cannot take into consideration possible changes that occurred afterwards. With regard to further tools for the analysis, the activity of pseudo patient investigation merits attention. In effect, as it is better specified in "Annex 1 – Methodology", this tool is relatively innovative in terms of its application to studies on the health care policy environment, though in our specific case it has some particular limitations that need to be kept in mind:

- The limited number of staff in NCPs and the low number of persons contacting the individual NCPs per day led to repeated interactions with the pseudo patients, which risked compromising the integrity of the exercise. Our consultants had to pay particular attention to this point as a low level of activity would make it more likely for them to be identified as pseudo patients and attract a biased answer.

The study was hampered by a succinct lack of quantative data available – analysis of patient mobility and preferred medical destinations was therefore not performed. In addition the broad array of topics (eHealth, health technology assessments, European reference networks, rare diseases etc.), the absence of Member State data, and the impact of time lag in decision-making in addition to the narrowed size of the evaluation presented numerous challenges. This study was therefore unable to measure at least in

quantative terms the full effects of the Directive's implementation in its initial years. In this vein it remains uncertain whether the suppositions deduced are relevant to the entirely of the National Contact Points or the provisions of the Directive or merely a representative handful. Nevertheless we succeeded in gaining substantial insights into the Directive through wide use of sampling and through identifying the main trends and obstacles.

Results arising from triangulation have been gained through a specific focus group. The fact that the emerging results remain limited could be explained by the low number of patients currently making use of the Directive. Despite such limitations, this report clearly contributes to the evidence base on the present state of implementation.

1.3 Evaluative questions and analytical tools

The relevant specifications in the Terms of Reference listed the evaluative questions that guided the study. The evaluative questions are presented in "Annex 7 – Evaluative questions".

In order to answer the abovementioned evaluative questions, we used the following analytical tools:

- Desk research;
- Web analysis ("Annex 2 – Web analysis");
- Online survey ("Annex 3 – Online survey");
- Pseudo Patient Investigation ("Annex 4 – pseudo patient investigation");
- Stakeholder interviews ("Annex 5 – Stakeholder interviews").

More specifically, the following table identifies the relation between tools and EQs. Noticeably, stakeholder interviews contributed to answering to most of EQs.

Table 1- Correlation between evaluative questions/analytical tools

Dimen-sions	Areas	EQs	Desk research	Web analysis	Online survey	Pseudo Patient Investiga-tion	Interviews	COVERAGE
Reimbursement	Dissemination of information	EQ 1			■		■	■
		EQ 2				■	■	■
		EQ 3		■	■	■	■	■
		EQ 4					■	■
		EQ 5			■			■
	Processes and outputs	EQ 6			■		■	■
		EQ 7			■		■	■
		EQ 8		■	■	■	■	■
		EQ 9					■	■
		EQ 10		■	■	■	■	■
		EQ 11			■	■	■	■

Dimen-sions	Areas	EQs	Desk research	Web analysis	Online survey	Pseudo Patient Investiga-tion	Interviews	COVERAGE
	Adm. Burdens	EQ 12			■		■	■
	Benchmarking/ Best Practices	EQ 13					■	■
		EQ 14	■				■	■
		EQ 15		■			■	■
Quality and safety	Dissemination of information	EQ 16		■	■	■	■	■
		EQ 17				■	■	■
		EQ 18					■	■
		EQ 19					■	■
	Processes and outputs	EQ 20			■		■	■
	Sustainability	EQ 21		■		■	■	■
	Adm. Burdens	EQ 22			■		■	■
	Bench./ Best Pract.	EQ 23					■	■
Undue Delay	Undue Delay	EQ 24	■	■			■	■
		EQ 25	■	■			■	■
		EQ 26	■	■			■	■
		EQ 27	■	■			■	■
		EQ 28	■	■			■	■

1.4 Selection of Member States

The focus countries were selected since they represent a sufficiently large and balanced combination of different country characteristics related to the qualitative/quantitative features summarised in the following table:

Table 2 - Rationales for the selection of Member States[1]

Rationale	Austria	Belgium	France	Germany	Hungary	Italy	Lithuania	Malta	The Netherlands	Slovenia	Spain	Sweden	Note
GDP 2013 in €'000	€38.1	€35.6	€32.1	€34.2	€10.2	€26.7	€11.8	€17.9	€38.3	€17.5	€22.5	€45.5	Average 28 EU countries: €26.6
% of EU average[2]	143%	134%	121%	129%	38%	100%	44%	67%	144%	66%	85%	171%	100%

[1] Data source: Eurostat.

[2] Arrows indicate GDPs higher or lower than the average.

Rationale	Austria	Belgium	France	Germany	Hungary	Italy	Lithuania	Malta	The Netherlands	Slovenia	Spain	Sweden	Note
	↑	↑	↑	↑	↓	↑	↓	↓	↑	↓	↓	↑	
Total health expenditure % of GDP	10.8	10.5	11.6	11.3	7.9	9.2	6.6	8.7	11.9	8.9	9.3	9.5	
Type of health care system[3]	Social health insurance	Social health insurance	Social health insurance	Social health insurance	National health service	National health service	Social health insurance	National health service	Social health insurance	Social health insurance	National health service	National health service	
Presence of "multiple"/ "central" HIPs	Multiple	Multiple	Multiple	Multiple	Single	Multiple	Single	Single	Multiple	Single	Multiple	Multiple	
Location on the European continent	West	West	West	West	East	South	North	South	West	East	South	North	
Size of the country's population in million	8.5	11.5	65.6	80.5	9.9	59.7	3.0	0.4	16.8	2.1	46.7	9.6	313.8

Our selection of the countries was primarily based on the consideration that the largest share of patient mobility is expected among neighbouring countries where cross-border healthcare is already well established[4]. The existence of bilateral agreements on cross-border care and pre-existing agreements between regions of Member States (e.g. Meuse-Rhine EU-Region, Slovenia and Friuli Venetia Giulia and Veneto in Italy, and Austria and Hungary[5]) were also taken into account.

The focus countries include both large (i.e. Germany) and small (i.e. Malta) countries, since it has been argued that it may be more difficult for small countries to provide some forms of highly specialised care; therefore patients are more frequently travel abroad to receive treatment[6].

The focus countries represent an appropriate geographical distribution along the North/South and East/West axes.

[3] Social Health Insurance is based on single or multiple insurances while the National Health Service is financed from general taxation.

[4] Impact assessment on the application of patients' rights in cross border healthcare, {com(2008) 414 final}, {sec (2008)2164}.

[5] Cross-border Health Care in the European Union, Mapping and analysing practices and policies; European Observatory on Health Systems and Policies, Brussels 2011.

[6] Impact assessment on the application of patients' rights in cross-border healthcare, Com (2008) 414 final, Sec (2008) 2164.

The presence of different healthcare systems (e.g. Beveridge and Bismarck type), and also the presence of single or multiple HIPs and the centralised or decentralised administration of healthcare (national, regional, council-level, etc.) were also taken into account in order to foster representativity.

Key economic indicators like GDP per capita and percentage of healthcare expenditure on GDP were also taken into consideration.

With the limited 12 focus countries used in this study, we dispose nonetheless of a sample covering 62%, i.e. almost two third of the total EU population.

2 METHODOLOGY

The research and evaluation methodology adopted in the study is designed to improve the efficiency of the collection of data and information necessary to respond to the EQs. Figure 1 shows the conceptual and methodological framework used in this study.

In this report, preference has been given to a non-nominal use of stakeholder interview and survey material. More details on how the methodology was applied at each stage are provided in "Annex 1 – Methodology".

Desk research

Desk research was carried out on all 28 MSs during and after the inception stage in order to prepare the individual evaluative tools. The aim of the research was to obtain an understanding of the Directive's framework, its application in each country, the information on the study's three areas of interest for the analysis (reimbursement, quality and safety and undue delay) and the presence of useful information on the healthcare system. A stakeholder mapping for all the different target categories covered by the analysis was also developed during this stage. The desk research was carried out both online and based on reports and publications on cross-border healthcare.

The sources used in the analysis are reported in the bibliography.

Web analysis

Web analysis was carried out on all the websites of the 32 NCPs. The websites analysed relate to 32[7]countries or territories, as Scotland, Wales, England, Northern Ireland and Gibraltar were analysed for the UK.

The analysis was carried out by preparing an evaluation grid with 48 Specific Analytical Items ("SAI"). Details of the SAIs are provided in the "Annex 1 – Methodology in the section entitled "Web analysis". The purpose of the SAIs is to analyse the website design, its functionalities, its ease of access, and as well as to gauge whether a citizen would be able to find the information required under the Directive and what is necessary to access cross-border healthcare (CBHC) services. The analyses were carried out between 6 October 2014 and 6 November 2014 and reflect the state of the websites within this timeframe[8]. Compared to earlier studies performed on the NCP websites[9], the findings indicate that most NCP websites have been significantly upgraded and updated and now include sections that were previously lacking or missing, specifically, in terms of the availability of the websites in languages other than the national language(s), the greater number of sections available in English and, generally, the presence of information useful to citizens. The data collected by the various teams in the different countries have been grouped centrally and entered into a single database where they have been analysed to standardise replies, if any, with a single, objective benchmark.

Given the amount of data collected, the SAIs were grouped into twelve evaluation categories and a multidimensional and multivariate system designed in order to make

[7] Hungary and Sweden have two different NCP websites for inbound and outbound patients.

[8] No changes to the websites shall be taken into consideration after such date.

[9] Obtaining health care in another European Union Member State: how easy is it to find relevant information? A. Santoro, A.Silenzi, W. Ricciardi; M. McKee, 2014.

the analyses more effective and to determine a common evaluation parameter[10]. The results of the analysis are attached as "Annex 2 – Web analysis".

Online survey

The aim of the online survey was to ask individual NCPs and their managers how the NCPs function, how they are organised, and request certain quantitative data presently unavailable from other sources. The NCPs were also asked about their opinion on the level of information on the Directive available for patients, and on how they interact with citizens. To ensure consistency between the various countries, a questionnaire with 59 questions was drawn up. After a piloting exercise, it was sent to the 12 individual NCPs of the focus countries of this study. The online survey ran from 13 November to 23 December 2014. Ten complete or partially complete online questionnaires had been received by 23 December. In order to obtain all the necessary information, two ad hoc interviews were held with two NCPs after 23 December.

The data gathered were processed and the key findings are presented in "Annex 3 – Online survey".

"Annex 1 – Methodology" details the methodology used and the evaluation and analytical criteria adopted.

Pseudo patient investigation methodology

This activity was carried out to assess the NCPs' ability to respond to specific queries. The pseudo patient investigation was pursued due to its extensive use in research on the pharmacy/customer interface relationship[11]. Furthermore, this method is considered as a standard, recommended bi-annual operational practice in the statutory quality assurance scheme of the German Chamber of Pharmacists[12].

Three scenarios related to three different request types were developed. In two of these scenarios, a patient is seeking treatment in a foreign MS (outbound), and in the third, the patient is seeking information on having treatment in the country of the NCP contacted (inbound). The first two scenarios, which differ for the type of treatment required (subject to prior authorisation and otherwise), were carried out by 12 teams in the local languages. The third was carried out centrally on the 12 different NCPs.

The channels used were e-mail[13] and telephone. Further operational details are provided in "Annex 1 – Methodology" The aim of this exercise is not to assess service levels of the NCPs in the focus countries of this study, but rather to obtain the required information regardless of the channel used.

These activities were carried out between 14 and 28 November, 2014 and involved all the NCPs contacted.

10 The methodology is presented further in "Annexes 1 - Methodology and 2 – Web analysis".

11 http://www.ncbi.nlm.nih.gov/pubmed/15659003; Berger K1, Eickhoff C, Schulz M., Counselling quality in community pharmacies: implementation of the pseudo customer methodology in Germany.

12 http://www.abda.de/themen/apotheke/qualitaetssicherung0/angebote-qs-kammern/pseudo-customer0/.

13 http://www.ncbi.nlm.nih.gov/pubmed/19033478; Pohjanoksa-Mäntylä MK1, Kulovaara H, Bell JS, Enäkoski M, Airaksinen MS, Email medication counseling services provided by Finnish community pharmacies.

The information was entered into the standard evaluation grid and analysed by a single specialized team. "Annex 4 – Pseudo patient investigation" presents the results of this exercise.

Interviews

Following selection and mapping of stakeholders, a standardised interview schedule was designed for each stakeholder category[14].

The aim of the interviews was to respond comprehensively to the EQs in order to gather evidence on the areas of reimbursement, quality and safety and undue delay. The interviews were specifically tailored to the information value of each stakeholder. However, a common set of questions was raised with all stakeholders on their perception of the level of communication with patients regarding the Directive, and any strengths and weaknesses they would like to comment upon.

The interviews took place between 24 November 2014 and 23 December 2014. More than 120 stakeholders were contacted at both Member State and EU level, 50% (59) of which were ultimately interviewed or completed the online questionnaire.

The structured interviews were made available on the online platform offered and all stakeholders were sent an e-mail asking them to complete the questions or, alternatively, to request a face-to-face (or telephone) interview.

Direct interviews were sought with the health insurance providers and patients' groups in order to facilitate the acquisition of additional information. Details of the procedure are presented in "Annex 1 - Methodology" and the interview key findings in "Annex 5 – Stakeholder interviews".

Information analysis and streamlining/standardisation of evidence

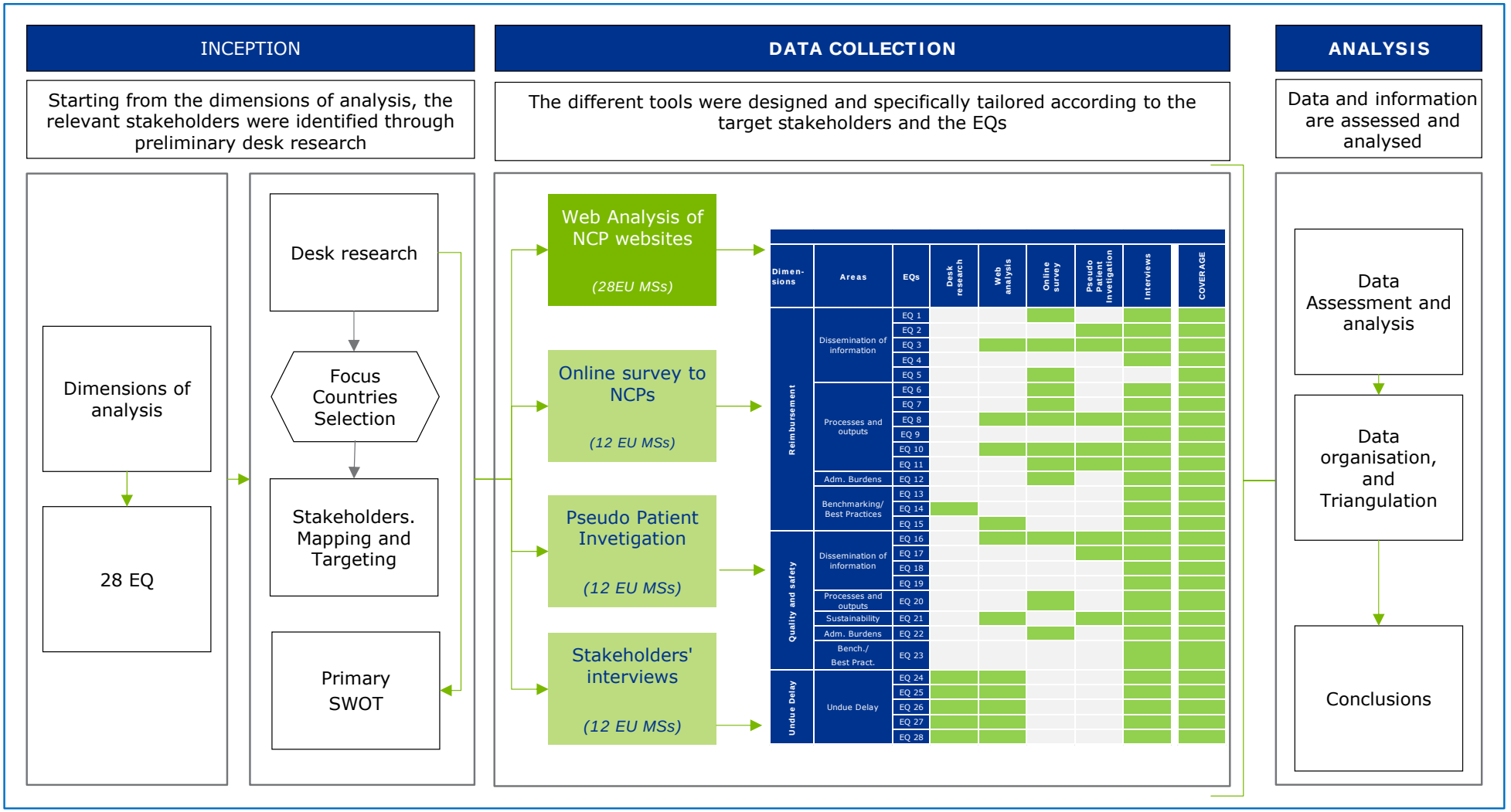
Following data collection via the various tools, the information related to each tool was analysed while careful consideration was given to whether any subjective elements could arise from the responses obtained during the pseudo patient investigation exercise.

The basis for the conclusions can be deemed solid and with a good level of data completeness: the analyses of the websites of the NCPs of 32 countries, 100% of the online surveys, 36 Pseudo Patient investigation exercises via the various channels (telephone and e-mail) and 50% of stakeholders replied to the interviews or online questionnaire.

All data and information were entered into a single database and analysed centrally and a dedicated team carried out the triangulation to align it with the EQs.

[14] The Stakeholder Categories involved in the study, according to the ToR were the Nationa Contact Points, healthcare providers organisation, individual healthcare insurance providers, patient groups, trade unions, ombudspersons and healthcare inspectorate/audit bodies.

Figure 1–Overview of the conceptual and methodological framework



3 MAIN FINDINGS ON THE EVALUATIVE QUESTIONS

The following chapter presents the main findings, structured around the main evaluative categories (reimbursement, quality and safety, undue delay) for all of the 28 evaluative questions put forward in the Terms of Reference.

3.1 Reimbursement

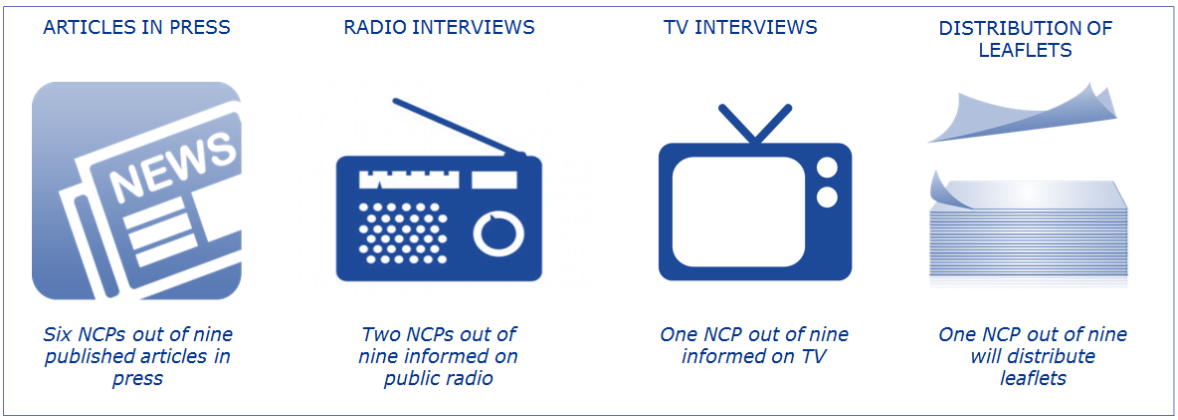
Dissemination of information

1. Have patients been informed in their MS of affiliation of the existence and contact details of the National Contact Point?

Information campaigns targeted at the general public only took place during a short period of time during which the transposition into national legislation took place. Other than via this campaign, patients can find contact details (and comprehensive information) only via the NCP websites, which presupposes that they are made aware of their existence. The awareness of patients of the existence of National Contact Points is consequently considered to be low in most Member States.

The online surveys showed that six out of nine NCPs launched communication campaigns to inform the general public about their activities. Depending on the Member State, these activities were performed over different periods between September 2013 and October 2014. The communication channels used were:

Figure 2 - Channels used to inform the public (N=9)



Through the interviews, we discovered that other stakeholders also undertook communication campaigns, mostly addressed to registered members of their entity, as shown in the following:

- **Healthcare providers:** Two healthcare providers out of the six interviewed launched an institutional communication campaign to the members of their organisation via their internal newsletter/magazine.
- **Trade Unions:** One out of four trade union organisations interviewed undertook a communication campaign among its members when the Directive was adopted.
- **Regional / National authorities**: Four out of six authorities assert that various activities were carried out to promote the Directive, such as coordination

meetings with main stakeholders, articles in the press, national meetings of regional experts and large-scale professional press conferences.

Surprisingly, none of the communication campaigns were targeted to frontline healthcare prescribers. As a consequence, four out of five of them assert that neither the National Contact Point nor any other organisation undertook an effective communication campaign on cross-border healthcare.

This opinion is also shared by most of the patient groups interviewed (four out of six), which think that patients are generally not informed about the Directive 2011/24/EU.

This opinion is also shared by NCPs which, in spite of the general communication campaigns they undertook themselves, consider patient awareness of the Directive and of the very existence of the NCPs to be low (eight out of nine).

2. Having requested information from the National Contact Point have patients received sufficient information on the possibility of accessing cross-border care and on their entitlements and the corresponding level of reimbursement?

National Contact Points communicate the general rules of entitlements and levels of reimbursement applied by Member States in a consistent way. Further, based on the evidence collected through a 'pseudo patient investigation' exercise, it was established that patients receive sufficient information on the level of reimbursement upon request from the National Contact Points. In addition, most of the NCPs confirmed that they provide information on the level of reimbursement.

As pointed out by De La Rosa[15], appropriate information is the basic requirement to enable patients to exercise their (other) rights on cross-border healthcare in practice. An important mechanism to ensure the provision of information was the establishment of National Contact Points[16].

The pseudo patient investigation exercise revealed that eight out of twelve (Scenario 1) and ten out of twelve (Scenario 2) NCPs provided the information on the level of reimbursement, explaining that the amount to be reimbursed shall be equal to national or local tariffs[17] applied in the MS of affiliation.

Furthermore, in order to have a comprehensive view on the reimbursement level, NCPs were asked in the online survey whether national tariffs to which patients could refer to are available. Five NCPs answered positively, providing the corresponding web links (although not all of them redirect exactly to a tariff scheme), while the others explained that the national tariffs are not provided, because local tariffs are applied.

[15] S. de la Rosa, 'The Directive on cross-border healthcare or the art of codifying complex case law', Common Market Law Review 49(1) (2012) 34-38.

[16] Nys H.; European Journal of health law 21 (2014) 1-14; The Transposition of the Directive on Patients' Rights in Cross-Care Healthcare in National Law by the Member States: Still a Lot of Effort to Be Made and Questions to Be Answered; Editors: J.C.J. Dute, Herman Nys and Henriette Roscam Abbing.

[17] Only when asked about the specific amount for the specific treatments used in the exercise the NCPs were not able to give such details.

3. What are the geographical disparities regarding patient information in relation to cross-border care and reimbursement practices? Is relevant information made only available at certain source points so that patients encounter problems to access it or is information made freely available?

No significant geographical disparities have been identified in relation to being able to access information on cross-border care and reimbursement practices. Information is available and accessible for the general public primarily on the websites of National Contact Points or relevant authorities (e.g. health/social services ministries, public health insurance providers and national or regional health systems). Most National Contact Points can also be accessed via phone.

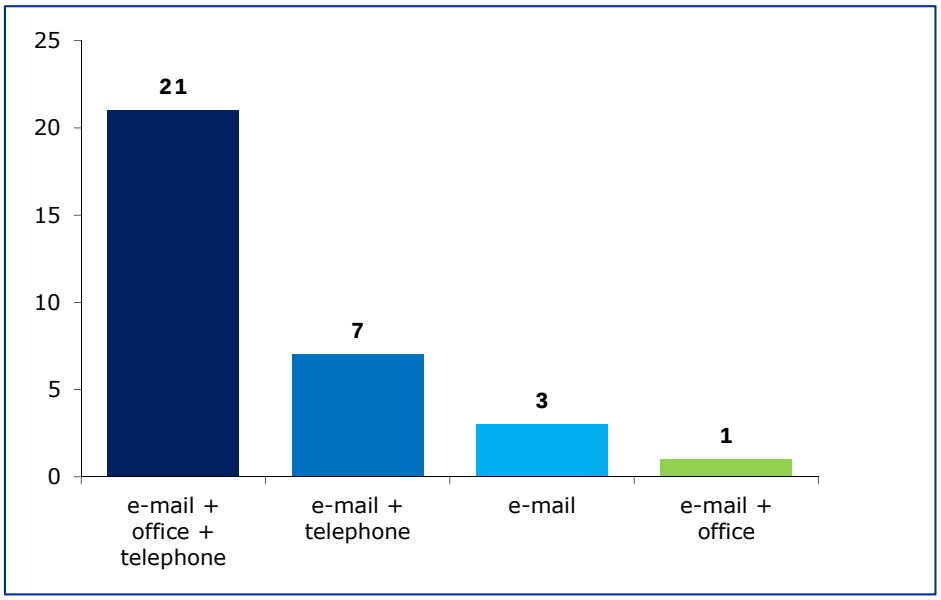
The web analysis shows that all 32 NCPs of the EU Countries have an available website. The available contact channels for each NCP are summarised in the following table:

Table 3 – Availability of communication channels

Countries / Channel	Austria	Belgium	Bulgaria	Croatia	Cyprus	Czech Republic	Denmark	England	Estonia	Finland	France	Germany	Gibraltar	Greece	Hungary	Ireland	Italy	Latvia	Lithuania	Luxembourg	Malta	Northern Ireland	Netherlands	Poland	Portugal	Romania	Scotland	Slovakia	Slovenia	Spain	Sweden	Wales
Email / contact	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Phone Nr.		■	■	■	■	■	■	■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■	■	■	■	■	■	■
Office address for visits			■		■	■	■		■	■	■	■		■	■	■		■	■	■		■		■	■	■		■	■	■	■	

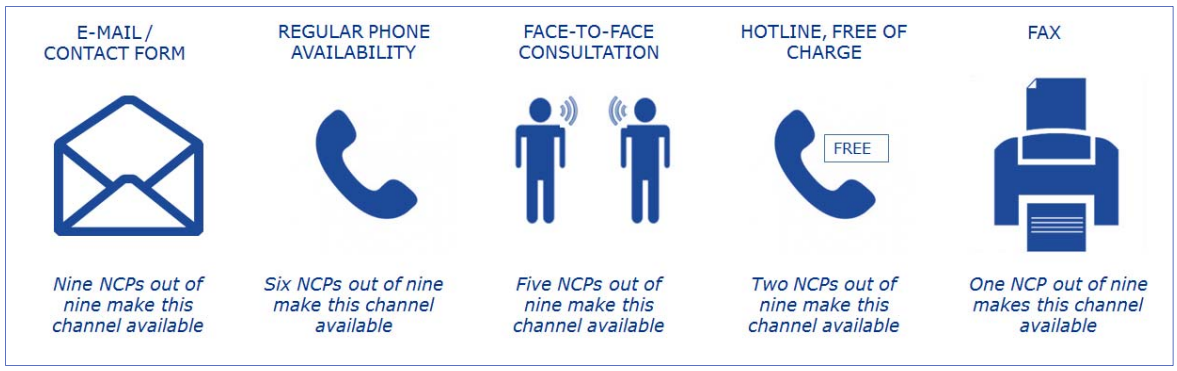
Contact details are available for 21 NCPs through all three channels: e-mail, phone number and office address for visit, and 28 have both email and phone availability. Only four NCPs do not provide access to phone number. Finally, all countries offer at least email details or a contact form, which may well indicate that these are the commonly preferred channels of communication.

Figure 3 - Available channels of the National Contact Points on the 32 websites analysed



The online surveys[18] showed that, other than the websites available for all NCPs, there are various other ways to contact them, summarised in the following figure. E-mail is the most common means of contact[19] while telephone is the second most common.

Figure 4 - means of contacting the NCP



Each NCP selected the available channels through which they can be contacted. As a result, it is possible to contact six NCPs out of nine[20] by telephone, while five NCPs offer the opportunity for face-to-face interaction with office staff.

In addition to the items listed above, two NCPs plan to include additional contact and communication channels such as social media and face-to-face opportunities.

[18] Sent to a sample of 12 focus countries.

[19] All nine NCPS answered that e-mail is available. This is confirmed by the web analysis that shows that all NCPs have an available e-mail address/contact form.

[20] Nine NCPs provided information on this topic.

Figure 5 - Additional channels under consideration (N=9)

Even though the use of Skype[21] is increasingly widespread in the private sector, no NCP offered the possibility of using this channel.

4. Do patients request prior authorisation, not only for hospital inpatient care (Art.8), but also for ambulatory care, as a tool to clarify reimbursement conditions? Do patients contact insurers prior to seeking cross-border care? If so, is the supply of information neutral?

Almost half of the National Contact Points made publicly available on their website the type of healthcare subject to prior authorisation. However, interpreting these lists usually requires some degree of medical expertise. Therefore, in most cases patients inevitably need to contact their National Contact Point or their health insurer provider to enquire whether prior authorisation is required or not. Patients contact insurers primarily to obtain more information on cross-border care and to clarify reimbursement conditions. The evaluation has identified no signs of the information being distorted or biased.

Article 8 of the Directive 2011/24/EU states that, given certain conditions (e.g. treatments that involve overnight hospital accommodation of the patient in question for at least one night), patients need prior authorisation from their country of affiliation. These conditions are not always clearly identified by EU countries: only sometimes do they provide detailed specific information on the treatments for which patients should request prior authorisation.

The web analysis shows that 66% (21 out of 32) of NCP websites provide information on which treatments require prior authorisation, grouped by broad categories, and that twelve provide detailed lists of specific treatments for which patients need prior authorisation.

The online surveys also showed that NCPs publish lists/categories of treatments to which patients can refer in order to ask the prior authorisation. Six out of nine[22] National

[21] The website reveals that some providers of the private sector are offering skype availability: http://imedtreatmentsabroad.com/health-in-spain/cross-border-healthcare-information.

[22] The answer was provided by nine out of twelve NCPs.

Contact Points provided a non-exhaustive list that identifies treatment considered cost-intensive and thus requiring prior authorisation. Three respondents referred patients to the categories included in the Directive and made no reference to further detailed lists.

However the interviews showed that fifteen out of twenty health insurance providers refereed to the fact that patients in their country do not really know whether a treatment is subject to prior authorisation[23] or not and therefore tend to request prior authorisations even when such are not strictly necessary.

The interviews indicated that nineteen out of twenty health insurance providers are actually contacted by patients about cross-border healthcare. The information provided did not show any distortion.

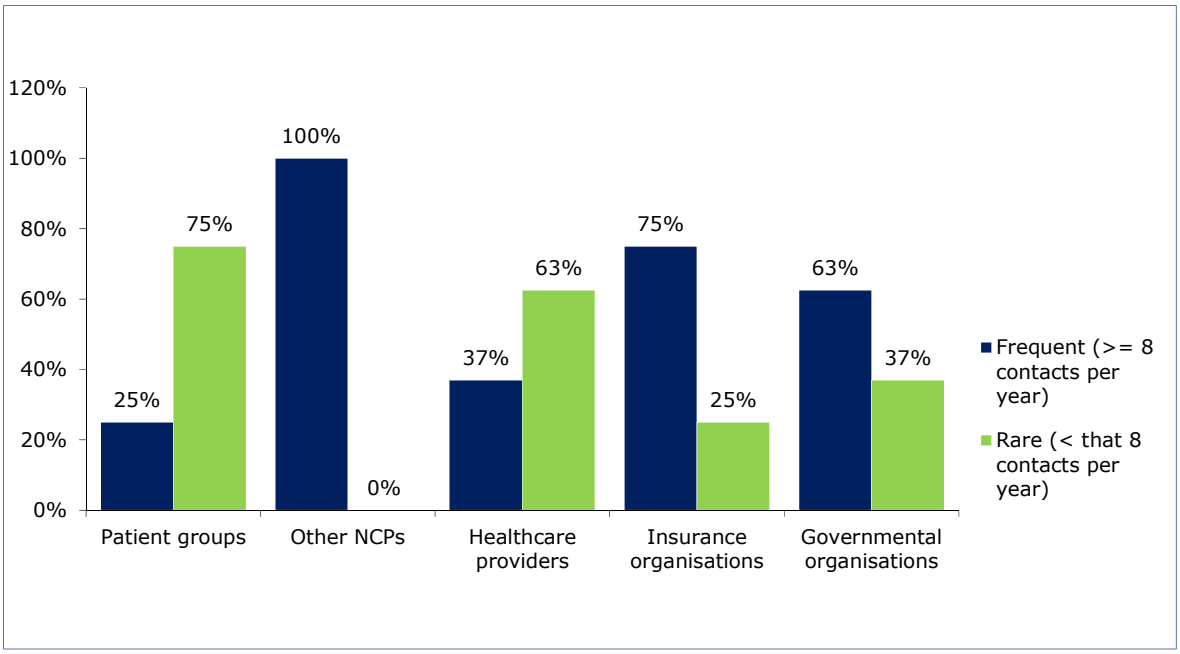
5. What is the level of co-operation between different NCPs with regard to information on quality and safety of cross-border care and invoicing?

Survey evidence indicates that the general level of co-operation between different NCPs is relatively intensive. A strong emphasis was found on enhancing the frequency and practical relevance of co-operation between National Contact Points. Indirectly, it has also had an impact on improving their co-operation with healthcare providers, insurers, patient groups and other governmental organisations. According to the interviews with health insurance providers, issues related to quality and safety are the most frequent topic on which NCPs co-operate on.

In the online survey six out of the eight NCPs that answered the question stated they have more than 15 contacts per year with other NCPs in the EU; two NCPs declared between eight and 15 contacts per year, adding that they are determined to improve cooperation with "regional" NCPs and with the relevant Member States where significant patient flow is detected.

[23] Two insurers explained that within their countries no treatments are subject to prior authorisation.

Figure 6 - NCPs' level of cooperation with stakeholders (N=8)



According to one NCP, the strength of the Directive lies in making the healthcare system more patient-oriented. Despite the role that patient groups could have in achieving this objective, as can be seen from the above figure, the attention given by the interviewed NCPs to patient organisations is almost non-existent.

Some patient groups have their own channels through which they inform patients. An interesting example are the helplines organised across Europe to inform patients about rare diseases[24]. Each of these helplines received on average 140 calls in November 2012, comparatively higher than those received by NCPs (less than 100 per month)[25]. According to the study, "A European Network of Email and Telephone Help Lines Providing Information and Support on Rare Diseases: Results From a 1-Month Activity Survey", more inquiry-categories could be established to provide information on patients' rights regarding cross-border care and the EU Directive 24/2011.

[24] Francois Houyez, Rosa Sanchez de Vega, Tuy Nga Brignol, Monica Mazzucato, Agata Polizzi; A European Network of Email and Telephone Help Lines Providing Information and Support on Rare Diseases: Results From a 1-Month Activity Survey; Published online: 2014 May 5: doi: 10.2196/ijmr.2867.

Processes and outputs

6. Have patients been correctly reimbursed following the use of cross-border care? To what extent are national authorities in MSs monitoring whether healthcare providers comply with their duties under Art.4.2 (supply of information, including on treatment options, quality standards)?

Only two out of eight National Contact Points indicated that complaints from patients regarding the overall reimbursement process would be relatively frequent. In most Member States, however, the overall number of cases referred under the Directive is still low[26]. Occasional evidence from patient groups and patient ombudsmen indicates that those individual cases have been dealt with appropriately through established complaint procedures. It is therefore concluded that there are currently no significant challenges around reimbursement processes.

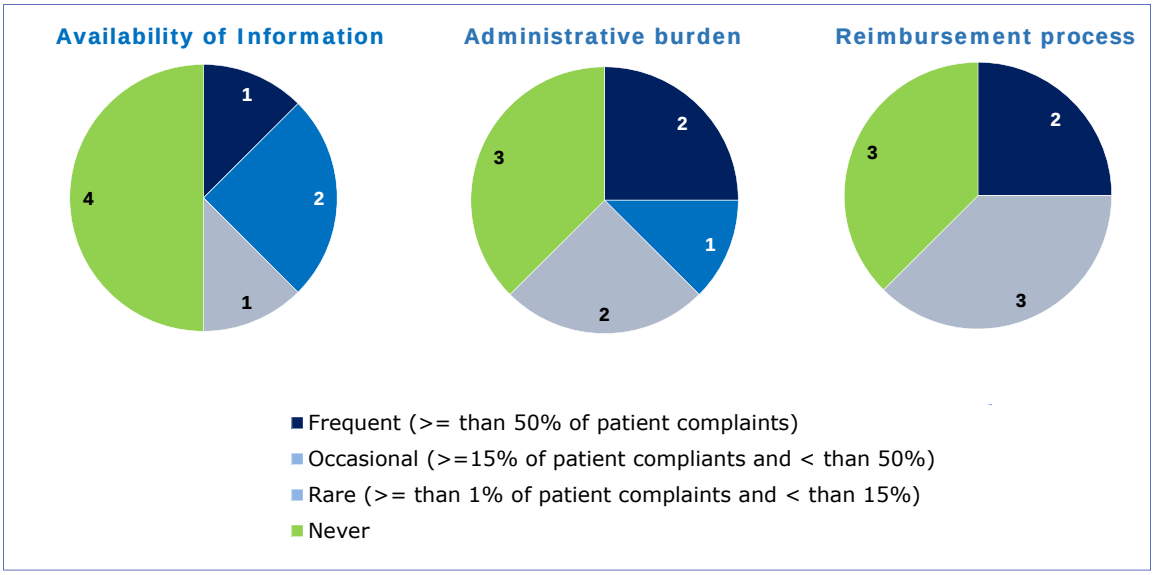
Related to the provisions of Article 4.2 (b)[27], six out of eight NCPs do not have access to a formal monitoring system on healthcare providers. Where such monitoring exists, it usually only covers the review of published licenses, and lists and registers of medical professions. It should be noted that no universal definition of 'quality standards' currently exists across the Member States that would support cross-border healthcare provision.

The topics that patients ask about more frequently are "administrative burdens" regarding the admission process and reimbursement process, as shown in the following figure:

[26] The only public data are that in Finland there are 200 requests for treatment abroad and in the Netherlands providers treated 2.731 inbound patients. The stakeholders interviewed in all the other countries explained as only few people were treated under the Directive.

[27] Healthcare providers provide relevant information to help individual patients to make an informed choice, including on treatment options, on the availability, quality and safety of the healthcare they provide in the Member State of treatment and that they also provide clear invoices and clear information on prices, as well as on their authorisation or registration status, their insurance cover or other means of personal or collective protection with regard to professional liability. To the extent that healthcare providers already provide patients resident in the Member State of treatment with relevant information on these subjects, this Directive does not oblige healthcare providers to provide more extensive information to patients from other Member States.

Figure 7 - NCP estimates of the frequency of patient complaints by topic



As regards monitoring, the online survey showed six out of eight[28] NCPs do not have access on a formal process to monitor whether healthcare providers comply with their duties according with art. 4.2 of the Directive.

7. Do MSs competent authorities have mechanisms to track the number of foreign patients using healthcare in their country?

Monitoring practices of inbound and outbound patients differ significantly across Member States. Some of them already apply functioning monitoring systems that track the number of foreign patients treated. Others have not implemented such systems yet, and thus cannot provide reliable data on the number of cross-border cases to be referred to.

The online survey and the interviews showed that five out of ten NCPs monitor the number of national patients using healthcare abroad, with regards to the EU Directive 24/2011. On the on hand, six out of eight NCPs stated that they do not have monitoring system for inbound patients.

Healthcare providers interviewed monitor both national and cross-border patients, checking and registering their nationality. Three out of six providers stated they monitor the number of foreign patients treated and, two of them stated that monitoring systems differentiate patients who arrange appointments in order to be treated (planned care) and patients treated in emergencies.

[28] The other two NCPs made reference to their national quality system. No indication on specific monitoring system used to verify the compliance with article 4.2 is provided.

8. In what way and to what extent are different contextual issues of:

a) language

b) invoicing

c) patient confidentiality

affecting/impeding reimbursement processes? Which obligations for translation of invoices are in place in different Member States?

The National Contact Points reported various practices and rules regarding language and translation requirements, which primarily reflect the practices of the healthcare insurance providers of the different Member States.

The National Contact Point reported different practices regarding invoices. In some Member States, National Contact Points and insurance providers apply a flexible approach and accept the original invoices, whereas other Member States require translations of the invoices into the national language, placing the administrative burden on patients.

The issue of patient data confidentiality has not been quoted by the stakeholders contacted as a factor impeding the reimbursement process.

The online survey mentioned the documentation required to be submitted by the patient in order to be reimbursed; five NCPs provided an answer. The following figure represents the answers provided:

Table 4 - Documentation to be submitted in order to be reimbursed

National Contact Point	Medical docs.		Invoices		Referral note from a national HCP	Other
	Original language	Translated	Original language	Translated		
NCP 1						
NCP 2						
NCP 3						
NCP 4						
NCP 5						
NCP 6						
NCP 7						
NCP 8						
NCP 9						
NCP 10						
NCP 11						
NCP 12						
TOTAL	5	2	5	3	5	2

Legend

- Answer not available
- Yes
- Answer not selected

Regarding the invoices, two NCPs stated that no translation is needed while another two said only a translated invoice is accepted. Yet another said that both documents are required, not specifying the reason. It is supposed that the need for a translated document supported by its original is in line with traditional public accounting requests.

The interviews with the health insurance providers highlighted different outcomes. Sixteen out of twenty health insurance providers request the invoice in its original language, while six require a translation of the said invoice.

Table 5 - Documents to be submitted for reimbursement

Health insurance provider	Medical documentation		Invoices		Referral note from a national HCP	Other
	Original language	Translated	Original language	Translated		
HIP A						
HIP B						
HIP C						
IP D						
HIP E						
HIP F						
HIP G						
HIP H						
HIP I						
HIP J						
HIP K						
HIP L						
HIP M						
HIP N						
HIP O						
HIP P						
HIP Q						
HIP R						
HIP S						
HIP T						
HIP U						
TOTAL:	**13**	**6**	**16**	**6**	**8**	**5**

Legend

- Answer not available
- Yes
- Answer not selected

It is worth highlighting that, in some cases, there are inconsistencies between the answers provided by National Contact Points and health insurance providers of the same country regarding the documents needed by patients for the reimbursement.

As an example, the NCP and HIP of Sweden are part of the same healthcare system but have different needs regarding the language in which medical documents must be presented in order to be accepted. Conversely, the NCP and HIPs of Italy gave the same information on the language in which documents must be submitted.

These uncertainties were identified by patient groups interviewed as one of the biggest barriers to cross-border healthcare. Even the organisations in charge are sometimes not aware of the information they are supposed to deliver. All stakeholders elaborated on the way the National Contact Point and the health insurance provider are prepared to help patients in this matter, although they agreed that it would be advantageous to have invoices and medical prescriptions translated into a national language or in English. Therefore, in most cases, obligations to translate documents appear not to be formally required (either for patients or for authorities) but, as patient groups stated during the interviews, this is still a "grey area" in the practical aspects of the operative implementation of the legislation.

The issue of patient data confidentiality has not been quoted by the stakeholders contacted as a factor impeding the reimbursement process. In any case, in some Member States, e.g. in the Netherlands, the rules on patients' privacy[29] states that healthcare providers needs patient's consent for passing on information to third parties and for allowing access to, or provision of a copy of the data contained in, the medical records to a third party[30].

9. *On invoicing:* Are insurers or NHSs just as ready to adapt to reimbursement claims for healthcare received from a health care provider not based in their own system?

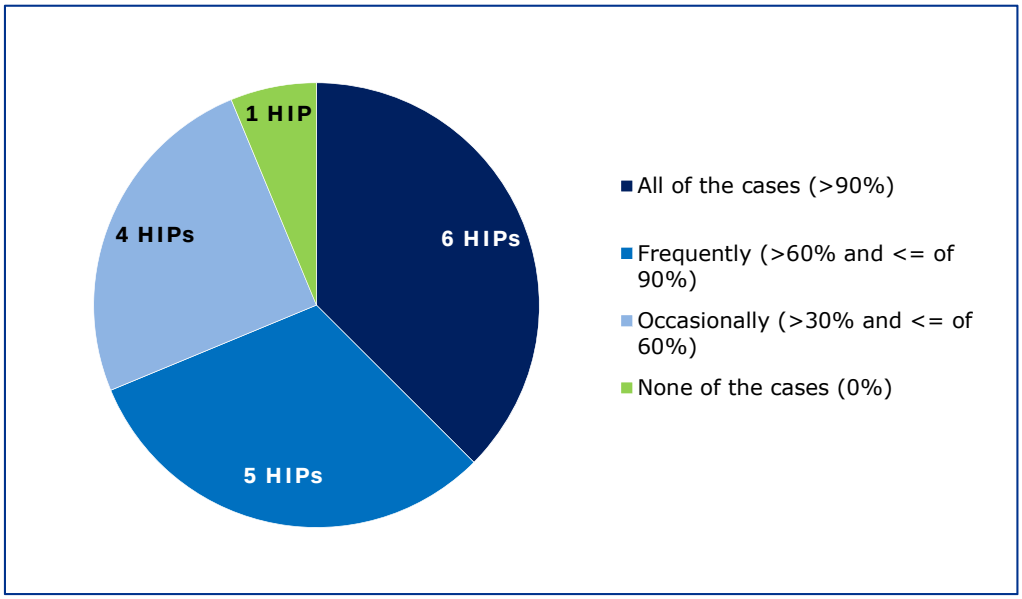
Evidence from interviews conducted with health insurance providers indicates that in most cases foreign invoices are well understandable and can be processed without much difficulty. Due to different formats, some invoices require more work to process, but to date these can be managed by existing available internal resources.

The interviews with the health insurance providers which answered this questions (16 out of 22) showed, as presented in the following pie chart, that eleven insurers can understand and process invoices from foreign healthcare providers in all or most cases, and that only one stated that are difficult to understand. Only one healthcare insurance provider stated that the administrative procedures and processes used to deal with a cross-border case are not straightforward since it employs four people solely to it.

[29] Act on the Medical Treatment Contract (art. 7:457 and 7:459).

[30] Bongers L.M.H. and Townend D.M.R.; The Implementation of the Directive on the Application of Patients' Rights in Cross-border Healthcare in the Netherlands; European Journal of health law 21 (2014) 65-78; Editors: J.C.J. Dute, Herman Nys and Henriette Roscam Abbing.

Figure 8 - HIPs answers to the ease they have in processing foreign documentation



10. *On pricing:* Which domestic tariffs are de facto being applied? Is it the agreed tariffs between health insurers and providers or those for private patients, which are applied by providers who do not adhere to the collectively agreed tariffs? Are there other tariffs being used?

Foreign patients are charged by healthcare providers that are affiliated with the Member State healthcare system, at the usually binding public tariffs. These tariffs are most often publicly available and can be determined at national or regional level. Private providers that are not affiliated with the Member State healthcare system can apply their own tariffs, which are set independently.

All the NCPs that answered the question (four out of twelve) during the pseudo patient investigation exercise explained that the tariff scheme that hospitals apply to European patients under the Directive is the same as the one used for national citizens wishing to receive treatment by directly paying the binding public tariffs including for individuals that pay the entirety of the costs of treatment instead of only reimbursing a share of it.

The interviews indicated that four out of five healthcare providers apply the tariffs publicly agreed for national or regional citizens while the costs for additional services are applied separately. Only one of them answered that they apply the tariffs applicable to private patients.

11. *On non-intended effects*: Who in practice bears the responsibility for accessing planned healthcare investigation/treatment across borders in a) finding relevant intelligence on potential treatments/outpatient care investigations, b) bearing the burden of proof in demonstrating to insurers that the treatment/investigation has been carried out, c) bearing the responsibility to submit the correct documentation, including accurate translations of medical records and accurate invoices?

The ultimate responsibility for finding information on treatment and outpatient care options lies with the patient that seeks cross-border healthcare. Nevertheless, most National Contact Points help patients with lists, contact details of hospitals, information about available services and ratings by users, where available.

The burden of proof in demonstrating that the treatment has been carried out also lies with the patient. They always have to provide the insurer with appropriate invoice and appropriate medical documentation. A significant share of Member States also require accompanying translations to be submitted by patients. No cases have been reported yet where the insurer went to carry out additional investigation to verify a patient claim.

Web analysis shows that 24 out of 32 NCP websites provide information on the services that healthcare providers offer. In addition, eighteen of them make a tool available that shows which healthcare providers provide the treatments they are searching for. This information was confirmed (although only partially) by the pseudo patient investigation exercise, in which seven out of 12 NCPs explained to patients that the healthcare providers they indicated were authorised to perform the treatment. None of the NCPs recommend a specific healthcare provider, thus the ultimate responsibility to make this investigation lies with patients. Nevertheless, NCPs help patients in making this choice via the above-mentioned tools.

In addressing EQ 8, the findings showed that the documents patients have to submit and the relative language in which they must be submitted were already well detailed. Evidence provided in EQ 8 is referred to. It should be noted that both some National Contact Points (five Member States out of 12) and health insurance providers (five Member States out of 12) generally ask for a referral note from a national healthcare provider.

Administrative burden

12. What are the administrative burdens of the reimbursement processes in relation to cross-border care, such as National Contact Points, transaction costs, invoicing costs, costs associated with patient outflow and inflow?

At present, the volume of cross-border cases based on the Directive is modest. In order to handle the flow of patients, in some cases, the designated NCP merges his/her NCP functions with other functions in his organisation. In one case, the reported NCP resource allocation decreased from 0.7 to 0.3 FTEs during the course of 2014 in view of the limited needs verified for this assistance. However, as more patients become informed about the Directive, there is a risk that the NCP-related activities will be superseded by other priorities, while demand increases, which could lead to bottlenecks and delays.

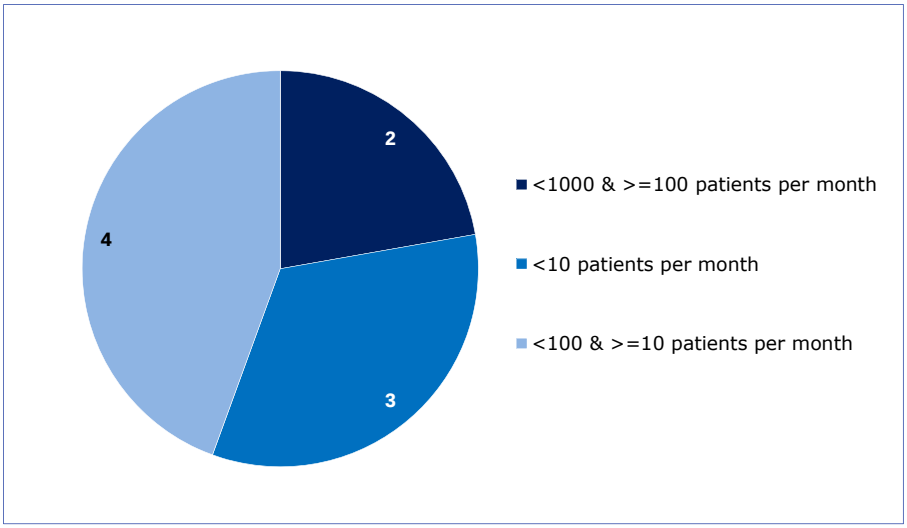
Regarding prior authorisation and corresponding reimbursement, each cross-border healthcare claim requires an individual assessment on a case-by-case basis by health insurers. As a result it can lead to a high administrative workload per claim for health insurers. The main sources of this administrative burden on insurers include translation costs (where not covered by patients) and the review and processing of medical documentation. There is no reliable information available yet on the costs associated with patient inflow and outflow.

The online survey shows that NCPs are structured in different ways, employing between one to three FTEs.

Of the eight NCPs that answered the question, five have established a dedicated office while in two other countries the activities are carried out by the departments responsible for international relations. Of the five NCPs that have established a dedicated office, one NCP only has one employee working 70% of his/her time, while four have between two and three employees working full time for the NCP. It is worth highlighting that, given the lack of activity, one NCP informed us that it plans to decrease its dedicated work-force.

Again in the online survey, seven NCPs out of nine stated they received less than 100 requests per month, and no NCPs received above 1000 requests, as shown in the figure below.

Figure 9- Average frequency of patients requesting information from the NCP



The interview shows that eight out of 15 insurers state they incur administrative costs related to cross-border healthcare, mainly represented by the translation of invoices and bank transaction fees.

Benchmarking / Best practice

13. Is there an established benchmark / best practice in the Member State regarding reimbursement such as: reimbursement will occur in the same number of days as for internal procedures or such days augmented by a fixum (national deadline + x days) and how does it compare with cross-border healthcare processes?

Evidence on established benchmarks/best practices regarding the time needed for the reimbursement is not presently available. These data, collected through interviews with the insurers, show that the cross-border healthcare reimbursement processes are normally slightly longer. Supposedly, this could derive from the time needed for the translation of the invoices.

Reimbursement practices in Member States - as illustrated in the following table - have lead times for reimbursement ranging nationally from seven to 90-180 days while those under the Directive range from 21 to 90-150 days.

Table 6 - Time needed for reimbursement

HIPs	Nationally	Directive
HIP A	n/a	30 days
HIP B	n/a	30-90 days
HIP C	n/a	n/a
HIP D	n/a	21 days
HIP E	7 days	Depends on cases
HIP F	n/a	n/a
HIP G	n/a	n/a
HIP H	28-42 days	n/a
HIP I	n/a	n/a
HIP J	90-180 days	90-150 days
HIP K	n/a	90 days
HIP L	60 days	60-90 days
HIP M	n/a	n/a
HIP N	n/a	n/a
HIP O	n/a	45 days
HIP P	10 days	30 days
HIP Q	n/a	n/a
HIP R	2-3 days	2-3 days
HIP S	30 days	30 days
HIP T	n/a	30 days
HIP U	n/a	30 days

As shown in EQ 11, the translation of the invoices is an activity likely to add work to the health insurance providers.

14. How efficient are the reimbursement processes in different Member States in relation to a) established individual national benchmarks or b) benchmarks established in the transnationally operating private health insurance sector?

According to the desk research carried out on a number of leading private health insurance companies offering healthcare assistance[31], it appears that the insurers directly pay to the providers for treatments received by their insured. In cases in which patients have to pay upfront, reimbursement varies from those paying within 48 hours and others paying 30-60 days after the presentation of the documentation. This lead time is slightly shorter than the one for reimbursement under the Directive.

Stakeholder interviews with private health insurance providers in the healthcare sector explained that reimbursement occurs after submission of relevant documentation in 48 hours (one out of three) or in 30/60 days (two out of three)[32].

As shown in EQ 13, the lead time for reimbursement is around 30-90 days, with the exception of one insurance that reimburses patients for cross-border healthcare within two/three days and another one in 90-150 days. This latter HIP reimburses patients for treatments received in its Member State in 90-180 days.

15. What are the most recent tools regarding payment systems and reimbursement of healthcare?

Healthcare providers usually require the treatments to be settled by patients via cash, bank transfer or by credit card. When larger amounts are involved, they will usually require payment in advance. Patients are generally reimbursed by insurers via bank transfer, however, due to the limited number of reimbursed cases so far, no robust trend or common approach can be identified.

All five healthcare providers usually require the treatments to be settled by patients via cash, bank transfer or by credit card.

The only two NCP websites that provide information on tools for reimbursement describe bank transfers as being the most common method.

[31] We focused on programs regarding healthcare assistance for traveller, expatriated and international healthcare programs.

[32] Desk research was carried out on the website of some private Health Insurance Providers which offer Healthcare assistance and Crossborder healthcare.

3.2 Quality and Safety

Dissemination of information

16. To what extent are patients in the Member States informed about the quality and safety of cross-border healthcare before and after their choice, including information on where to seek help in case of harm? How easy was it to find information (availability) and how accessible was it to a non-specialist audience (accessibility)? What determines patients' first choice of a provider situated outside their home country?

National Contact Points indicate that some high-level, generic information is provided on quality and safety of cross-border healthcare. However, only a few websites publish practical and easily understandable information (for instance, on aspects of the quality of healthcare providers) to help patients make an informed choice.

Most National Contact Points provide information on the authority to be contacted in the event of harm. Nevertheless, detailed information on the procedure to be followed is rarely available for patients.

Based on the stakeholder interviews conducted with patient groups, patients usually rely on information from other patients. The main drivers influencing their first choice are the perceived quality of the healthcare provider, the waiting time at the destination and the expected costs regarding the healthcare and any additional expenses.

Seven out of eight NCPs answered in the online survey that they provide information both on quality and safety. Two of them gave as reference their own website. The web analysis shows that information on quality and safety is usually generic, as it refers to national laws, regulations and policies, national quality strategies, certifications required by the healthcare system and regulatory activities. Few NCPs give easily understandable information[33] on the aspects of the quality of healthcare providers. One of the few NCPs that made available this detailed information was the German one:

[33] Rating made by other patients, number of treatments per year, etc.

Figure 10 - Statistics on healthcare providers, German NCP

Name	Distance (air line)		Recommendation of patients	medical care	nursing care	Organization and service
Hospital of the Augustinians , Cologne Expand departments	1.2 km	427	81%	80%	78%	76%
St. Mary's Hospital , Cologne Expand departments	1.4 km	82	70%	78%	75%	77%
Eduardus Hospital , Cologne Expand departments	1.7 km	524	87%	85%	84%	81%
Malteser Hospital St. Hildegard , Cologne Expand departments	2.2 km	352	77%	81%	78%	74%
Lutheran Hospital Cologne-Weyertal , Cologne Expand departments	2.4 km	362	78%	82%	78%	73%
University Hospital of Cologne , Cologne Expand departments	2.6 km	1853	82%	83%	81%	74%
St. Antonius Hospital, Cologne , Cologne Expand departments	2.9 km	247	73%	79%	78%	73%

The web analysis shows that 19 out of 32 NCP websites provide general information on whom to contact in the event of harm. Pseudo patient investigation confirmed that only three out of 12 NCPs provide information on this matter. To more specific questions, such as the procedure to be followed in the event harm occurs, only two NCPs were able to answer.

Three out of five patient groups interviewed highlighted that patients rely on the experiences of others who have already been treated by that healthcare provider. Patient groups added that the other information on which patients rely on are the specialised knowledge and reputation of doctors, and the availability of on-the-spot assistance during the treatment.

Patient groups interviewed explained that in their view, patients' choice is influenced by the perceived quality of the healthcare provider, the expected costs for the healthcare and any additional expenses and the waiting time at the destination. The latter is considered by four of them as the main factor influencing patients' choices.

17. Has the provision of information by the Member State of affiliation been impartial in regards to the patient's options for treatment?

The results of the pseudo patient investigation exercise indicate no evidence of the information provided by the National Contact Points being biased or distorted. Patient groups have reported no cases for complaints in this respect either.

The evidence supporting the answer is provided in "Annexes 4 – Pseudo patient investigation exercise" and 5 – Stakeholder interviews".

18. What information in terms of quality and safety does the patient consider useful in relation to cross-border healthcare?

Patient groups reported various factors that are considered by patients in making their choice. Those include, for instance, positive feedback from other patients, specialised knowledge and reputation of medical professionals, the availability of on-the-spot assistance during treatment and proven quality of the treatment.

Looking at the way information on quality and safety is presented on different websites, it appears that the attempt is to relay as a quality parameter recommendations from other patients or from specifically appointed commissions. As far as healthcare proper is concerned, some items like mortality rate, number of treatments administered etc. are being used. These items are often summarised in such a way they are easily understandable. It is worth considering the fact that in the interviews, two healthcare providers state that in any case patients' choice is mainly based on experiences of close persons, physicians or advice from specialised staff.

19. How many patients in the Member States refrain from using cross-border care as a result of poor information in relation to requests from the National Contact Point?

A significant proportion of patients refrain from using cross-border healthcare as a result of poor information according to patient groups. This appears to be the result of insufficient information on reimbursement and prior authorisation.

Through desk research it was found that quality and safety seems not to be the most important driver to refrain from using cross-border care. This finding was confirmed by the six patient groups interviewed, who identified as the main reasons the insufficient provision on reimbursement and prior authorisation[34]. The figure below shows the opinions of patient groups surveyed:

[34] This outcome could be compared with the result of the study Barriers to cross-border health care: can behavioural insights help? , Dr Charlotte Duke, London Economics. http://londoneconomics.co.uk/wp-content/uploads/2013/10/Cross-border-healthcare-presentation-30.09.13-Final.pdf.

Figure 11 - Main reasons patients refrain from using cross-border care as estimated by patient groups interviewed

Processes and outputs

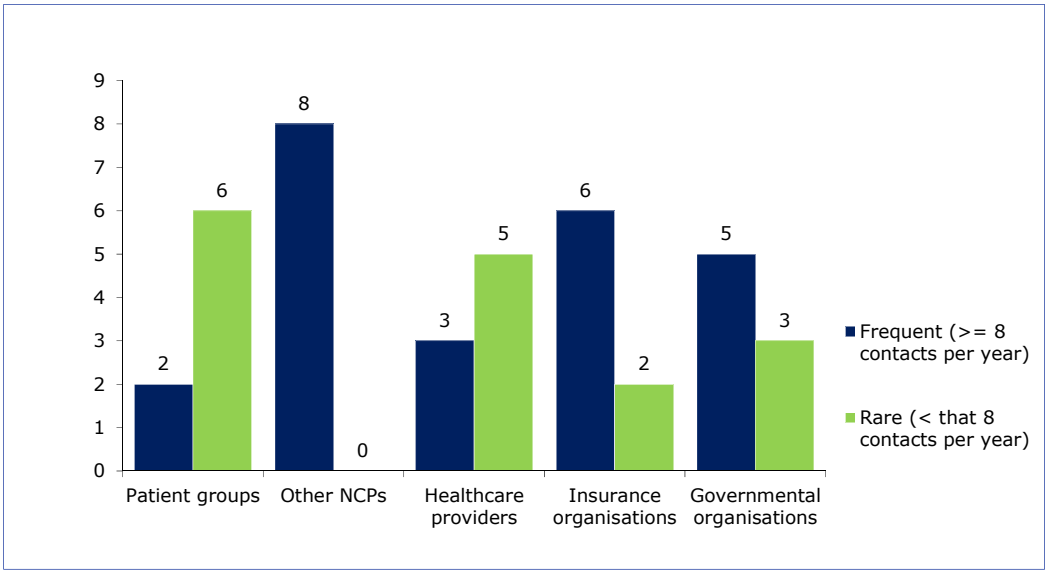
20. What is the level of patient-oriented co-operation between health professionals and health organisations in relation to cross-border care?

Interview and survey outcomes indicate that the focus is mainly on the development of co-operation between National Contact Points across Europe. National Contact Points frequently seek consultation from and provide information to each other, which is an important practical benefit of the implementation of the Directive. Patient groups have also organised professional events and seminars, thus facilitating the overall level of knowledge and co-operation among the various stakeholders of the healthcare sector.

The co-operation is less frequent and mostly formal between insurers and healthcare providers and the existing bilateral agreements are usually not explicitly related to the Directive.

As shown in the following figure, the results of the online survey indicate that NCPs collaborate with various entities with different frequencies.

Figure 12 - NCPs' level of cooperation with stakeholders



Despite the low level of cooperation between patient groups and NCPs, one of the NCPs expressed an intention to set up office visiting hours with patient rights representatives. One of them also explained that several conferences and seminars were organised with the aim of facilitating cooperation and the spread of knowledge among the main stakeholders involved in the implementation of the Directive.

Six out of thirteen healthcare insurance providers explained that agreements with healthcare providers exist, although not strictly related to the Directive. In this regard, a number of formal agreements have been mentioned, implementing agreements also on pricings for selected treatments.

21. To what extent are patients able to receive follow-up treatment, including recognition of prescriptions in their MS of affiliation after usage of cross-border healthcare?

Interviewees unanimously responded that physicians are generally obliged by law and most certainly by deontological standards to provide follow-up treatment to patients after receiving medical care in another Member State. In addition to this, no evidence indicates that there have been any complaints from patients regarding follow-up treatment in their Member State of affiliation.

In order to obtain follow-up treatment, patients are generally required to provide their general practitioner with the medical documentation received.

Four out of five frontline healthcare prescribers, eight out of eleven HIPs and four out of six HCP that answered the question explained that healthcare providers are obliged to provide follow-up treatments. Frontline healthcare prescribers also explained that this requirement is part of their usual deontological standards. In the pseudo patient investigation exercise, NCPs answered a specific question related to the documentation needed for follow-up treatment, explaining that a medical referral note is needed.

Administrative burden

22. What are the administrative burdens on Member States in relation to the number of patients who benefit from cross-border care, regarding quality and safety; how do these issues affect the operations of cross-border care?

As the number of patients benefiting from cross-border care under the Directive is still modest the only burden identified so far is on the one hand to enquire for and on the other hand to provide evidence on whether the healthcare providers selected by patients meet the national minimum standards. This activity includes correspondence with the selected institutions and the verification of information.

One of the requirements for granting prior authorisation is to check whether healthcare providers meet the required minimum safety standards. It was noted by one insurance provider during the interview stage the need to contact directly a foreign National Contact point to clarify these requirements. This highlights that information on safety standards is oftentimes scant, difficult to obtain and not easily comparable for insurance providers across countries.

Benchmarking / Best practices

23. Is there a reference standard on how to address issues of language barriers, interoperability, continuity?

In addressing issues of language barriers, a commendable practice has been identified with healthcare providers that frequently accept foreign patients and provide language assistance and translation for them.

An organisation of frontline healthcare prescribers identified a clear need for an easy-to-use system for e-invoicing and electronic patient records to enhance cooperation between healthcare professionals and the interoperability of healthcare systems in different Member States. No evidence has been identified by the study regarding the emergence of such solutions between Member States[35].

Follow-up treatments are granted by both legal obligations and deontological standards for patients following cross-border healthcare, thus continuity of care is generally ensured.

Interviews with a private organisation of healthcare providers showed that their affiliated healthcare providers make a translation service available to patients to address issues of language barriers.

An organisation of frontline healthcare prescribers highlighted, as potential development of the functioning of the Directive, the need for an easy-to-use system for e-invoicing and electronic patient records to enhance cooperation between healthcare professionals and the interoperability of healthcare systems in different Member States.

[35] Electronic prescriptions are slowly spreading in the European Union, Mäkinen M1, Rautava P, Forsström J, Aärimaa M., Telemed J E Health. 2011 Apr;17(3):217-22. doi: 10.1089/tmj.2010.0111. Epub 2011 Mar 5.

The stakeholders interviewed unanimously stated that the right to receive follow-up treatment is guaranteed and, thus, continuity of care seems to be granted in each Member State. Nonetheless, healthcare providers and frontline healthcare prescriber organisations highlighted the need for a minimum set of personal and clinical data, such as European rules that have already been established for prescriptions of medical products and medical devices[36].

3.3 Undue delay

24. What is the definition of waiting times/undue delay in different Member States?

Waiting time is the number of days needed for a patient to receive a specific treatment at a specific healthcare provider, usually from the time of referral by a general practitioner or specialist[37]. To inform patients, some health insurance providers and healthcare providers publish 'waiting times' which are in fact the average waiting times for individual patients at a specific healthcare provider for a specific treatment.

As defined by the study "The Right to Health at the Public/Private Divide"[38]: 'Undue delay is defined as the period within which medical treatment is necessary with respect to the patient's medical condition, the history and probable course of the patient's illness, the degree of pain the patient is in and/or the nature of the patient's disability.' There is no availability of public data on undue delay with the exception of a few Member States which have established standardised measures for various waiting times[39].

Some health insurance providers and healthcare providers publish the average waiting times for individual patients at a specific healthcare provider for a specific treatment. For instance, the following figure shows the average waiting times for a computed tomography in the Lazio Region for the month of January 2015:

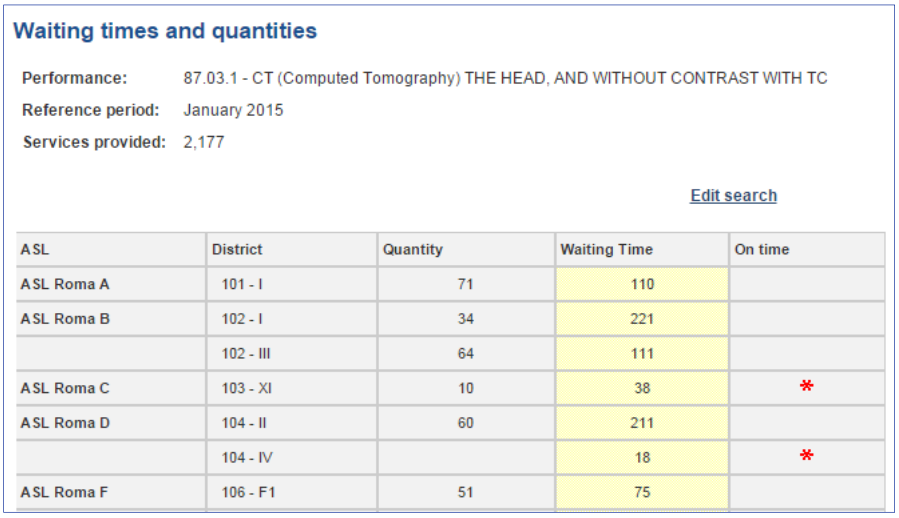
[36] Directive 2012/52/EU of 20 December 2012 laying down measures to facilitate the recognition of medical prescriptions issued in another Member State.

[37] For definitions see Siciliani, L., V. Moran and M. Borowitz (2013), "Measuring and Comparing Health Care Waiting Times in OECD Countries", *OECD Health Working Papers*, No. 67, OECD Publishing. http://dx.doi.org/10.1787/5k3w9t84b2kf-en.

[38] Flood, C. M., and Gross, A. (eds.) (2014), "The Right to Health at the Public/Private Divide", Cambridge University Press.

[39] This definition is provided also by art. 8.5 of the EU directive 24/2011.

Figure 13 - Outpatient waiting times for a computed tomography in Lazio Region, January 2015



Waiting times and quantities

Performance: 87.03.1 - CT (Computed Tomography) THE HEAD, AND WITHOUT CONTRAST WITH TC
Reference period: January 2015
Services provided: 2,177

Edit search

ASL	District	Quantity	Waiting Time	On time
ASL Roma A	101 - I	71	110	
ASL Roma B	102 - I	34	221	
	102 - III	64	111	
ASL Roma C	103 - XI	10	38	*
ASL Roma D	104 - II	60	211	
	104 - IV		18	*
ASL Roma F	106 - F1	51	75	

25. What are the waiting times in different Member States regarding healthcare? Are patients informed about their own waiting time?

Some Member States measure and publish waiting times for different medical treatments, either for inpatient or for outpatient care. The practice varies, with only a few Member States systematically publishing consolidated information about waiting times at regional or national level, serving thus as an indicator for patients seeking treatment. Among these Member States, only one National Contact Point[40] provides in its website the link for assessing national waiting times.

In general, patients can obtain information about waiting times without any significant difficulty. Interviews with representatives of patient groups indicate that where waiting times are not published, patients can usually turn directly to the healthcare provider and the insurer to get this information.

Through desk research, it was found that some HCPs and HIPs of Member States publish waiting times for different medical treatments (e.g. see EQ 24). Conversely some Member States publish national waiting times for inpatient care, as the following table shows:

[40] Danish NCP, at the weblink: http://www.esundhed.dk/sundhedskvalitet/NIV/NIV/Sider/Venteinfo.aspx.

Table 7 - Average inpatient waiting time from specialist addition to list to treatment[41]

	Hip replace-ment	Knee replace-ment	Cataract surgery	Hystere-ctomy	Prostat ectomy	Cholecys tectomy	Hernia repair	CABG[42]	PTCA[43]
Finland	127	149	114	94	68	90	96	58	34
Netherlands	46	44	33	35	32	35	36	27	16
Portugal	128	206	66	86	101	134	120	24	
Spain	127		89		91	89	87		
UK-England	90	97	66	70	41	81	71	63	40
UK-Scotland	90	94	70	53	55	77	82	47	33

Five of out of six patient groups stated that patients are knowledgeable about their waiting times and two out of six stated that this is because patients can usually turn directly to the healthcare provider and the insurer for this information, or access it on the internet.

26. What are the practices regarding undue delay in different Member States (individual assessment vs. standardised waiting times)?

In most Member States undue delay is determined based on individual assessment by clinical specialists or general practitioners. However, there are Member States that assess undue delay on a standardised basis which is legally binding, while others provide indicative guidelines on the acceptable maximum waiting time for specific treatments. The approach of Member States towards limiting waiting times considerably varies, with some Member States even providing additional rights to patients automatically in case the maximum waiting time has been exceeded (e.g. offering care from private healthcare providers).

It was found that four countries[44] state and clearly explain on the NCP websites that waiting time is always individually assessed.

This assessment is confirmed by the interviews, in which eleven out of thirteen health insurance providers that answered the question and four out of six frontline healthcare prescriber organisations explained that waiting time is generally individually assessed in their countries. Only two countries of the frontline healthcare prescribers interviewed have standardised waiting times for all treatments.

According to the literature, standardised acceptable waiting times are applied in Denmark, limiting the provision of treatment to a maximum waiting time of four

[41] Siciliani, L., M. Borowitz and V. Moran (eds.) (2013), measuring and comparing health care waiting times in OECD countries, OECD health working paper no. 67, http://www.oecd.org/health/workingpapers.

[42] Coronary artery bypass graft.

[43] Percutaneous transluminal coronary angioplasty.

[44] Estonia, Spain, Sweden and Luxembourg.

weeks[45]. A similar provision also exists in the Netherlands, in the form of guidelines known as "treek norms". These norms define:

- For outpatient and extramural care a waiting time of five weeks. All patients should be able to obtain outpatient care within that time-limit, and 80% within three weeks.

- For hospital care a waiting time of eight weeks, within which all patients should be treated, and at least 50% of these within three weeks.

However it appears that actual waiting times are much longer[46].

In Denmark, if the hospital to which a patient is referred to foresee that the maximum waiting time cannot be complied with, the patient should be given the option to choose another public hospital or a private hospital or clinic at public cost.

27. What are the entitlements in different MSs regarding waiting times in relation to healthcare?

Different approaches exist regarding patients' entitlements in case of waiting time not considered medically justifiable. Insurers usually provide assistance to patients in finding affiliated hospitals that can treat patients in due time within the Member State. In some Member States patients are entitled to receive healthcare from private providers in their own country and at their own expense and be subsequently reimbursed by the insurer.
Without prejudice to Article 8.6 (a), (b), (c) of the Directive, in addition to these options, the Directive grants the right to patients to seek healthcare in another Member State with prior authorisation if waiting time have been exceeded.

The transposition of the Directive into national legislation of Member States has granted an additional right. It states that, without prejudice Article 8.6 (a), (b), (c) of the Directive, if the waiting time is not considered justifiable, prior authorisation to patients seeking cross-border healthcare in another Member State must be granted.

As shown in EQ 26, in Denmark, if the hospital to which a patient is referred to foresee that the maximum waiting time cannot be complied with, the patient should be given the option to choose another public hospital or a private hospital or clinic at public cost. Also in Italy, the national healthcare plan for waiting lists[47], states that if waiting times for treatments[48] are not complied with, the healthcare institutions should indicate public and private but accredited providers able to ensure that the treatment is carried out within the time-limit. If none of these national healthcare providers can perform the treatment via public access in due time, these providers have to treat the patient as a

[45] Siciliani, L., M. Borowitz and V. Moran (eds.) (2013), Waiting Time Policies in the Health Sector: What Works?, OECD Health Policy Studies, OECD Publishing. http://dx.doi.org/10.1787/9789264179080-en.

[46] Yves Jorens, Barbara De Schuyter, Cindy Salomon, Towards a Rationalisation of the EC Co-Ordination Regulations Concerning Social Security, Academia Press, 2008.

[47] Cittadinanzattiva – Rapporto PiT Salute 2011.

[48] Only for 58 outpatient treatments. Details available at: http://www.cittadinanzattiva.it/approfondimenti/salute/liste-di-attesa/2897-nuovo-piano-nazionale-sul-contenimento-delle-liste-dattesa.html.

private one. Since being given treatment as private patient is generally more expensive, the occurring additional costs are covered by the Local Health Authority.

The web analysis showed the English National Contact Point highlights similar patient entitlements regarding waiting time. Patients have the right not to wait longer than 18 weeks from the referral. Otherwise they are entitled to lodge a complaint using the "NHS complaint procedure". If the surgical intervention is cancelled by the hospital at the last minute for non-clinical reasons, the hospital should offer another binding date within a maximum of the next 28 days or fund the treatment at the time and the hospital of the patient's choice.

From the interviews conducted with health insurance providers, it emerged that in two countries and in one region undue delay is a concept that does not exist as patients are always treated in due time. Four out of sixteen insurances stated that they are not the responsible entity for finding an alternative treatment option for patients in their home country. In other cases the health insurance providers help patients find an alternative.

28. Are there any best practices or benchmarks in relation to processes regarding different issues of undue delay in the MS?

As in most Member States undue delay is individually assessed based on personal medical conditions, and there are only a few examples for applying legally-binding standardised waiting times, the evaluation has not identified any practice to referred to as particularly commendable at the present stage of implementing the Directive.

4 CONCLUSIONS AND SWOT ANALYSIS

4.1 Conclusions

This chapter presents a summary of the main findings of this study. It is important to underline the point that whilst the Directive is at its early stages of implementation, data available for analysis is scarce. This limitation is due to the fact that Member States have yet to begin appropriately monitoring patient inflows and outflows. At this stage it remains too early to comment on the full effects of the Directive on stakeholders and primarily patients, though a number of core conclusions can already be drawn from data hitherto collected.

Awareness of the Directive among Stakeholders

1) **Information and communication activities of National Contact Points and other relevant authorities focused particularly on reaching professional and medical audiences.** An attempt to reach the general public was made so far in some countries through mainstream media, this being primarily restricted to the time period of transposition of the Directive into national legislation (i.e. between autumn 2013 and early 2014). Over the past year, patients could consult the websites of healthcare authorities and NCPs for information on cross-border healthcare. Patients have good knowledge of the options available under the Regulation of 2004 linked to the European Health Insurance Card (EHIC) that are considered to be an appropriate tool for seeking healthcare treatment within the European Union. In contrast, this study found that patients are generally unaware of the existence of the Directive, and thus the least informed stakeholders. Although the Commission has provided support for the dissemination efforts of individual Member States, and more specifically of NCPs via a number of instruments, the Member States will need to increase their efforts in promoting the Directive to their citizens seeking cross-border care.

2) **Knowledge-sharing between National Contact Points and their co-operation with relevant authorities and medical organisations is improving.** The Directive and its transposition into national law have prompted a number of professional events, seminars and workshops resulting in intense knowledge-sharing among the newly established NCPs and fostering co-operation between NCPs and the relevant national authorities and medical-professional organisations. This knowledge sharing exercise may have contributed to the successful implementation of the Directive however it was noted that cooperation among stakeholders is often put in place just to find solutions to single patients' requests and issues and are not aimed at the more general purpose of standardisation of the procedures.

Information available to Patients on Cross-border Healthcare

3) **Responsibility for gathering relevant information about healthcare providers abroad, including on the quality of services rendered, and selecting an appropriate facility lies predominantly with the patients.** National Contact Points and insurers provide general assistance to patients, however, in some Member States this assistance is not tailored to their specific needs. National Contact Points tend to avoid the explicit provision of recommendations of healthcare providers to patients.

4) **Member States increasingly publish the list of treatments which are subject to prior authorisation. This facilitates patients' understanding of which treatments can be received abroad without the need to contact the health insurance providers in advance**. Insured residents of Member States are entitled to be reimbursed for a wide range of healthcare services received in another Member State. Beyond inpatient care, a significant proportion of outpatient treatments may also be subject to prior authorisation by the insurer in the Member State of affiliation. A number of NCPs and health insurance providers already publish the lists of treatments considered cost-intensive and thus subject to prior authorisation.

Quality and Safety of Cross-border Healthcare

5) **Patients find it challenging to determine the quality and safety of healthcare services.** According to Article 4.2 of the Directive, Member States must ensure that healthcare providers offer relevant information to help patients make informed choices concerning cross-border healthcare. However, the measurement and communication of quality and safety information is dependent on national law and, within national borders, patients' choice is largely guided by general practitioners' recommendations and/or other users. It could be necessary to make available to patients suitable tools to enable a quality and safety assessment of providers. This could be done by adding quality indicators on the search engine tools of the NCPs, such as the rating by the other patients. Also, the European Reference Network system could help to support the benchmarking efforts on quality and safety.

6) **No common approach currently exists to measure waiting times for diagnosis, and to assess undue delay within a specific Member State or across the European Union.** The practice of publishing waiting lists, types of treatments covered, measuring actual waiting times or reference points for undue delay varies significantly among Member States.

Administrative Burden

7) **Due to the early stage of implementation and the small number of test cases, the actual administrative burden on Member State authorities may increase in the future.** The longer-term consequences of the implementation of the Directive cannot yet at this stage be fully determined. What is clear however is that cross-border healthcare imposes a larger administrative burden than domestic cases, primarily for NCPs and insurers. It can be anticipated that as increasing number of patients exercise their rights to cross-border healthcare, the corresponding workload will increase substantially. In the future, emphasis should be placed on assessing potential gaps in capacity and address imbalances between information supply and demand in view of the additional administrative burden.

4.2 SWOT analysis

The SWOT analysis is the process of exploring the internal and external environments of an organisation or process and extracting strategies based on its strengths, weaknesses, opportunities and threats[49]. The following table summarises the various dimensions of the implementation of the Directive in order to provide a snapshot of the current situation and provide guidance for policy-makers, based on the findings of this study.

Strengths	Weaknesses
1. Patients rely on information provided by NCPs to make informed choices about healthcare providers **2.** Patients benefit from enhanced patient-oriented cooperation between NCPs and other professional stakeholders, i.e., healthcare providers and health insurance providers **3.** Patients benefit from the recognition of follow-up care subsequent to cross-border healthcare treatments **4.** Patients benefit from rules related to waiting times in the Directive, having the right to be treated abroad when undue delay occurs	**1.** Patients were not directly targeted by information campaigns, instead the focus leaned towards medical professionals. **2.** Patients are often given predefined responses concerning the procedure for accessing cross-border healthcare. Answers are based on the legal text of the Directive rather than being appropriately tailored to the patient's query **3.** Patients have difficulty in interpreting quality and safety information about cross-border healthcare **4.** Patients are not normally informed of their rights under the Directive by their frontline healthcare providers as these healthcare professionals do not have sufficient knowledge of the Directive **5.** Patients often refrain from choosing cross-border healthcare due to burdensome administrative procedures
Opportunities	**Threats**
1. Patients could benefit from improved quality and safety and shorter waiting times through competition between healthcare providers, stimulated by the Directive **2.** Patients could benefit from the introduction of an interoperable online health record system, as their clinical data would be available to healthcare providers **3.** Patients could benefit from targeted communication campaigns on the procedural processes of cross-border healthcare	**1.** Patients may encounter difficulties in proving to their insurers that the waiting time for treatment in their country of affiliation causes them undue delay **2.** As patient flow increases, patients may incur unforeseen administrative delays due to the case-by-case assessment of claims **3.** Increased patient flow may also result in further administrative burden for Member State authorities **4.** Opportunistic behaviour of healthcare providers in close proximity to national borders may hamper the implementation of the Directive **5.** Difficulties for patients in understanding quality and safety information may discourage them from using cross-border healthcare

[49] Ghazinoory, S. Abdi, M. Azadegan-Mehr, M. 2011, Swot methodology: A state of the art review for past, a framework for future, Journal of business economics and management.

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National Contact Point, Croatia: http://www.hzzo.hr/en/travel-insurance/english-emergency-care-in-the-eu

National Contact Point, Denmark: https://www.patientombuddet.dk/

National Contact Point, http://kontaktpunkt.sm.ee/eng/home.html

National Contact Point, http://www.crossbordercare.gi/cms_two.aspx?pageID=2

National Contact Point, http://www.eopyy.gov.gr/Home/StartPage?a_HomePage=Index

National Contact Point, http://www.hzzo.hr/en/travel-insurance/english-emergency-care-in-the-eu

National Contact Point, http://www.kela.fi/yhteyspiste

National Contact Point, http://www.nhs.uk/NHSEngland/Healthcareabroad/Pages/Healthcareabroad.aspx

National Contact Point, http://www.sante.gouv.fr/point-de-contact-national-pour-la-france.html

National Contact Point, Latvia, http://www.vmnvd.gov.lv/en/news

National Contact Point, Lithuania, http://www.lncp.lt/en

National Contact Point, Northern Ireland: http://www.hscboard.hscni.net/publications/Policies/270%20Information%20for%20patients%20travelling%20outside%20Northern%20Ireland%20for%20treatment.html

National Contact Point, Poland: https://www.ekuz.nfz.gov.pl

National Contact Point, Scotland, http://www.nhsinform.co.uk/rights/europe

National Contact Point, Slovakia, http://www.nkm.sk/

National Contact Point, Slovenia, http://www.nkt-z.si/wps/portal/nktz/home

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ANNEX 1

Methodology

The aim of the study is to have a better understanding of the functioning of the Directive 24/2011/EU after one year of full implementation in the different MSs, by mean of three different aspects:

- reimbursement;
- quality and safety;
- undue delay;

and to answer the evaluative questions (EQs).

The questions were categorised into different areas of analysis for each aspect, as shown in the following table.

Table 8 - Evaluative study framework

Dimension	**Area of analysis**		
Reimbursement	Dissemination of information	EQs	1-5
	Processes and outputs	EQs	6-11
	Administrative burdens	EQs	12
	Benchmarking/Best Practices	EQs	13-15
Quality and safety	Dissemination of information	EQs	16-19
	Processes and outputs	EQs	20
	Sustainability	EQs	21
	Administrative burdens	EQs	22
	Benchmarking/Best Practices	EQs	23
Undue delay	Undue delay	EQs	24-28

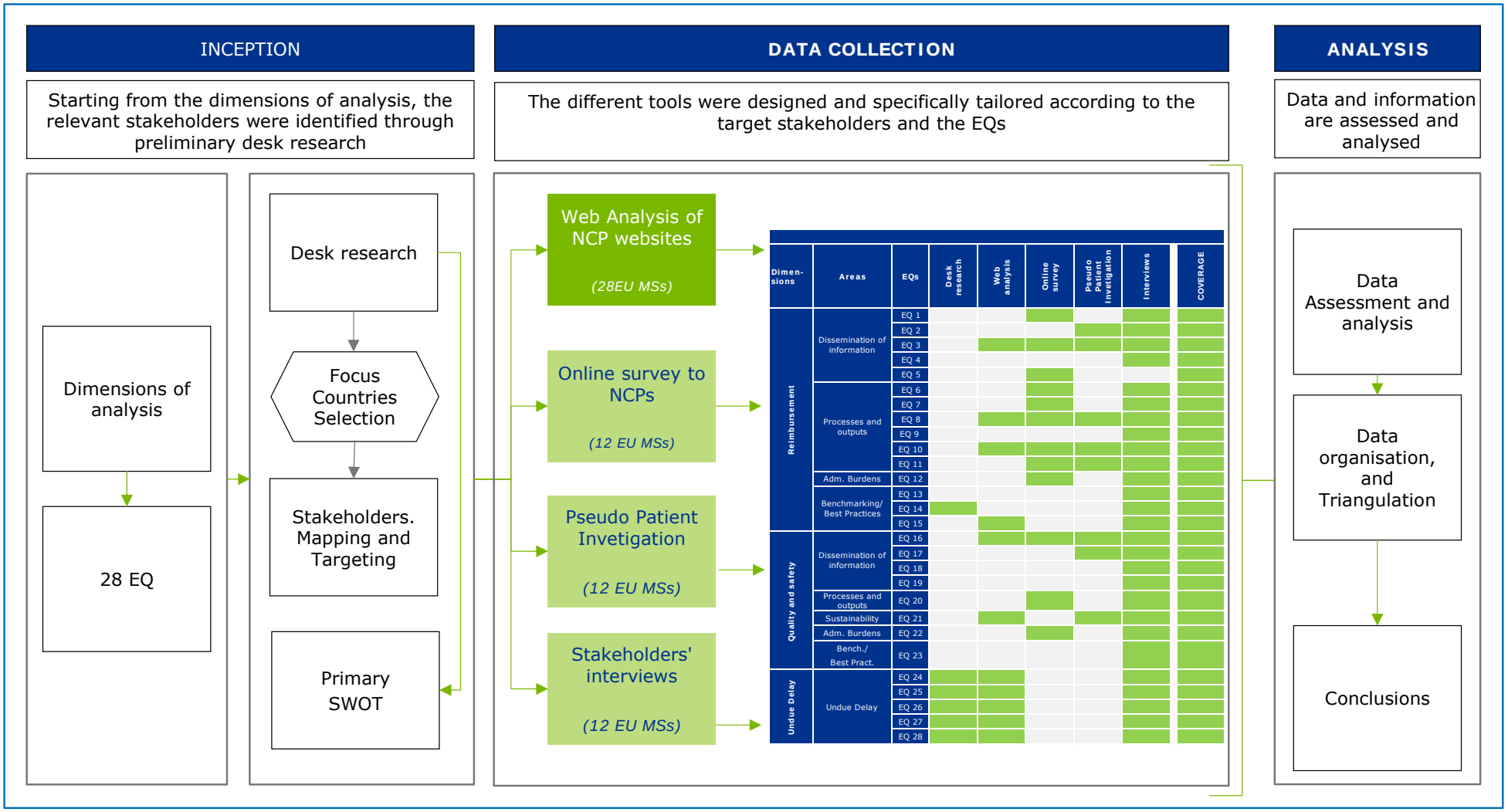
The evaluative study has to deal with several complex issues, the most important of which is the number of countries involved, the different healthcare structures, and a significant number of stakeholder groups to be involved in the data gathering process. Another major complexity is the lack of reliable quantitative data on patient flows under the Directive.

Based on these key features, the evaluative strategy was developed combining different tools aimed at gathering information from the different Member States. In order to ensure efficient and effective data collection and analysis with a view to achieving the main objectives of the study, we focused on a limited number of countries for the in-depth research[50].

Our approach is summarised in the following figure:

[50] See pargraph 1.5 Selection of Member States.

Figure 14 - Overview of the conceptual and methodological framework



During the inception stage we already carried out in-depth desk research on the countries aimed at investigating the main characteristics and functioning of the national healthcare systems and the main stakeholders involved in the cross-border healthcare process. The initial outcome of this activity was the stakeholder mapping. The analysis was subsequently complemented to enhance the robustness of the stakeholder maps.

In parallel, various tools were designed and developed along the evaluative questions to be used for collecting data from multiple sources.

Combining the different tools, which were tailored to each specific analysis target, enabled the different EQs to be answered and to have a clear view on the Directive's functioning in different countries, as well as its strengths and weaknesses, together with the positions of different stakeholders in relation to the Directive.

The data collection stage started on 6 October 2014 with the web analysis, and was completed on 23 December 2014. Meanwhile, the triangulation of the information obtained and the analytical activities were carried out. This process was completed by mid-January 2015.

Problems encountered

Throughout the data collection stage the teams were confronted with the absence or lack of adequate and reliable quantitative data related to patient flows under the Directive. Almost all contacted stakeholders stated that data is not available regarding this. Monitoring systems are currently under development, consequently consolidated datasets are not yet available.

Web analysis

Objectives:	Identification of patient information available on NCP websites on reimbursement, quality/safety, and undue delay.
Timing	From 6 October 2014 to 6 November 2014
Target	All 32 NCPs websites of EU countries.

The analysis was conducted on the websites of the 32 NCP websites of European countries (the UK was divided into: England, Gibraltar, Scotland, Wales and Northern Ireland). Web addresses are specified in the following table:

Table 9 - Web addresses of National Contact Points

Country	Web address
Austria	https://www.gesundheit.gv.at/Portal.Node/ghp/public/content/kontaktstelle-patientenmobilitaet.html
Belgium	http://www.health.belgium.be/eportal/Aboutus/crossborder_healthcare/index.htm?fodnlang=en
Bulgaria	http://www.nhif.bg/web/guest/home
Croatia	http://www.hzzo.hr/en/travel-insurance/english-emergency-care-in-the-e
Cyprus	http://www.moh.gov.cy/moh/cbh/cbh.nsf/index_en/index_en?OpenDocument
Czech Republic	http://www.cmu.cz/
Denmark	https://www.patientombuddet.dk/Klage-_og_sagstyper/International_Sygesikring/Nationalt_kontaktpunkt_for%20_behandling%20_i%20_EU_EOES.aspx?sc_lang=en
England	http://www.nhs.uk/NHSEngland/Healthcareabroad/Pages/Healthcareabroad.aspx
Estonia	http://kontaktpunkt.sm.ee/eng/home.html
Finland	http://www.kela.fi/yhteyspiste
France	http://www.sante.gouv.fr/point-de-contact-national-pour-la-france.html
Germany	http://www.eu-patienten.de/
Gibraltar	http://www.crossbordercare.gi/cms_two.aspx?pageID=2
Greece	http://www.eopyy.gov.gr/Home/StartPage?a_HomePage=Index
Hungary	http://www.eubetegjog.hu/ (for outbound patients) http://www.patientsrights.hu/ (for inbound patients)
Ireland	http://hse.ie/eng/services/list/1/schemes/cbd/CBD.html
Italy	http://www.salute.gov.it/portale/temi/p2_6.jsp?lingua=english&id=3811&area=healthcareUE&menu=vuoto

Country	Web address
Latvia	http://www.vmnvd.gov.lv/en/news
Lithuania	http://www.lncp.lt/en
Luxembourg	http://www.cns.lu/?&language=en
Malta	https://ehealth.gov.mt/healthportal/chief_medical_officer/eu_healthcare_entitlement_unit/applying_ehic.aspx
Northern Ireland	http://www.hscboard.hscni.net/publications/Policies/270%20Information%20for%20patients%20travelling%20outside%20Northern%20Ireland%20for%20treatment.html
Poland	https://www.ekuz.nfz.gov.pl
Portugal	http://diretiva.min-saude.pt/inicio-4/
Romania	http://www.cnas-pnc.ro/?l=en
Scotland	http://www.nhsinform.co.uk/rights/europe
Slovakia	http://www.nkm.sk/
Slovenia	http://www.nkt-z.si/wps/portal/nktz/home
Spain	http://www.msssi.gob.es/pnc/home.htm
Sweden	http://www.socialstyrelsen.se/healthcare-visitors-sweden/about-swedish-healthcare-system/nbhw-national-point-contact (for inbound patients) http://www.forsakringskassan.se/privatpers/utomlands/om_du_planerar_vard_utomlands/er (for outbound patients)
The Netherlands	http://www.cbhc.nl
Wales	http://www.nhsdirect.wales.nhs.uk/travelhealth/NCPs/

Consideration has only been given to publicly-available information. As regards information available only upon request, please see "Annex 4 – Pseudo patient investigation" with the outcomes of the Pseudo patient investigation exercise.

Design

Starting from the EQs and the primary in-depth analysis of the documentation[51] available on the NCP websites, a set of 48 Specific Analytical Items (SAIs) has been designed.

[51] A study used as a starting point for the extended elaboration of the SAIs was: Santoro A., Silenzi A., Ricciardi W.; McKee M., Obtaining health care in another European Union Member State: how easy is it to find relevant information?, European Journal of Public Health august 2014, Oxford Univerity Press

The SAIs were organised in a specific electronic evaluation grid, which was used to gather information. The existence of information and a summary of the content available on the website were reported in the evaluation grid.

To present the results, the SAIs were re-organised into the following 12 categories:

- **Easy to find**: includes the existence of an independent NCP address (i.e. as opposed to it being hosted by another website, typically the Ministry of Health's) and looks at whether the website can be opened without any difficulty. It also considers the order in which the website was listed in the results of two different Google searches:
  - National Contact Point + name of the country;
  - National Contact Point + healthcare + name of the country.
- **Available channels**: includes the presence of e-mail, telephone and office addresses.
- **Available languages**: includes the availability of the website in different languages, even if only partly translated.
- **User-friendly**: includes how easy is it for users to find relevant information (measured in terms of time spent on the website), also related to the presence of the following sections: frequently asked questions (FAQs); most visited pages; a Media Library containing videos regarding cross-border healthcare.
- **Updates**: availability of the data of the last update of the information on the website.
- **Information on healthcare providers**: includes a description of the health system, the presence of information on healthcare providers (e.g. available services), the presence of information on contact details of national healthcare providers and the presence of tools to find a specific national healthcare provider in EU countries and the presence of various statistics on healthcare services provided.
- Patients' rights: includes:
  - presence of information on patients' rights to seek treatment in other EU country;
  - presence of information on the definition of waiting time;
  - presence of information on patients' rights in case of undue delay;
  - presence of information of patients' rights in the event of harm;
  - presence of information on access to hospitals for disabled patients;
  - presence of information on how to access electronic medical records;
  - presence of information on mechanisms to settle disputes (e.g. reimbursement issues);

  - presence of information for rare disease patients;
  - presence of information on complaint procedures in case of follow-up treatment issues.

- **Information on prior authorisation**: includes:
  - presence of information on which treatments require prior authorisation;
  - presence of list of treatments requiring prior authorisation;
  - presence of information on procedures to obtain the reimbursement;
  - providing form for prior authorisation;
  - presence of information on time period for requests to be dealt with.
- **Information on quality and safety**: includes:
  - presence of information on national legislation and policies regarding patient safety;
  - information on medical certifications and qualifications required by the national healthcare system;
  - presence of information on the national quality strategy;
  - presence of information on compliance checks and regulatory activity with respect to quality and safety standards (e.g. hospital inspection bodies, etc.).
- **Information on reimbursement**: includes:
  - presence of information on which treatments are reimbursed;
  - presence of information on which treatments are not to be reimbursed;
  - presence of requirements for the recognition of invoices/clinical information;
  - presence of information on time period for reimbursement;
  - presence of information regarding payment tools for reimbursement;
  - presence of information on type of tariffs to be applied.
- **Contacts of the other NCPs**: includes the presence of the e-mail address of the other National Contact Points or provision of the web-link of the EU's list of National Contact Points.
- **Clarity in differentiating EU policies**, specifically the Regulation 883/2004 and the Directive 2011/24/EU.

Conducting the data collection

Four teams of two consultants assessed and evaluated the 32 NCP websites between 6 October 2014 and 6 November 2014.

The twelve categories of SAIs were divided into three main types:

- **Type 1:** categories comprised only of one or two SAIs, where the presence/absence of information or the features of information were assessed.
- **Type 2:** categories comprised of more than one SAI in which a standardised threshold could be defined.
- **Type 3:** more complex categories where collected values have been clustered by topic and heterogeneous information has been analysed leveraging a statistical approach.

The following table presents the twelve categories broken down into the three evaluation types:

Table 10 - Type of SAIs

Category	Evaluation type
Updates	Type 1
Contacts of the other NCPs	Type 1
Clarity in differentiating EU policies	Type 1
Available channels	Type 2
Available languages	Type 2
Easy to find	Type 2
User-friendliness	Type 3
Info on healthcare providers	Type 3
Patients' rights	Type 3
Info on prior authorisation	Type 3
Info on quality and safety	Type 3
Info on reimbursement	Type 3

In order to evaluate the categories of the third type, the following statistical approach has been used:

Table 11 - Process to define the SAIs of the third type

- A maximum score was defined for each SAI.
- The sum of the maximum achievable SAI scores defined the maximum score for each category.
- A score for each SAI was defined for each website, by assessing the presence/absence of information.
- The sum of the scores that NCP addresses obtained in each category was divided by the maximum achievable score of that same category.
- For each category, NCP websites were ranked on the base of the score obtained.
- Quartiles were established.
- Countries were divided into the following groups:

The upper quartile (75th percentile) separated the NCP websites with the highest scores from the others.

The 2nd and 3rd quartiles (25th or 50th percentiles) include NCP websites with an average score.

The lower quartile (25th percentile) separated the NCP websites with the lowest scores from the others.

Limitations of the tool

The nature of the exercise involved the following limitations:

- the websites were analysed and assessed during the period 6 October 2014 to 6 November 2014;
- the websites were assessed both in the national language and in English, if available. When the team was not able to understand the language of the MS in question, a computer-aided translation was used;
- if the NCP site is embedded in the Ministry of Health website, or in another institutional website, the assessment was conducted only on the cross-border section.

Template used for the web analysis

Website analysis				
Section 1 - Web Description				
#	**Questions**	**Answers**		
1	NCP Address			
2	Indipendence of the NCP's address	Indipendent website ☐	Part of another website ☐	If part of another website, please indicate the organization to which the website is part:
3	Accessibility	Easy to open ☐	Page not found ☐	No longer exists ☐
4	Order in search (Google, Bing, Yahoo) for: "NCP + the name of the MS"	1st ☐	2nd-5th ☐	6th or after ☐
5	Order in search (Google, Bing, Yahoo) for: "NCP + healthcare + the name of the MS"	1st ☐	2nd-5th ☐	6th or after ☐
6	By clicking EU DG Sanco NCP's contact list, it opens:	Same address ☐	Other address ☐	Page not found ☐
7	Presence of e-mail address	Yes ☐	No ☐	If yes specify: *(text box)*
8	Presence of the office address	Yes ☐	No ☐	If yes specify where: *(text box)*
9	Presence of telephone numbers	Yes ☐	No ☐	If yes specify details: *(text box)*
10	Language	National ☐	English ☐	If other specify: *(text box)*
11	Friendliness of the interface for users (measured in time needed to find information)	High (<=10 minutes) ☐	Medium (>10 & <= 20 minutes) ☐	Low (>20 minutes) ☐
12	Presence of information on inbound patients	Yes ☐	No ☐	If yes specify the type of information: *(text box)*
13	Presence of information on outbound patients	Yes ☐	No ☐	If yes specify: *(text box)*
14	Presence of frequently asked questions	Yes ☐	No ☐	If yes, specify which: *(text box)*
15	Presence of information that clearly distinguish the EU Regulation 883/2004 and the EU Directive 24/2011	Yes ☐	No ☐	If yes specify: *(text box)*
16	Presence of most visited pages	Yes ☐	No ☐	If yes, specify which: *(text box)*
17	Last date of update of information	Yes ☐	No ☐	If yes specify when: *(text box)*
18	Presence of background information about the website (e.g. organisation responsible for the website)	Yes ☐	No ☐	If yes specify which: *(text box)*
19	Media Library containing video's regarding cross-border healthcare	Yes ☐	No ☐	If yes specify the link *(text box)*
Section 2 - Healthcare providers				
20	Presence of a description of the Health system	Yes ☐	No ☐	If yes, which information are provided? *(text box)*
21	Presence of information (e.g. available services) of healthcare providers	Yes ☐	No ☐	
22	Presence of information on contact details of national healthcare providers	Yes ☐	No ☐	
23	Presence of tools to find a specific national healthcare provider in Member States	Yes ☐	No ☐	If yes, specify the link and if the tool allows for identification of GPs, inpatient and outpatient care *(text box)*
24	Presence of statistics on healthcare services	Yes ☐	No ☐	If yes, which categories? *(text box)*

Website analysis				
Section 3 - Patients' rights				
#	**Questions**	**Answers**		
25	Presence of information on patients' rights to seek treatment in other MSs	Yes ☐	No ☐	
26	Presence of information on the definition of waiting time	Yes ☐	No ☐	If yes, specify if standardised: *(text box)*
27	Presence of information on patients' rights in case of undue delay	Yes ☐	No ☐	If yes specify: *(text box)*
28	Presence of information of patients' rights in case of harm	Yes ☐	No ☐	If yes specify: *(text box)*
29	Presence of information on access to hospitals for disabled patients	Yes ☐	No ☐	
30	Presence of information on how to access to electronic medical records	Yes ☐	No ☐	
31	Presence of information on mechanisms to settle disputes (e.g. reimbursement issues)	Yes ☐	No ☐	If yes, who is the responsible subject who settles disputes? *(text box)*
32	Presence of information for rare disease patients	Yes ☐	No ☐	If yes specify: *(text box)*
33	Presence of information on complaint procedures in case of follow up treatments issues	Yes ☐	No ☐	If yes, which is the procedure? *(text box)*
Section 4 - Procedures requiring prior authorization				
34	Presence of information on which treatments require prior authorisation	Yes ☐	No ☐	If yes, which categories? *(text box)*
35	Presence of lists of treatments requiring prior authorisation	Yes ☐	No ☐	If yes, which lists? *(text box)*
36	Presence of information on procedures to obtain the reimbursement	Yes ☐	No ☐	
37	Providing schemes/form for prior authorisation	Yes ☐	No ☐	
38	Presence of information on time period for requests to be dealt with	Yes ☐	No ☐	If yes, how long? *(text box)*
Section 5 - Quality and safety standards set by MSs				
39	Presence of information on national laws, regulations, policies regarding patient safety	Yes ☐	No ☐	If yes, which laws? *(text box)*
40	Information on medical certifications and qualifications required by the national healthcare system	Yes ☐	No ☐	If yes, which? *(text box)*
41	Presence of information on the national quality strategy	Yes ☐	No ☐	
42	Presence of information on compliance checks and regulatory activity with respect to quality and safety standards (e.g. hospital inspection bodies, etc)	Yes ☐	No ☐	If yes, which? *(text box)*
Section 6 - Entitlements for reimbursement of costs				
43	Presence of information on which treatments are reimbursed	Yes ☐	No ☐	If yes, which? (e.g. provided by the statutory health insurance) *(text box)*
44	Presence of information on which treatments are not to be reimbursed	Yes ☐	No ☐	If yes, which? *(text box)*
45	Presence of requirements for the recognition of invoices/clinical information	Yes ☐	No ☐	If yes, which? *(text box)*
46	Presence of information on time period for reimbursement	Yes ☐	No ☐	If yes, how long? *(text box)*
47	Presence of information regarding payment tools for reimbursement	Yes ☐	No ☐	If yes, which? *(text box)*
48	Presence of information on type of tariffs to be applied	Yes ☐	No ☐	If yes, which? *(text box)*
Section 7 - NCPs contact details				
49	Presence of information on the other NCPs contact details	Yes ☐	No ☐	If yes, which? *(text box)*
Other considerations				

Online survey

Objectives:	Obtaining information from the subjects directly involved in the application of the Directive.
Timing	13 November 2014 – 23 December 2014 A period of six weeks from the beginning of the activities has been considered as a reasonable timeframe to complete the exercise.
Target	NCPs of focus countries[52].

Apart from data needed to answer the relevant EQs, the questionnaires were used to gather further information and meaningful insights on the implementation of the Directive and its present functioning.

The steps in conducting the online survey were the following:

- Preparation of draft copies of the questionnaire (excel template).
- Discussion of the draft soft copy with the contracting authority.
- Finalisation of the soft copies including the corrections and modifications agreed upon.
- Digitalisation of questionnaires based on the finalised drafts in a web-based solution.
- Piloting the questionnaires for internal discussion and potential corrections.
- Agreement of the final version of the questionnaire with the contracting authority.
- Gathering contact details of NCPs.
- Launching the survey.
- Sending reminders to non-answering NCPs.
- Codification of data gathered.
- Checking the consistency of the data obtained.

Design

Starting from the EQs, a questionnaire consisting of 59 questions was designed and implemented based on an online platform.

[52] Focus countries are Austria, Belgium, France, Germany, Hungary, Italy, Lithuania, Malta, Netherlands, Slovenia, Spain, Sweden.

Questionnaires form a structured, focused way of asking the National Contact Points about specific topics using a well-defined, logically-structured set of questions. The questionnaire was reviewed with the collaboration of DG SANTE.

In order to ensure the robustness of the tool a test was conducted on NCP1. The results were analysed, and the necessary adjustments implemented.

After the test exercise, an email was sent to all NCPs of the focus countries, presenting the activities and the aim of the evaluative study. Several reminders were sent to the NCPs to complete the survey.

The online survey template is presented in "Annex 3 – Online survey".

Conducting the data collection

The online survey activities were centrally managed by a team of consultants.

The completed online surveys were downloaded from the platform and uploaded into the single database used for further analysis.

Not all the 12 interviewed NCPs answered all questions. The following table outlines which NCPs answered the online survey:

Table 12 - Answers to the online survey

NCP	Complete	Partial	Not provided
NCP 1			
NCP 2			
NCP 3			
NCP 4			
NCP 5			
NCP 6			
NCP 7			
NCP 8			
NCP 9			
NCP 10			
NCP 11			
NCP 12			

Legend

Answer

All the answers were analysed. The findings of the analysis are presented in "Annex 2 – Web analysis".

Limitations of the tool

As per the introduction letter sent to all the NCPs, the results are reported anonymously.

Template of the online survey

National Contact Points	
#	**Question**
1	Name of the National Contact Point
2	E-mail address
3	Country code
4	Function of the person filling out the survey
5	Has the National Contact Point been established in national legislation?
6	Since when has the NCP been operational to the general public?
7	Since when has the website been accessible to the general public?
8	What are the possible ways of contacting the NCP?
9	Do you plan to add communication channels in order to become more accessible to the general public? If yes, which channels do you want to add?
10	Are you aware of any activities carried out in order to inform the general public about the existence of the NCP?
11	Can you indicate the time period at which the activities referred to above were running?
12	Do foreign patients contact you when seeking cross-border healthcare in your country?
13	According to your experience, what is the level of awareness of patients regarding the existence of the Directive 2011/24/EU?
14	According to your experience, what is the level of awareness of patients regarding the existence of the NCP?
15	Average frequency of patients requesting information from the NCP (or estimation if the number is not available)
16	Average number of information requests in the course of a single cross-border healthcare process initiated by any stakeholder (i.e. from the initial information request until the end of the reimbursement process for one single outbound patient), please be as specific as you can be with regards to the data gathered since your NCP function has been set up
17	How many FTEs (full-time equivalent) work for the NCP function?
18	What kinds of treatments are subject to prior authorization in your country? Please describe briefly
19	Has a detailed list of treatments that are subject to prior authorization been published?
20	What is the time-limit for granting/refusing a prior authorization's request?
21	Please briefly describe the process of reimbursement for treatment obtained abroad for patients of your country (from filing the claim until receiving the reimbursement)
22	Is there a national tariff for treatments?
23	Are there domestic reimbursement rules other than the tariffs that are applied?
24	Are there any specific rules on tariffs that are applied for cross-border healthcare?
25	According to your experience, have health insurance companies experienced difficulties in the recognition of treatments provided in another MS? (E.g. due to different basket of treatments)?
26	In your view, does paying the costs of cross border healthcare upfront cause any difficulty for the outbound patients?
27	Is your country opting for arranging other methods of payment (e.g. use of S1 forms according to the Regulation EC No 883/2004)?

National Contact Points	
28	What kind of documentation must be submitted by the patient in order to be reimbursed?
29	What is the time-limit for the reimbursement of a patient's invoice starting from the delivery of the documentation?
30A	Is there a possibility to cover the extra costs of the patients as well (e.g. accommodation, travel, etc.)?
30B	Which documents are needed in order to have this kind of reimbursement (e.g. bills, translation of bills)?
31	Are you involved in a process to monitor whether healthcare providers comply with their duties (e.g. supplying of information on treatments options, implementation of quality standards, etc.)?
32	Is there a system in place to monitor the number of national patients using healthcare abroad with the EU Directive 24/2011?
33	Is there a system in place to monitor the number of foreign patients using healthcare by providers of private and/or public national healthcare?
34	Is it possible to come to any conclusion as to the typical visited countries by outbound patients under the Directive 24/2011?
35	Please provide comments on the potential reasons (e.g. price, geographical proximity, waiting times, quality/ safety issues, etc.) for the patient's country of choice
36	Is it possible to come to any conclusion as to the typical countries of origin of inbound patients seeking cross-border healthcare under the Directive 24/2011?
37	Please provide comments on the potential reasons (e.g. price, geographical proximity, waiting times, quality/ safety issues, etc.) for which patients are originating from these 5 countries
38	If it is possible to come to general conclusions as to the origin of foreign patients, the majority of cases come from:
39	Is it possible to come to any general conclusions as to the type of treatment sought by inbound and respectively by outbound patients?
40A	Please evaluate the frequency of information requests by patients seeking cross-border healthcare regarding the following topics: Admission process
40B	Please evaluate the frequency of information requests by patients seeking cross-border healthcare regarding the following topics: Quality/Safety of healthcare providers
40C	Please evaluate the frequency of information requests by patients seeking cross-border healthcare regarding the following topics: Waiting time
40D	Please evaluate the frequency of information requests by patients seeking cross-border healthcare regarding the following topics: Medical documentation
40E	Please evaluate the frequency of information requests by patients seeking cross-border healthcare regarding the following topics: Reimbursement process and level of costs
40F	Please evaluate the frequency of information requests by patients seeking cross-border healthcare regarding the following topics: Travel and accommodation
40G	Please evaluate the frequency of information requests by patients seeking cross-border healthcare regarding the following topics: Language used
41	Do you provide information on quality and safety?
42	What information on quality and safety do patients usually require?
43	Do you provide information on quality and safety of specific healthcare providers?
44	What is the primary language used by inbound patients during the process of seeking and receiving cross-border healthcare? Please tick the top 5 among the languages of the EU
45	Please indicate which languages the NCP function is able to work in

National Contact Points	
46	Is there any feedback from patients or authorities regarding the quality and safety of the cross-border healthcare received?
47A	Please evaluate the frequency of patient complaints regarding the following categories: Quality and safety
47B	Please evaluate the frequency of patient complaints regarding the following categories: Reimbursement process
47C	Please evaluate the frequency of patient complaints regarding the following categories: Waiting time
47D	Please evaluate the frequency of patient complaints regarding the following categories: Administrative burden
47E	Please evaluate the frequency of patient complaints regarding the following categories: Language
47F	Please evaluate the frequency of patient complaints regarding the following categories: Availability of information
47G	Please evaluate the frequency of patient complaints regarding the following categories: Quality and safety of information
48	Do national patients request information about how to proceed in case of harm arising from the healthcare received abroad?
49	Do foreign patients request information on how to proceed in case of harm arising from the healthcare received in a national hospital?
50	Which entity, at the national level, handles complaints from patients in case of harm?
51A	How would you rate the level of cooperation with Other NCPs?
51B	How would you rate the level of cooperation with Healthcare providers?
51C	How would you rate the level of cooperation with Insurance organizations?
51D	How would you rate the level of cooperation with Governmental organizations?
51E	How would you rate the level of cooperation with Patient groups?
51F	Short overall explanation
52	Can you identify any best practices regarding the process of cross-border healthcare either in your country or in any other country?
53	Do you receive enquiries about the relevant provisions under Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems?
54	Does your function provide information about the relevant provisions under Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems?
55	Do you experience difficulties in communicating the difference between the relevant provisions of the Directive 2011/24/EU and those of the Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems?
56	What are the most important lessons that you have learned since the implementation of the Directive 2011/24/EU?
57	What do you consider to be the strength of the Directive 24/2011?
58	What could be improved or developed in the Directive?
59	Do you have any other comments/suggestions?

Pseudo patient investigation exercise

Objectives:	Highlighting the differences between the expected information according to the provisions of the Directive and the information actually provided by the NCPs in response to specific queries under the different scenarios.
Timing	From 14 November 2014 to 28 November 2014.
Target	NCPs of focus countries[53].

For the purposes of this study, Pseudo patient Investigation aims at investigating the experiences of potential patients who wish to find out about the possibilities of receiving healthcare abroad. The choice of a pseudo patient investigation method was warranted by its extensive use in research on the pharmacy/ costumer[54] interface relationship and more specifically its rank as a standard, recommended bi-annual operational practice in the statutory quality assurance scheme of the German Chamber of Pharmacists[55].

The main goals of the exercises were to:

- Assess the quality and comprehensiveness of the information provided to citizens by NCPs. Real life scenarios were implemented by asking for information related to reimbursement issues and the quality and safety of healthcare in that/those country/ies, thereby focusing on these topics:
  - types of interventions/treatments which are subject to prior authorisation;
  - documentation to be delivered in order to obtain prior authorisation;
  - time needed by HIPs to process the prior authorisation requests;
  - specificities regarding the reimbursement process;
  - which healthcare providers offer the desired treatment;
  - information about providing follow-up treatment in their Member State of affiliation;
  - information regarding fees to be charged by healthcare providers in the foreign country.
- Assess the potential (additional) administrative burden (and its financial implications) when actually receiving planned cross-border healthcare:
  - documents to be delivered to domestic health insurance providers/authorities in order to be reimbursed;

[53] Focus countries are Austria, Belgium, France, Germany, Hungary, Italy, Lithuania, Malta, Netherlands, Slovenia, Spain, Sweden.

[54] Alessandra R. Mesquita a, Divaldo P. Lyra Jr.a,*, Giselle C. Brito a, Blcie J. Balisa-Rocha a,Patrcia M. Aguiar a, Abilio C. de Almeida Neto . Developing communication skills in pharmacy: A systematic review of the use of simulated patient methods, PEC Patient Education and Couselling.

[55] http://www.abda.de/themen/apotheke/qualitaetssicherung0/angebote-qs-kammern/pseudo-customer0/.

  - possible language barriers when presenting a foreign medical prescription at home.

- Assess the potential good practices regarding reimbursement of cross-border healthcare:
  - information on tariff schemes applied in other MSs;
  - information about the level of reimbursement to expect in home country.
- Assess the good practices in informing patients on the quality and safety of cross-border healthcare:
  - information regarding quality of healthcare providers in MSs;
  - information on equality of treatment between foreign and national patients.
- Assess the procedure to be followed in the event of claims for harmful treatments.

Design

In order to ensure a robust approach, the consortium invited an expert in Pseudo Customer/Patient investigation exercises to facilitate the design of the activities and provide training to the consultants performing them.

Our team of consultants performed the investigation exercise[56] to test the NCPs of the focus countries with three scenarios (patient's story). Two scenarios refer to situations in which national patients contact the NCP of their Member State of affiliation to be informed about treatment options in other EU Member States[57]. The third one refers to a situation in which a patient contacts an NCP of a foreign Member State seeking information on how to obtain treatment in that given Member State[58].

For each scenario, a "standard" email and a specific evaluation grid was designed[59]. Email and phone calls, when possible, were the contact channels used to perform the task.

Following the email a call to the NCP was made after three days in order to get confirmation regarding the answers or to obtain the information needed to complete the evaluation grids.

[56] The consultants of the consortium received ad hoc training from a Pseudo customer investigation/pseudo patient investigation expert. In accordance with the methodology and recommendations of the expert, the direct involvement of the consultants in the exercise is essential for the knowledge of the Directive and the aims of the study. The consultants were trained on specific approach and methodology in performing phone calls, and on the regulatory constraints foreseen for this activity (privacy, etc. …).

[57] These scenarios were carried out in the respective national languages, by the national team.

[58] This scenario was carried out in English centrally.

[59] The e-mail and the evaluation grid are presented at the end of this paragraph.

Conducting data collection

For Scenarios 1 and 2, a team of two consultants for each focus country (12 teams) performed the activities in the respective national language by sending an email and by calling the NCP.

A team of two consultants centrally performed Scenario 3, in English, by sending an email and calling the NCPs.

All the teams acted avoiding any risk of being discovered while performing the phone calls. During the same phone calls the consultant team completed the evaluation grids.

Although the NCPs should have provided all the information the Pseudo patients asked, what emerged was that, depending on the information requested, NCPs often had to refer the Pseudo patients to other institutions. In this case, the methodology was to follow the NCPs' indications until the final suggested institution was reached.

For all scenarios, our consultants simulated the request of a patient asking for information.

Following the e-mail, a telephone call was made to every NCP (typically after three days)[60], repeating the questions sent in their e-mail, or asking for additional information. In particular, questions were structured the same way as in the e-mail, which in turn followed closely the order of questions to be completed in the evaluation grid by the Pseudo patient.

In some cases, more than one attempt was needed to carry out the phone call. National Contact Points typically answered the questions within ten minutes and only for one NCP in Scenario 3 took 19 minutes to answer the questions as it has provided more detailed information[61].

The evaluation grids prepared by the teams for the e-mail and the phone calls have been centrally collected and uploaded into a single database. Subsequently, all the information gathered was analysed and normalised by a central team.

Limitations of the tool

The nature of the exercise involved the following limitations:

- the NCPs are normally made up of one to three operators;
- most NCPs receive no more than five contacts per day on average;
- the aim of the exercise is to obtain the required information, regardless of the channel used;
- the aim of the exercise is not to judge the quality of the NCP's performance, but to obtain the required information only. Subjective evaluations were avoided.

[60] Some of the Member States do not have an available phone number for citizens in need of information.

[61] The NCP employee guided the pseudo patient through the website, suggesting where to find the requested information.

Templates of the pseudo patient investigation exercise

Scenario 1: Outbound patients seeking for an orthopaedic visit in a foreign Member State

The textual guides that pseudo patients followed during their phone calls and e-mails for scenario 1 was the following:

Dear Sir or Madam,

My name is X. I have heard that EU rules allow people to be treated in other EU countries and claim reimbursement. I am very interested in having a consultation with an orthopaedic specialist in X. However, before proceeding I have some questions to submit to your attention:

- *I understand that EU law requires that I only need to receive formal permission to travel for treatment where the care involves an overnight stay. My consultation would be as an outpatient, so I am assuming that I do not need to seek permission before travelling – can you please confirm this?*
- *If I did get treatment there, would I be reimbursed? If yes, how much would I be reimbursed?*
- *And what documents would I need to make the reimbursement claim?*
- *Are there any other formalities I would need to carry out before going for this consultation?*
- *And is there any other information that it would be important for me to know before I received treatment? For example, if I get a prescription abroad, can I fill it in my home country?*

Grateful for your reply, I look forward to hearing from you.

Pseudo Patient Investigation - Evaluation grid				
Mystery shopper name			Start date	
Country code			End date	
Channels	*Telephone* ☐ *E-mail* ☐		Telephone call duration	
Telephone number/e-mail address				

Scenario 1 - Patient that does not need a prior authorisation (visit of an orthopaedic specialist as a day patient)				
#	**Questions**	**KPI and Metrics**		
1	Able to enter into contact with National contact points and number of trials	Yes ☐	No ☐	If yes, number of contacts and nº of days for the answer
2	Was it explained if the treatment requires prior authorization?	Yes ☐	No ☐	If yes, description of the answer
3	Was the amount that will be reimbursed for the specific treatment clearly defined?	Yes ☐	No ☐	If yes, which is the amount
4	Was it explained which documents are needed to make the reimbursement claim?	Yes ☐	No ☐	If yes, description of the answer
5	Was it explained in which language the medical prescription has to be in order to be recognized in another MS?	Yes ☐	No ☐	If yes, description of the answer
6	Was it explained in which language the invoices have to be in order to obtain the reimbursement?	Yes ☐	No ☐	If yes, description of the answer
7	Are there any formalities imposing burdens on patients seeking cross-border healthcare?	Yes ☐	No ☐	If yes, description of the answer
8	Was it explained which documents patients need in order to receive follow up treatments in their home country?	Yes ☐	No ☐	If yes, description of the answer
9	Does the National Contact Point provided any other information?	Yes ☐	No ☐	If yes, description of the answer

Scenario 2: Outbound patients seeking an MRI scan on knee in a foreign Member State[62]

Dear Sir or Madam,

My name is X. I am interested in receiving healthcare treatment in X and have been looking on your website for more information. My GP has told me that I need to get an MRI scan on my right knee following a sports injury. I understand that I can get this done during a trip next month to X, which will be very convenient for me. However, before proceeding I have some questions to submit to your attention:

- *Do I need to apply for a prior authorisation before getting the treatment? If so, can you tell me how I do this (e.g. what documents should I provide) and how long it will take for me to get a response?*
- *If I get this authorisation (or if it is not needed) could you tell me how much of the cost of the treatment I will be reimbursed? How would I go about claiming this reimbursement?*
- *Any other information you could provide me with that would be relevant to my case would be very welcome. For example, if I get a prescription abroad, can I fill it in my home country?*

Grateful for your reply, I look forward to hearing from you.

Pseudo Patient Investigation - Evaluation grid				
Mystery shopper name			Start date	
Country code			End date	
Channels	*Telephone* ☐ *E-mail* ☐		Telephone call duration	
Telephone number/e-mail address				
Scenario 2 - Patient that needs a prior authorisation (MRI scan on knee following a sports injury)				
#	**Questions**	**KPI and Metrics**		
1	Able to enter into contact with National contact points and number of trials	Yes ☐	No ☐	If yes, number of contacts and n° of days for the answer
2	Was it explained if the treatment requires prior authorization?	Yes ☐	No ☐	If yes, description of the answer
3	Was it explained which documents are needed to make the prior authorization request?	Yes ☐	No ☐	If yes, description of the answer
4	Was the time-limit defined for the prior authorization request?	Yes ☐	No ☐	If yes, description of the answer
5	Was the amount that will be reimbursed for the specific treatment clearly defined?	Yes ☐	No ☐	If yes, description of the answer
6	Was the procedure to be followed in case of claim for the reimbursement explained?	Yes ☐	No ☐	If yes, description of the answer
7	Was it explained in which language the medical prescription have to be in order to be recognized in another MS?	Yes ☐	No ☐	If yes, description of the answer
8	Was it explained in which language the invoices have to be in order to obtain the reimbursement?	Yes ☐	No ☐	If yes, description of the answer
9	Was it explained which documents are needed to obtain follow-up treatments once the patient travel back home?	Yes ☐	No ☐	If yes, description of the answer
10	Did the National Contact Point provide any other information?	Yes ☐	No ☐	If yes, description of the answer

Scenario 3: Inbound patient seeking hip replacement treatment

Dear Sir or Madam,

My name is X, and I live in Y. I am interested in using my EU rights to get a hip replacement operation done in your country, as I understand that the waiting lists are much shorter than in my own. I was thinking about approaching [name of hospital], and I would like to check that they are authorised to perform the procedure. I would also like to know if there are any other hospitals you could recommend. Furthermore, before proceeding I have some questions to submit to your attention:

- *I assume that, as an EU citizen, I have the same right to ask for treatment there as anyone else, could you confirm that this is the case?*
- *Do I also need to show your hospitals any special documents to be accepted as a patient?*
- *Could you also tell me what the treatment will cost or if there are any rules about the prices the hospital can charge?*
- *I would also like to know more about what my rights would be if something went wrong.*
- *Finally, my reimbursement authority tells me that I will need a detailed invoice that clearly sets out the treatment received and the cost of it. Will your hospital provide this to me? If so are they able to provide it my own language so that I do not need to get it translated?*

Grateful for your reply, I look forward to hearing from you.

Pseudo Patient Investigation - Evaluation grid					
Mystery shopper name			Start date		
Country code			End date		
Channels	*Telephone* ☐ *E-mail* ☐		Telephone call duration		
Telephone number/e-mail address					
Scenario 3 - Patient that contacts a foreign NCP to obtain information on seeking for care in that MS (hip replacement)					
#	**Questions**	**KPI and Metrics**			
1	Able to enter into contact with National contact points and number of trials	Yes ☐	No ☐	If yes, number of contacts and n° of days for the answer	
2	Was the information about quality of healthcare providers in the MS of treatment given?	Yes ☐	No ☐	If yes, description of the answer	
3	Was the information about the authorisation to seek for healthcare in a specific healthcare provider given?	Yes ☐	No ☐	If yes, description of the answer	
4	Were the authorisation criteria to provide treatments under the Directive 24/2011 of healthcare providers given?	Yes ☐	No ☐	If yes, description of the answer	
5	Do quality and safety criteria to be met for the authorisation are described?	Yes ☐	No ☐	If yes, description of the answer	
6	Is the patients' right to be treated as national citizens in healthcare providers ensured?	Yes ☐	No ☐	If yes, description of the answer	
7	Was it explained if hospitals require additional documents to treat patients (under the Directive 24/2011)?	Yes ☐	No ☐	If yes, description of the answer	
8	Was it explained which tariffs are de facto applied by the hospitals?	Yes ☐	No ☐	If yes, description of the answer	
9	Was the subject responsible in case of harm clearly defined?	Yes ☐	No ☐	If yes, description of the answer	
10	Was the procedure to be followed in case of harm explained?	Yes ☐	No ☐	If yes, description of the answer	
11	Was it explained which obligations healthcare providers of MSs have regarding medical invoices?	Yes ☐	No ☐	If yes, description of the answer	

Stakeholder interviews

Objectives:	The aim is to obtain information from the stakeholders directly involved in the application of the Directive.
Timing	From 24 November 2014 to 23 December 2014.
Target	Stakeholders of the focus countries[63].

The interview process was comprised of the following steps:

- **Selection of interviewees:** this selection already took place as part of the Inception Report through stakeholder mapping complemented by desk research on the functioning of the different health care systems and the role, influence and position of the different stakeholders. Our strategy was to examine a broad panel of entities in order to divulge as much information as possible whilst balancing the number of stakeholders for each category.

- **Planning the interview**: the consortium drew up a specific interview guide for each type of stakeholder, considering their position and potential knowledge. This guide is a structured checklist enabling the interviewer to deal with the most important questions. The purpose of the interview, the time needed and the level of confidentiality (this being very high because of the decision to keep the interviewees' identities anonymous) were explained to the interviewees.

- **Course of the interview**: the interviewers had an objective, unbiased and open approach towards the interviewees and the information provided by them in order to achieve a good understanding of the subject matter and the context. In some cases, the interview transcript was checked by the interviewees. The interviewers took notes in order to be able to summarise the findings.

- **Analysis of results**: this final stage consisted of the analysis of the conversations and the interpretation and comparison of the information provided by the interviewees in order to determine common and divergent viewpoints.

Phone and face-to-face interviews were conducted with all the main stakeholders who gave their availability, especially as regards HIPs and patient groups. Stakeholders who were not available for an interview completed a structured online questionnaire tailored to the areas relevant for their organisation.

From a selection of almost 120 stakeholders we conducted 59 interviews over a four-week period.

Design

Based on the EQs and the stakeholder mapping, a structured interview guide and template was designed for each stakeholder category. This helped the consortium

[63] Focus countries are Austria, Belgium, France, Germany, Hungary, Italy, Lithuania, Malta, Netherlands, Slovenia, Spain, Sweden.

interact with different stakeholders using a tailored approach, aggregate data and compare information collected.

The interviewed stakeholder groups were:

- health insurance providers;
- healthcare providers;
- patient ombudsmen;
- national/regional authorities;
- patient groups;
- audit bodies;
- confederation of trade unions and trade unions;
- frontline healthcare prescriber organisations.

The stakeholders were selected at national and European level.

A specific interview guide, drawn on an initial stakeholder analysis, was established based on the type of stakeholder and considering their position and potential knowledge. Considering the great number of stakeholders, an online version of the interview questionnaire was developed in order to offer the possibility of directly answering the questionnaire without external support.

Conducting the data collection

All stakeholders were contacted via email, asking for an interview or to complete the online questionnaire[64]. A team of at least two consultants performed the face-to-face/telephone interviews and filled the evaluation grid. The information collected from the interviews carried out in different countries were centrally collected in the survey platform and recorded in a single database.

The following table shows the number of interviews completed for each stakeholder category.

[64] The study used only the questionnaire received in the period. In some case due internal authorisation procedures of the stakeholders was not possible to obtain any answer during the activity time frame.

Table 13 - Interviews by group

Stakeholders	Number of interviews per group
1. Health insurance providers	21
2. Healthcare providers	6
3. Patient ombudsman	8
4. National/regional authorities	6
5. Patient groups	6
6. Audit bodies	2
7. Confederation of trade unions and trade union	4
8. Frontline healthcare prescriber organisations	6
Total	**59**

Limitations of the tool

The nature of the exercise involved the following limitations:

- we used all the interviews and online questionnaire available in the time frame of the activity;
- all interviews were conducted with the constraint of anonymity;
- the answers of individual interviewees might be affected by personal perceptions/opinion regarding the topic.

Templates of the interviews

Health insurance providers	
#	**Question**
1	Name of the Health insurance provider
2	E-mail address
3	Country code
4	Function of the person filling the survey
5	Do patients contact you for information about cross-border healthcare?
6	If so, do you provide information about the Directive 24/2011, the regulation 883/2004 or both?
7	Based on your experience, are patients generally informed about treatments to which they are entitled under their benefit basket (i.e. treatments to be reimbursed), whether at home or abroad
8	Based on your experience, are patients generally informed about treatments which are subject to prior authorization under the EU Directive 24/2011?
9	What kind of documentation must be submitted by the patient in order to be reimbursed? (tick all that apply)
10	Based on your experience, in what percentage of cases can you understand and process invoices from foreign healthcare providers?
11	Do different national tariffs/insurance rates lists exist?
12	Which insurance rate plan do you apply to your insured patients using cross-border healthcare under the EU Directive 24/2011?
13	Please briefly describe the process of reimbursement for treatment obtained abroad for patients of your country (from filling the claim until receiving the reimbursement)?
14	Can you briefly describe the course of an outbound patient seeking cross-border healthcare in another Member State (requesting prior authorization, reimbursement, etc.)?
15	Are there any additional processes for patients opting for cross-border care (e.g. confirmation of their benefit basket/entitlements)?
16	Do patients who request reimbursement or prior authorization have to pay any transaction costs?
17	Do you have any administrative cost burden regarding the administration of the reimbursement processes in relation to cross-border care?
18	When assessing undue delay, are you responsible for identifying and offering alternative treatment options in your home country?
19	How long do patients have to wait on average in order to: a) have their documents processed under the Directive? b) get the reimbursement for cross-border healthcare? (please indicate the number of days)
20	How long do patients have to wait on average in order to: a) have their documents processed when seeking care in their Member State of affiliation? b) Get reimbursement for a treatment provided on a national basis? (only for Member States with a social health insurance)
21	Do you think maximum time limits within which reimbursement and prior authorization requests must be dealt with are reasonable?
22	Do they also take into account individual circumstances when processing requests?
23	Which evaluative quality and safety system related to healthcare is applied in your country?

Health insurance providers	
24	Do you provide any information on quality and safety of healthcare providers abroad?
25	How are patients' rights ensured with regards to follow-up care when the treatment is provided in a foreign Member State? Who is ensuring patients' rights?
26	Do you have any cooperation agreement with foreign healthcare providers?
27	Are you the subject responsible for assessing waiting time of individual patients?
28	How are patients informed on their own waiting time?
29	Is waiting time individually assessed or standardised?
30	Are there national rules on access within your country (e.g. for undue delay)?
31	Have you done any specific communication campaign on cross-border healthcare?
32	Can you identify any best practices regarding the process of cross-border healthcare either in your country or in any other country?
33	What are the most important lessons that you have learned since the implementation of the Directive 2011/24/EU?
34	What do you consider to be the strength of the Directive 24/2011?
35	What do you consider to be the areas of further development of the Directive 24/2011?
36	Do you have any other comments/suggestions?

Healthcare providers	
#	**Question**
1	Name of the healthcare provider or healthcare provider organisation
2	E-mail address
3	Country code
4	Function of the person filling the survey
5	Are your members aware of the EU Directive 24/2011?
6	Have you done any communication campaign on cross-border healthcare?
7	Based on your experience, do cross-border patients mention that they will follow a treatment exercising their rights based on the Directive 24/2011 when making an appointment?
8	Do you or your members give information on the treatment options, services provided, prices, authorization or registration status, insurance liability cover and on your quality and safety standards to patients?
9	Do you or your members require additional information/documentation from cross-border patients who make an appointment for a treatment?
10	Do cross-border patients require additional information/documentation before/after the treatment? (e.g. copy of medical records, details on invoices)
11	Do patients normally request a translation of their invoices?
12	Do you or your members monitor how many cross-border patients you treat?
13	Does this monitoring system mark any difference between foreign patients who make their appointments in order to be treated (planned care) and patients being treated in emergencies?
14	Are the rates being applied equal to the ones related to patients accessing public healthcare or to those accessing healthcare as private individuals?
15	How is quality and safety measured and monitored?
16A	If so, do your members communicate it to patients?
16B	If yes, quality and safety data are available at:
17	Which payment tools are available to patients in order to pay for the treatment?
18	Do you or your members provide any information to patients regarding procedures to follow in case of harm?
19	Do you or your members have any cooperation agreement with healthcare professionals (e.g. GPs) related to cross-border healthcare?
20	Do you or your members have any obligation in providing follow up treatments to patients who were treated in another Member State?
21	Can you identify any best practices regarding the process of cross-border healthcare either in your country or in any other country?
22	What are the most important lessons that you have learned since the implementation of the Directive 2011/24/EU?
23	What do you consider to be the strength of the Directive 24/2011?
24	What do you consider to be the areas of further development of the Directive 24/2011?
25	Do you have any other comments/suggestions?

Trade Unions and confederations of trade unions	
#	**Question**
1	Name of the Trade Union or Trade Union Federation
2	E-mail address
3	Country code
4	Function of the person filling the survey
5	Are patients informed about Directive 24/2011?
6	Have you done any communication campaign on cross-border healthcare?
7	Did any other subject make a communication campaign in cross-border healthcare?
8	Based on your experience, following information from the National Contact Point did patients get sufficient information on a possible access to cross-border care, on their entitlements and the corresponding level of reimbursement?
9	Do you perceive any geographical disparities regarding patient information in relation to cross-border care and reimbursement practices?
10	Did you get any complaints from patients who were not correctly reimbursed following the use of cross-border healthcare?
11	Did you get any complaints from patients regarding issues of language (e.g. translation of invoices and medical prescriptions)?
12	Did you get any complaints from patients regarding the invoices' acknowledgement?
13	Did you get any complaints regarding lack of clarity in the procedure to be followed in case of harm?
14	Did you get any complaints regarding the refusal of prior authorization?
15	Did you get any complaints regarding the refusal from a healthcare provider to provide follow up treatments?
16	Did you get any complaints regarding the refusal to prior authorization due to the treatment being provided only within a time-frame considered clinically acceptable?
17	Which are the opportunities that you see from the application of the Directive 24/2011?
18	Which are the threats that you see from the application of the Directive 24/2011?
19	Can you identify any best practices regarding the process of cross-border healthcare either in your country or in any other country?
20	What are the most important lessons that you have learned since the implementation of the Directive 2011/24/EU?
21	What do you consider to be the strength of the Directive 24/2011?
22	How could the Directive 24/2011 be further developed?
23	Does your Member State make a clear distinction between the rights patients have under the Directive and those they have under the Regulation 883/2004 (to ensure that patients are not deprived of some of their rights through lack of information or knowledge about their options)?
24	Do you have any other comments/suggestions?

Patient groups	
#	**Question**
1	Name of the Patient Group or Patient Group Federation
2	E-mail address
3	Country code
4	Function of the person filling the survey
5	Based on your experience, are patients generally informed about Directive 24/2011?
6	Have patients been informed in their Member States of affiliation about existence and contact details of National Contact Point?
7	Has any patient requested information from your side on the Directive after having contacted the National Contact Point?
8	Do you perceive any geographical disparity with regard to patient information?
9	Do patients know which treatments are subject to a prior authorization?
10	Have patients been correctly reimbursed following the use of cross-border healthcare?
11	Based on your experience, do healthcare providers (whether public or private) give all the information needed by patients who are being treated?
12	Do patients have any obligation with regard to translation of documents and/or invoicing documentation?
13	Which tariffs are used to reimburse patients in cross-border care?
14	Do patients ask you the procedure to be followed in case of harm?
15	Where can patients find information about the procedure to be followed in case of harm in your country?
16	In your opinion, what causes patients' first choice of a provider located outside their home country?
17	Have patients complained about the non-impartiality of information concerning patient's options for treatment?
18	Which kind of information does the patient consider useful in terms of quality and safety in relation to cross-border healthcare?
19A	How many patients, in your opinion, refrain from using cross-border care as a result of poor information related to their requests? Reimbursement
19B	How many patients, in your opinion, refrain from using cross-border care as a result of poor information related to their requests? Quality & Safety
19C	How many patients, in your opinion, refrain from using cross-border care as a result of poor information related to their requests? Prior authorisation
19D	How many patients, in your opinion, refrain from using cross-border care as a result of poor information related to their requests? Waiting time
19E	How many patients, in your opinion, refrain from using cross-border care as a result of poor information related to their requests? Other
20	Which rights do patients have with regard to follow-up when the treatment is provided in a foreign Member State?
21	Are patients informed about their own waiting time?

Patient groups	
22	Have patients complained to you on the basis of time taken to make an assessment of prior-authorisation in their case?
23	Have patients complained to you on the basis of incorrect reimbursement or time taken for reimbursement?
24	Has a prior authorisation request ever been refused to patients because of a treatment that could be given in a reasonable time limit?
25	Can you identify any best practices regarding the process of cross-border healthcare either in your country or in any other country?
26	What are the most important lessons that you have learned since the implementation of the Directive 2011/24/EU?
27	What do you consider to be the strength of the Directive 24/2011?
28	What do you consider to be the potential for development of the Directive 24/2011?
29	Does your Member State make a clear distinction between the rights patients have under the Directive and those they have under the Regulation 883/2004 (to ensure that patients are not deprived of some of their rights through lack of information or knowledge about their options)?
30	Do you have any other comments/suggestions?

Patient ombudsmen	
#	**Question**
1	Name of the Patient Ombudsman
2	E-mail address
3	Country code
4	Function of the person filling the survey
5	Are you aware of the existence of the EU Directive 24/2011?
6	Have cross-border patients in your country ever complained/sought redress and dispute resolution mechanisms?
7	Who is the person in charge to be contacted in case of complaints due to a refusal of a prior authorization, in your country?
8	Which procedure patients have to follow in order to complain for a refusal of a prior authorization?
9	Who is the person in charge to be contacted in case of complaints due to any harm?
10	Which procedures patients have to follow in order to complain for any harm?
11	Following the Directive, which procedure patients have to follow in case the amount reimbursed after a treatment provided in a foreign healthcare provider is not equal to the previously agreed amount?
12	Can you identify any best practices regarding the process of cross-border healthcare either in your country or in any other country?
13	What are the most important lessons that you have learned since the implementation of the Directive 2011/24/EU?
14	What do you consider to be the strength of the Directive 24/2011?
15	What do you consider to be the development potential of the Directive 24/2011?
16	Does your Member State make a clear distinction between the rights patients have under the Directive and those they have under the Regulation 883/2004 (to ensure that patients are not deprived of some of their rights through lack of information or knowledge about their options)?
17	Do you have any other comments/suggestions?

Frontline healthcare prescribers organisations	
#	**Question**
1	Name of the frontline healthcare prescriber
2	E-mail address
3	Country code
4	Function of the person filling the survey
5	Are your members aware of the EU Directive 24/2011?
6	Has the National Contact Point or any other organisation done a "communication" campaign on cross-border healthcare?
7	Have patients already asked to go abroad by using the Directive 24/2011?
8	Have you or your members made any recommendations about a foreign healthcare provider concerning treatment abroad?
9	Do you or your members have any obligation to write prescriptions for cross-border use?
10	Do you or your members cooperate with healthcare providers and/or health insurance providers in order to promote cross-border care?
11	Are you aware of any obligation in providing follow up treatments to patients who were treated in a foreign Member State?
12	What information do you require (e.g. details of treatment provided) in order to give follow up treatments?
13	Are in your country waiting times standardized or do you or your members assess it individually?
14	Do you or your members have any role in assessing whether the waiting time for individuals is reasonable?
15	Which entitlements do patients have when care cannot be provided within a medically justifiable time period?
16	Does the Ministry of Health or the National Contact Point provide you any guideline or obligations concerning the referral for cross-border healthcare?
17	Can you or your members identify any best practices regarding the process of cross-border healthcare either in your country or in any other country?
18	What are the most important lessons that you have learned since the implementation of the Directive 2011/24/EU?
19	What do you or your members consider to be the strength of the Directive 24/2011?
20	What do you or your members consider to be the development potential of the Directive 24/2011?
21	Do you or your members have any other comments/suggestions?

Authorities	
#	**Question**
1	Name of the Regional authority
2	E-mail address
3	Country code
4	Function of the person filling the survey
5	Which lists of treatments are subject to prior authorisation in your country?
6	Is the list of treatments subject to prior authorisation available?
7	What kind of activities have been carried out in order to promote the Directive?
8	Are the healthcare providers and authorities in your country open to accept patients from other countries (under the Directive)?
9	Are tariffs applied for both inbound and outbound patients equal to the ones related to patients accessing public healthcare or to those accessing as private individuals?
10	In your view, does paying the costs of cross-border healthcare upfront cause any difficulty to the patients?
11	Do you have any formal agreements with authorities in other Member States regarding healthcare?
12	What are the administrative cost burdens regarding transaction costs, invoicing costs and costs associated with patient inflow and outflow?
13	Do you have a monitoring system for inbound and outbound patients under the Directive 24/2011?
14	Do you take into consideration cross-border patients in your strategic healthcare planning?
15	Which are the opportunities that you see from the application of the Directive 24/2011?
16	Which are the threats that you see from the application of the Directive 24/2011?
17	Can you identify any best practices regarding the process of cross-border healthcare either in your country or in any other country?
18	What are the most important lessons that you have learned since the implementation of the Directive 2011/24/EU?
19	What do you consider to be the strength of the Directive 24/2011?
20	What do you consider to be the potential for development of the Directive 24/2011?
21	Do you have any other comments/suggestions?

Audit bodies	
#	**Question**
1	Name of the Audit Body
2	E-mail address
3	Country code
4	Function of the person filling the survey
5	Are you aware of the existence of the EU Directive 24/2011?
6	With regard to the Directive 24/2011, do you have any role?
7	Which kind of audit do you provide to healthcare providers?
8	Do you have a role in guaranteeing the quality and safety standards?
9	What are the quality and safety standards in your country?
10	Does the Directive influence the audit procedures you perform for the healthcare providers?
11	Do you have any kind of cooperation with other institutions for cross-border healthcare?
12	Can you identify any best practices regarding the process of cross-border healthcare either in your country or in any other country?
13	What are the most important lessons that you have learned since the implementation of the Directive 2011/24/EU?
14	What do you consider to be the strength of the Directive 24/2011?
15	What do you consider to be the development potential of the Directive 24/2011?
16	Has your Member State set out reasonable maximum time limits within which reimbursement requests must be dealt with?
17	Do they also take into account individual circumstances when processing requests?
18	Has your Member State set out reasonable maximum time limits within which prior authorization requests must be dealt with?
19	Do they also take into account individual circumstances when processing requests?
20	Do you have any other comments/suggestions?

ANNEX 2

Web analysis

Key findings

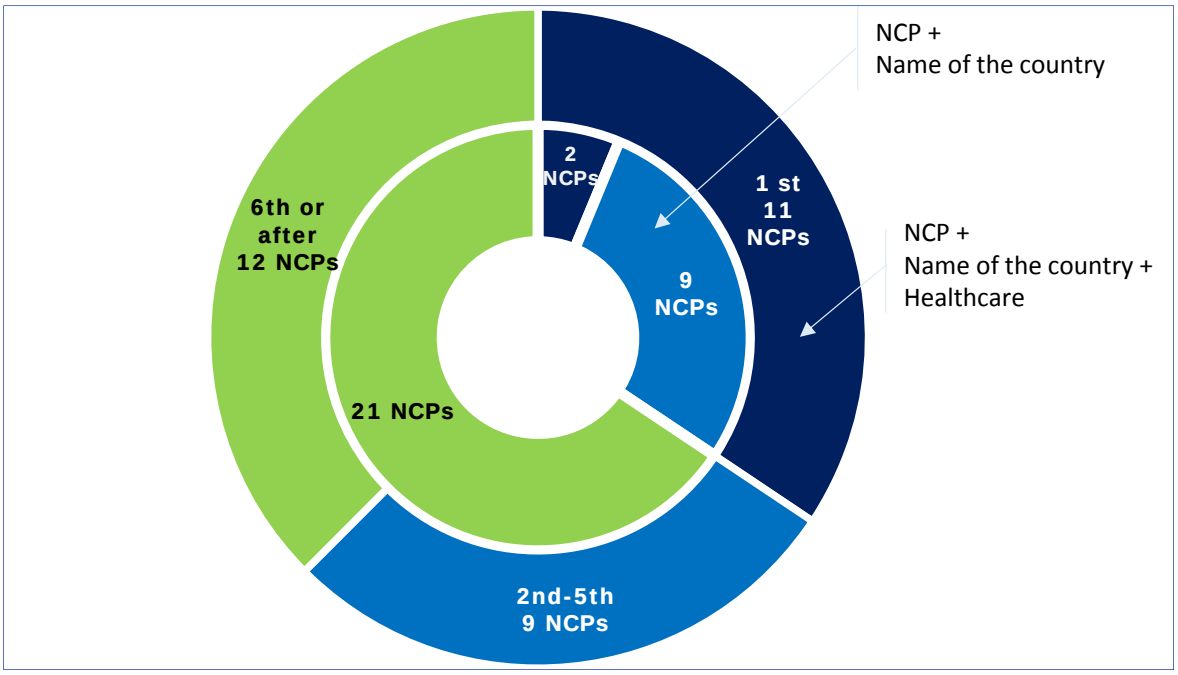
Article 6 of the Directive stipulates that each MS shall designate one or more National Contact Points which shall enable patients to make use of their rights in relation to cross-border healthcare. They shall provide patients with information concerning healthcare providers, procedures and mechanisms for seeking remedies according to the legislation of the MS as well as the legal and administrative options available to settle disputes, including in the event of any harm arising from cross-border healthcare.

The first item assessed was the degree of effort needed for users to find the NCP websites. All 32 websites are easy to open and none of them does not exist anymore or is impossible to access (e.g. page not found). We then checked how popular the websites are, by typing "National Contact Point + the name of the country" and "National Contact Point + the name of the country + healthcare" to see where Google ranks the NCP websites. The following chart shows the percentage of NCP websites ranked 1st, 2nd to 5th, and 6th or after by a Google search.

In the internal circle we present the results of typing "National Contact Point + the name of the country" in the search bar, while in the outer circle the results from typing "National Contact Point + the name of the country + healthcare" are presented.

Noticeably, results vary substantially by adding the word "healthcare" to the query, shifting from two to 11 NCP websites ranking 1st place in Google searches[65].

Figure 15 - Website popularity as ranked by website research



[65] This is very likely related to the fact that the denomination "National Contact Point" is also used with reference to structures providing guidance, practical information and assistance on Horizon 2020, a framework program for research sponsored by the European Commission.

Of the 32 NCP websites verified, only 24 were included in the document published by the European Commission (see Annex 6[66]). This is a striking result, particularly as this document is one of the first results of a query on Google including the words "National Contact Point + healthcare".

Afterwards, we checked the available contact channels to each NCP. The following table summarises our findings:

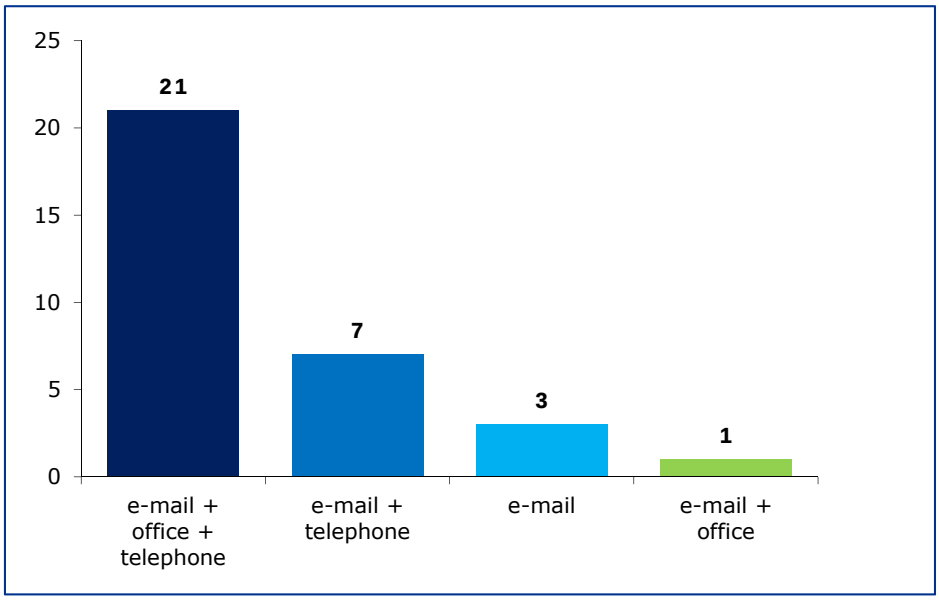
Table 14 - Availability of communication channels

Countries / Channel	Austria	Belgium	Bulgaria	Croatia	Cyprus	Czech Republic	Denmark	England	Estonia	Finland	France	Germany	Gibraltar	Greece	Hungary	Ireland	Italy	Latvia	Lithuania	Luxembourg	Malta	Northern Ireland	Netherlands	Poland	Portugal	Romania	Scotland	Slovakia	Slovenia	Spain	Sweden	Wales
Email / contact	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Phone Nr.		■	■	■	■	■	■	■	■	■		■	■	■	■	■		■	■	■	■	■		■	■	■	■	■	■	■	■	■
Office address for visits			■		■	■	■		■	■	■	■		■	■	■		■	■	■		■		■	■	■		■	■	■	■	

Contact details are available for 21 NCPs through all three channels: e-mail, phone number and office address, while 28 have both email and phone availability. Finally, all countries share at least the email details or a contact form, which suggest that these are the commonly preferred channels of communication.

[66] The website were consulted in the period from 6th October 2014 to 6th November 2014; subsequent variations have not been taken into account.

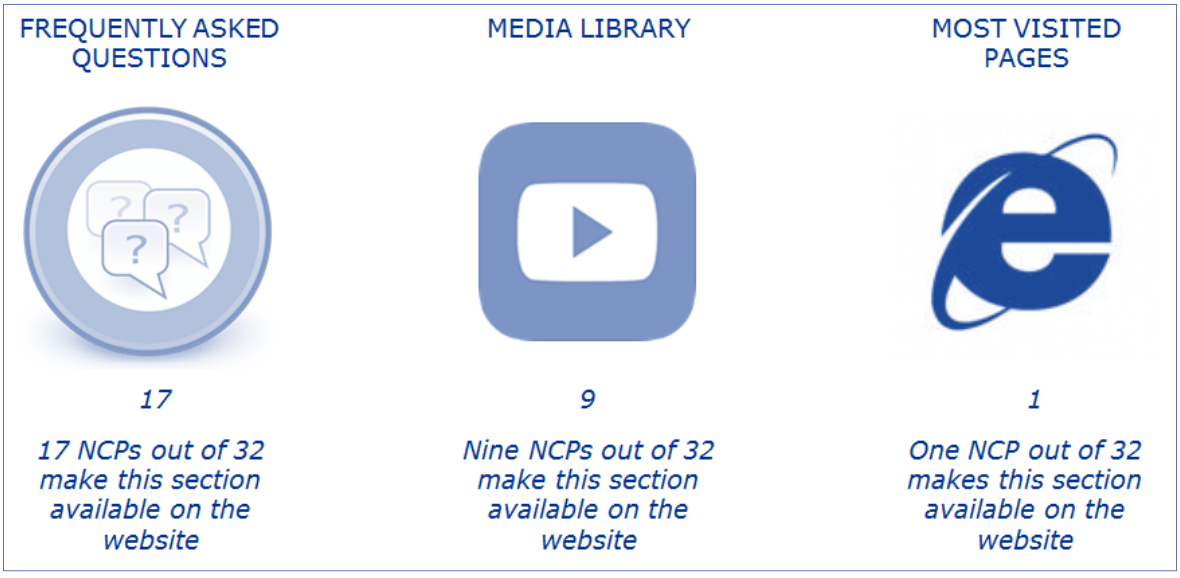
Figure 16 - Available channels of communication of the National Contact Point on the 32 websites analysed



We then proceeded by checking how easily users can contact the staff of the NCPs and in which language it is possible to search for information on the website. We found that English is the most common language in which websites are available (29 out of 32), a consequence of the fact that 22 countries feature English as a second alternative language. These sections are increasingly making available the same contents as those provided in national language.

Once users find the website, it is important to determine how easy it is for them to find the right information. The presence of a section showing "frequently asked questions", "most visited pages" and a "Media Library containing videos regarding cross-border healthcare" facilitate it, but also more generally the structure of the website, which was evaluated based on the time needed for the "analysts" to find the information.

Figure 17 - Presence of sections helping users to find information on the 32 websites analysed



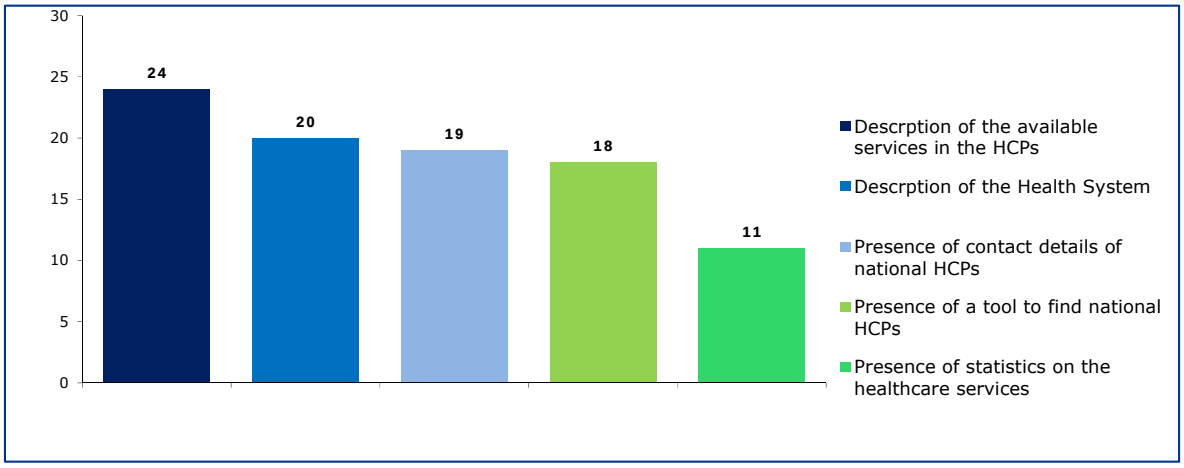
In 17 of the 32 websites analysed we found a FAQ section; only nine websites make available videos on cross-border healthcare and only the Hungarian site has a section showing the most visited pages.

The time needed by our consultants to find all information required in the evaluation grid was also used as a benchmark for an initial assessment of the website's user-friendliness and ease of navigation.

Website information to users

One of the needs NCPs have to meet is to provide information that helps users understand which providers are best for the treatment they seek, and how to contact them. In order to do so, NCPs should provide information on statistics[67] of the providers, a tool to search for providers showing contact details, a description of the available services and the national health system. The following chart shows the NCPs that provide this information:

Figure 18 - NCP websites which provide the information required, by topic



As can be seen in the above chart, 20EU countries provide a general description of their health system. The information provided usually refers to the nature of the healthcare system (e.g. social health insurance or national health system), main stakeholders and/or the functions of the Ministry of Health. Eighteen Member States make available on their NCP website a tool[68] to find national healthcare providers. The following figure shows an example of research carried out through the Italian search engine tool:

[67] e.g. patient satisfaction, medical qualifications, special therapy personnel, treatment-related equipment, treatment cases of the year.

[68] This tool was used to select hospitals suitable for the pseudo patient investigation.

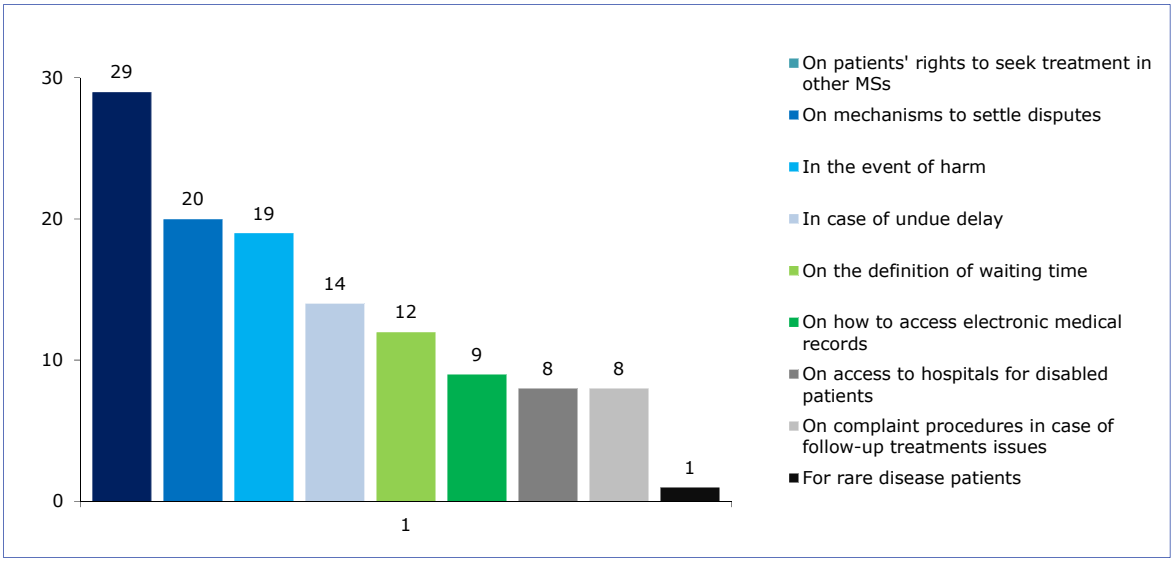
Figure 19 - Italian search engine tool

In some cases, patients are given access to statistics that allow a comparison of healthcare providers along criteria as diverse as user ratings and the number of cases per treatment. The following figure shows an example of statistics provided by the countries.

Figure 20 - Statistics on healthcare providers, German NCP

Information on patients' rights could reassure users who should seek for treatment in a foreign European country, by informing them about the procedure to follow in case of harm. The chart below shows to what extent patients' rights are described on NCP websites.

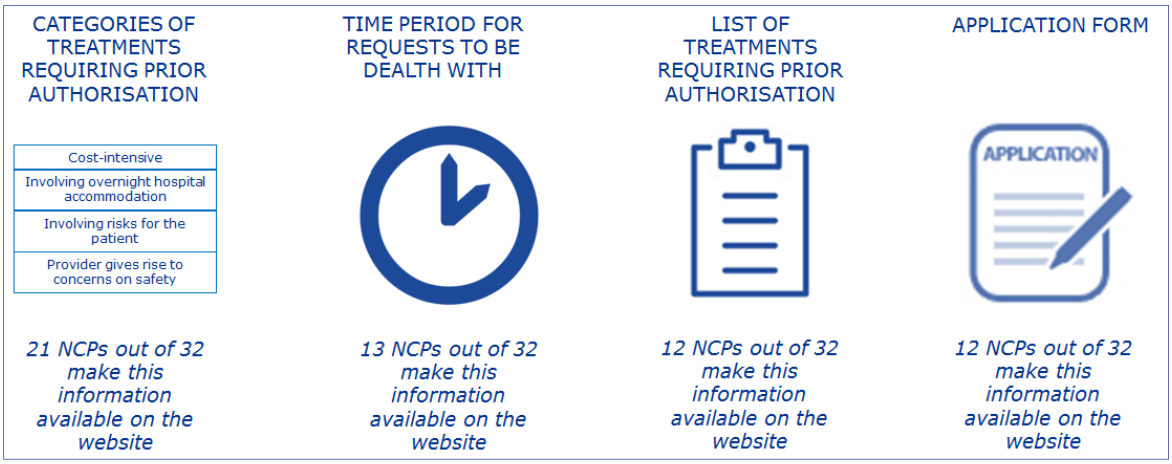
Figure 21 - NCP websites which contain information on patients' rights



Twenty-nine countries give information on patients' right to seek treatment in another European country, while 19 countries also provide information on whom to contact in the event of harm and/or share information on the procedure that patients should follow in the event harm occurs. Information related to how waiting time is defined, which according to the Directive is the medically justifiable time limit, is provided by twelve of the websites. EU countries differ in how this assessment is made: some have a standardised waiting time (for specific or all treatments), while others assess it case by case, taking into account the current state of health and the probable course of the patient's condition. In the event patients experience any problem in obtaining follow-up treatment after having returned to their home country, eight NCP websites inform them on whom to contact and/or share information on the procedure to be followed.

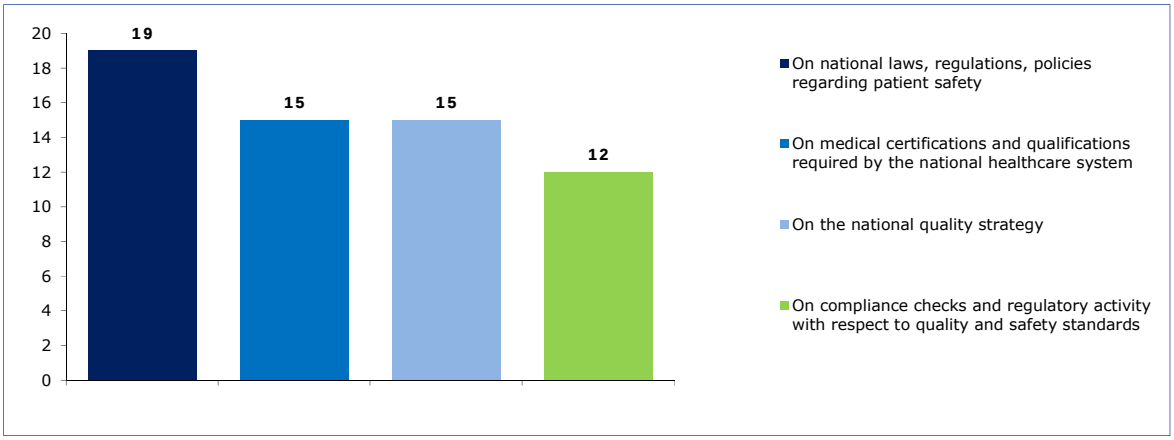
Article 8 of the Directive 2011/24/EU states that given certain conditions (e.g. treatments that involve overnight hospital accommodation of the patient in question for at least one night), patients need prior authorisation from their Member State of affiliation. These conditions are not always clearly explained by Member States: only some of them provide detailed information on the treatments for which patients need to request prior authorisation. As can be seen from the chart below, 21 EU Member States provide information on which treatments (grouped by broad categories) require prior authorisation. Conversely, only twelve provide detailed lists of specific treatments for which patients need prior authorisation. Thirteen NCPs provide information on the time period the health insurance providers need to process prior authorisation requests and only twelve NCPs provide the application form needed to formulate the request for prior authorisation on their website.

Figure 22 - NCP websites which contain information on prior authorisation



With regard to quality and safety, the following chart summarises the information that NCPs provide:

Figure 23 - NCP websites which provide information on quality and safety

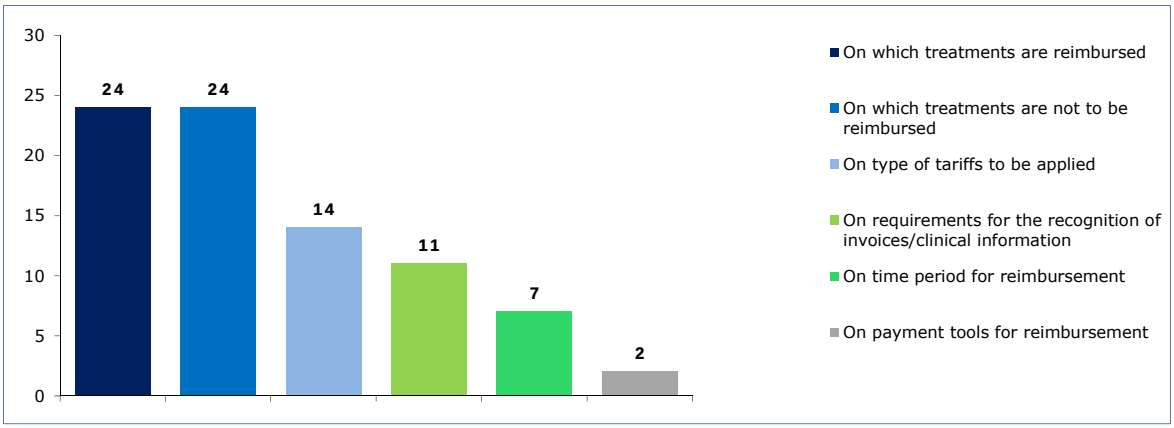


Nineteen NCPs provide information on national laws, regulations and policies regarding patient safety and only 15 provide information on the national quality strategy and on certifications required by the healthcare systems to operate.

Under Article 7 of the Directive 2011/24/EU the Member State of affiliation shall ensure that the costs incurred by an insured person who receives cross-border healthcare are reimbursed, if the healthcare in question is among the benefits to which the insured person is entitled in the country of affiliation.

In order to better explain to patients which treatments are subject to reimbursement, NCPs could provide more detailed information on the treatments that can be reimbursed and those that cannot, on the time period needed to reimburse the costs of treatments, and on specific requirements related to the invoices needed to receive the reimbursement. This information is not always provided, as the following figure indicates:

Figure 24 - NCP websites which provide information on reimbursement

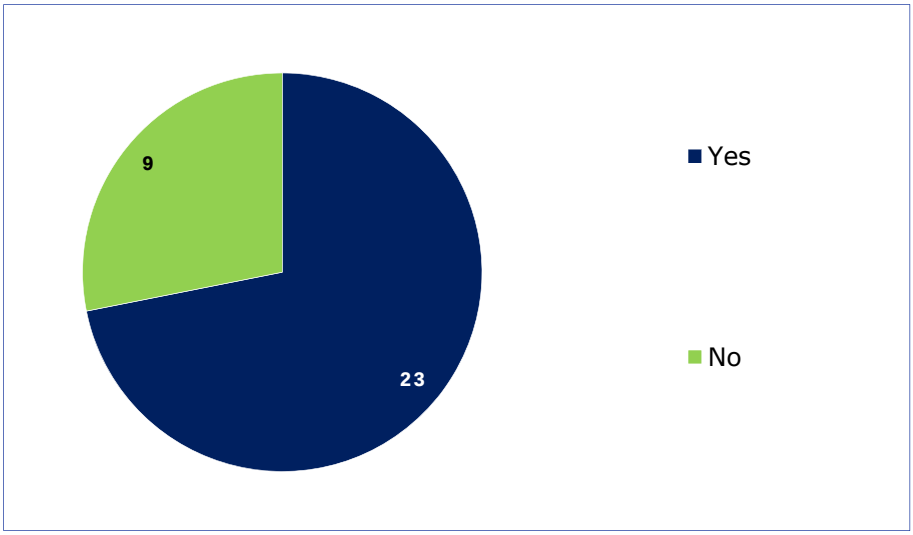


The figure shows that 24 NCPs define which treatments are to be reimbursed (e.g. those that are covered by the national statutory insurance) and, likewise, 24 NCPs define those which are not.

Eleven NCPs identify the requirements for the recognition of documentation.

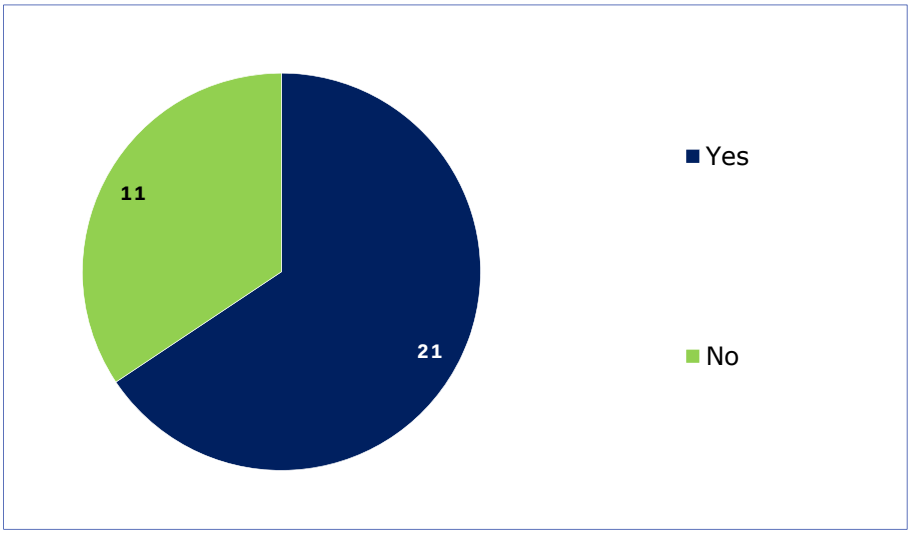
Once they receive authorisation to seek healthcare abroad, patients may need information on the laws, rules, and healthcare providers of the Member State in which they would like to receive treatment. In order to get this information they need to consult the website of other NCPs. Currently, only 23NCP websites provide links to the homepages of other NCPs.

Figure 25 - NCP websites providing information on contact details of other NCPs



In order to understand the procedure to seek treatment abroad, patients should be informed about the difference between the Regulation and the Directive. Accordingly, we evaluated whether there is a clear distinction between the two. As the following pie chart shows, 21 countries clearly differentiate the information of EU Regulation 883/2004 and EU Directive 24/2011.

Figure 26 - NCP websites which distinguish the EU Regulation 883/2004 and the EU Directive 24/2011



Summary of key findings and options for the improvement of NCP websites

Type 1 and 2

The following table defines the criteria used to assess the results presented in table 15, for each category of the first and second type:

Table 15 - Comparison methodology key – 1st and 2nd type

	1st type			*2nd type*		
Categories	**Updates**	**Contacts of the other NCPs**	**Clarity in differentia-ting EU policies**	**Available channels**	**Available languages**	**Easy to find**
Categories explanation	*NCPs upload the last date of information's update*	*Availability of contacts of the other NCPs through web links*	*Clarifications on the differences between Regulation 883/2004 and EU Directive 24/2011*	*NCP's available channels of communication*	*NCP's website available languages*	*Degree of easiness in finding the NCP's website*
	Presence of date of information's update	Presence of contacts of the other NCPs through web links (even if through EC web link*)	Presence of sections explaining the difference between Regulation and Directive	Presence of: E-mail + phone + office	Presence of information in national language, English and at least a third foreign language	Same address as EC* + (1st in one Google rank or between 2nd & 5th in both) or 1st in both Google ranks
	Not applicable	Not applicable	Not applicable	Presence of: E-mail + (phone or office)	Presence of information only in national language and in English	Between 2nd & 5th in Google rank + Same address as EC* or 1st in Google rank + between 2nd and 5th in the other Google rank
	Absence of date of information's update	Absence of contacts of the other NCPs	Absence of sections explaining the difference between Regulation and Directive	Presence of only e-mail as available channel	Presence of information only in national language	Only between 2nd and 5th in one Google rank

* see Annex 6, List of NCPs as provided by EC

To summarise the scores of the different NCP websites, an evaluation grid has been created, outlining the main strengths and weaknesses of each website.

These scores are not meant to evaluate the quality of information provided for each item, but only look at whether information was present at all. As a consequence, items featuring only partial information contributed to the overall score of the website just as much as those better detailed did.

The following table shows the results of the web analysis for the first and second types:

Table 16 - Assessing the available contents of the National Contact Points - 1st and 2nd type

	1st type			*2nd type*		
EU countries	**Updates**	**Contacts of the other NCPs**	**Clarity in differentia-ting EU policies**	**Available channels**	**Available languages**	**Easy to find**
Austria						
Belgium						
Bulgaria						
Croatia						
Cyprus						
Czech Republic						
Denmark						
England						
Estonia						
Finland						
France						
Germany						
Gibraltar						
Greece						
Hungary						
Ireland						
Italy						
Latvia						
Lithuania						
Luxembourg						
Malta						
Netherlands						
Northern Ireland						
Poland						
Portugal						
Romania						
Scotland						
Slovakia						
Slovenia						
Spain						
Sweden						
Wales						

The scores presented in the above table show that 15 out of 32 European countries publish the last date the information was updated. The assessment does not incorporate a judgment based on how recent the updates are, rather measures whether NCPs publish the last date on which they updated the information, so that patients can check if there have been further changes in relation to their topic of interest.

Patients would certainly benefit from a list of contacts to other NCPs, as when they seek cross-border care they may need to contact not only their own NCP but also the ones in the country where they seek healthcare. Providing a list already available on the European Commission's website (see "Annex 6 – List of NCPs as provided by EC")) is sufficient, and the nine NCPs that still do not have this list available on their website are recommended to include it.

Not all NCPs had been set-up with the purpose of fulfilling the informational requirements deriving solely from the EU Directive 24/2011, as most of them provide information more generally on cross-border healthcare. Twenty-one NCPs have designed their websites in order to avoid patient misunderstandings of the different European rules[69], often via FAQs which explain the differences between such regulations or in other sections of the website. However, eleven NCPs have still to make improvements in this area.

Contacting NCPs is considered to be easy[70], as more than half (21 out of 32) of the NCPs are available via three channels: e-mail, phone number and office address, and 28 have at least both email and phone availability. With regard to the languages in which patients can contact NCPs, the three NCPs which still do not provide information in English are advised to add this feature, as it is the most common language patients use to go abroad or, at least, provide the information for inbound patients in English. Inbound patients are the most interested subjects, as outbound patients are national citizens, and therefore search for information in the national language.

[69] EU Directive 24/2011 and EC Regulation 883/2004.

[70] Key findings of pseudo patient investigation, in "Annex 4 – Pseudo patient investigation", shows the efficacy of e-mail and phone call channels.

Type 3

Like for the first two types in the above tables, the following table defines the criteria used for each category of the third type:

Table 17 - Comparison methodology key – 3rd type

	3rd type					
Categories	**User friendly**	**Info on healthcare providers**	**Patients' rights**	**Info on prior authorisa-tion**	**Info on quality and safety**	**Info on reimbur-sement**
Categories explanation	*Users' friendliness in searching information on websites*	*Presence of information on healthcare providers*	*Presence of information on patients' rights*	*Presence of information on prior authorisation*	*Presence of information on quality and safety*	*Presence of information on reimbur-sement*
	4th quartile	4th quartile	4th quartile	4th quartile	4th quartile	4th quartile
	2nd quartile + 3rd quartile	2nd quartile + 3rd quartile	2nd quartile + 3rd quartile	2nd quartile + 3rd quartile	2nd quartile + 3rd quartile	2nd quartile + 3rd quartile
	1st quartile	1st quartile	1st quartile	1st quartile	1st quartile	1st quartile

An evaluation grid was created for the third type, outlining the main strengths and weaknesses of each website. These scores are not meant to evaluate the quality of information provided for each item, but only look at whether information was present at all. As a consequence, items featuring only partial information contributed to the overall score of the website just as much as those better detailed did.

The following table shows the results of the web analysis for the third type:

Table 18 - Assessing the available contents of the National Contact Points - 3rd type

EU countries	**User friendly**	**Info on healthcare providers**	**Patients' rights**	**Info on prior authorisa-tion**	**Info on quality and safety**	**Info on reimbur-sement**
Austria						
Belgium						
Bulgaria						
Croatia						
Cyprus						
Czech Republic						
Denmark						
England						
Estonia						

EU countries	User friendly	Info on healthcare providers	Patients' rights	Info on prior authorisa-tion	Info on quality and safety	Info on reimbur-sement
Finland						
France						
Germany						
Gibraltar						
Greece						
Hungary						
Ireland						
Italy						
Latvia						
Lithuania						
Luxembourg						
Malta						
Netherlands						
Northern Ireland						
Poland						
Portugal						
Romania						
Scotland						
Slovakia						
Slovenia						
Spain						
Sweden						
Wales						

Using frequently asked questions is needed to improve patients' understanding, as they can quickly identify the information they need and obtain it. Most visited pages serve the same function, as they redirect users to the topics that are usually requested. A media library and a clear and user-friendly web design are also considered as necessary tools to simplify understanding of the uploaded content. In the table, the green boxes show which NCPs address the information requirements based on these criteria, while the red boxes highlight those that need further improvement.

Providing information to help patients in selecting and contacting healthcare providers is also considered to be a crucial feature of NCP websites. A description of the national healthcare system, combined with statistical information on healthcare providers help patients understand which providers meet their needs, and tools/lists of healthcare providers with their contact details can help patients in contacting them to obtain more information and to make reservations for treatment. Some NCPs (green boxes) fulfil these needs particularly well, while others still have to add this type of information.

Some information regarding patients' rights, such as the possibility to seek treatment in another Member State are better highlighted than others. Providing information on the procedures to be followed in the event of harm could reassure patients that such mechanisms exist, as well as giving information on the definition of undue delay and enhancing patients' knowledge (and thus their use of the Directive's provisions) on cross-border healthcare. Informing patients about their rights is necessary to enable them to use the Directive. In this area, some NCPs have to do further work in explaining what those rights are (red boxes in the table), while others already provide most of the necessary information (green boxes in the table).

As for patients' rights, prior authorisation is a topic that should be elaborated and presented by NCPs in more detail. Grouping treatments for which patients need prior authorisation into broad categories (e.g. cost-intensive) is not considered as helpful, as patients are not always informed on the specificities (e.g. cost) of the treatments they need. Providing specific lists of treatments is more meaningful for patients, as they can simply check whether the treatment they need is among those requiring prior authorisation. Detailing this information, together with the time-frames NCPs or other authorities need to process the requests (even providing the application form for prior authorisation) can be very helpful to patients. In the table, green boxes highlights those NCP websites with the most informative contents on this topic in comparison to the others. Those with a red box still need to improve the availability of information to patients.

Some NCPs comprehensively assist inbound patients in understanding any quality and safety issues related to their choice (green boxes in the table). Providing information on national laws and quality strategies, medical certifications and compliance checks with quality and safety standards are considered necessary to make an informed choice.

Information on the reimbursement process is particularly important to patients living in countries in which healthcare is publicly financed. These patients are not accustomed to paying (for healthcare) upfront and then being refunded and thus clarity on the related rules is crucial for them. However, information specifying at least the differences between national healthcare reimbursement and cross-border healthcare also has to be provided in countries in which patients have to pay directly for the treatments received. A specific point that 24 NCPs address is the definition of which treatments are to be reimbursed under the Directive and which are not. It is often explained that only those treatments for which patients are insured nationally are to be reimbursed. It can also be important for patients to know how long they will have to wait before getting reimbursed and clear information on which documents should be submitted to obtain it. Some NCPs also provide information on payment tools for reimbursement and on tariffs nationally applied to cross-border patients. The most comprehensive NCP websites (green boxes) provide information on these topics while the others still have to upload some of this information.

ANNEX 3

Online survey

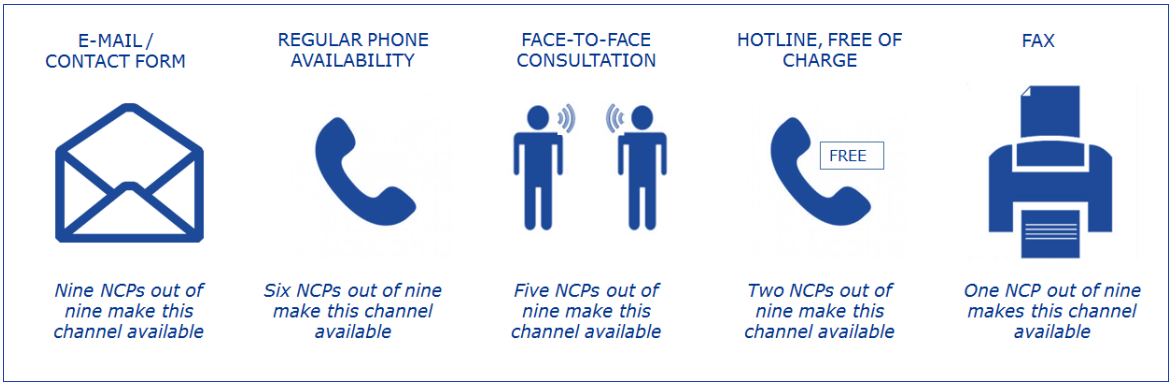
Key findings

The online survey aims to acquire information from the National Contact Points of the 12 focus countries.

General information on NCPs:

The NCPs stated they are fully operational for the general public[71]. The earliest time declared for becoming fully operational was October 2013, while the last NCP to become fully operational did so in April 2014. Other than the websites available for all NCPs, there are various other ways to contact them, summarised in the following figure. E-mail is the most common mean of contacting NCPs[72], while telephone is also common.

Figure 27 - Possible means of contacting the NCP (N=9)



Each NCP selected the available channels through which they can be contacted. The results show that it is possible to contact six of the nine[73] NCPs by telephone, while five NCPs offer the opportunity for face-to-face contact with office staff.

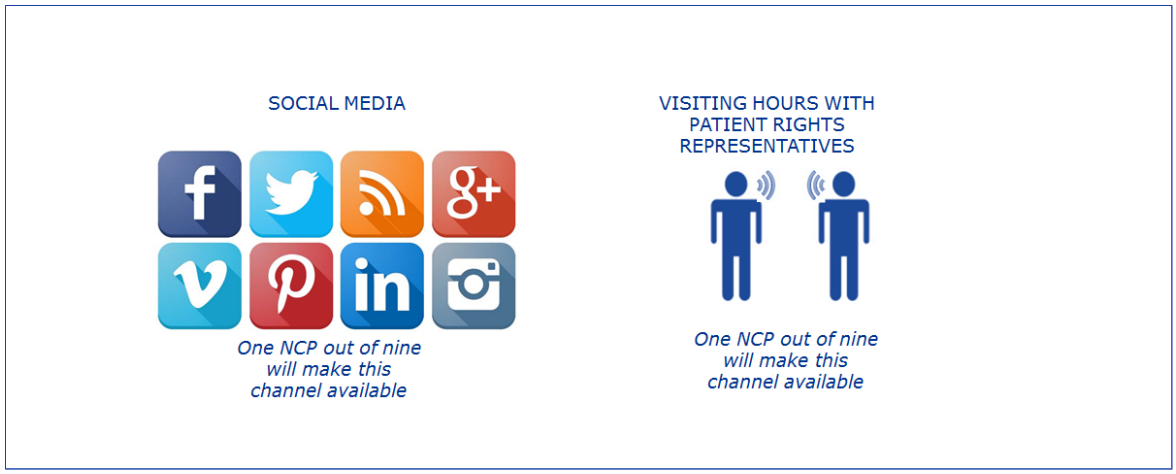
[71] Nine out of twelve NCPs provided information on this topic.

[72] All nine NCPs answered that e-mail is available. This is confirmed by the web analysis that shows each NCP has an available e-mail address/contact form.

[73] Nine NCPs provided information on this topic.

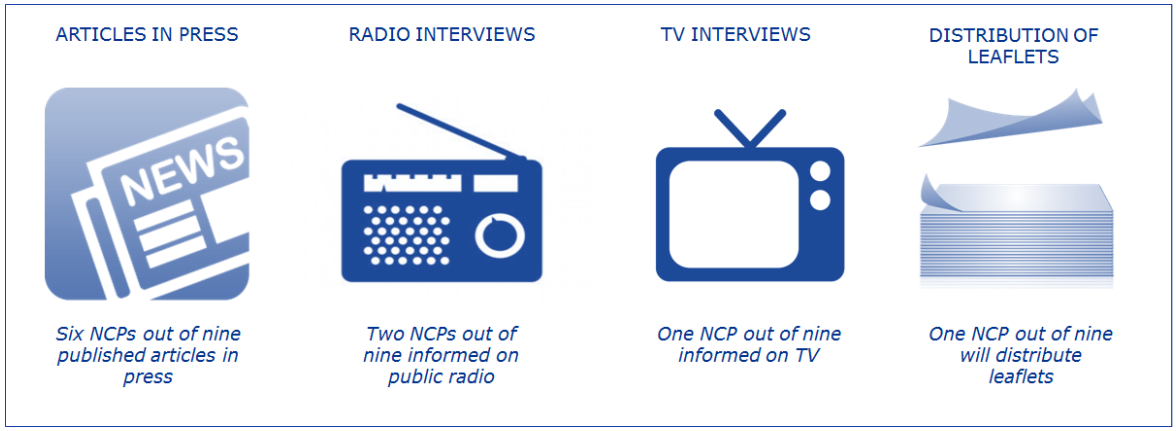
In addition to the items listed above, two NCPs plan to include additional channels such as:

Figure 28 - Additional channels under evaluation (N=9)



Six of the nine NCPs launched communication campaigns to inform the general public about the activities they carry out. The channels they used were:

Figure 29 - Channels used to inform the public (N=9)

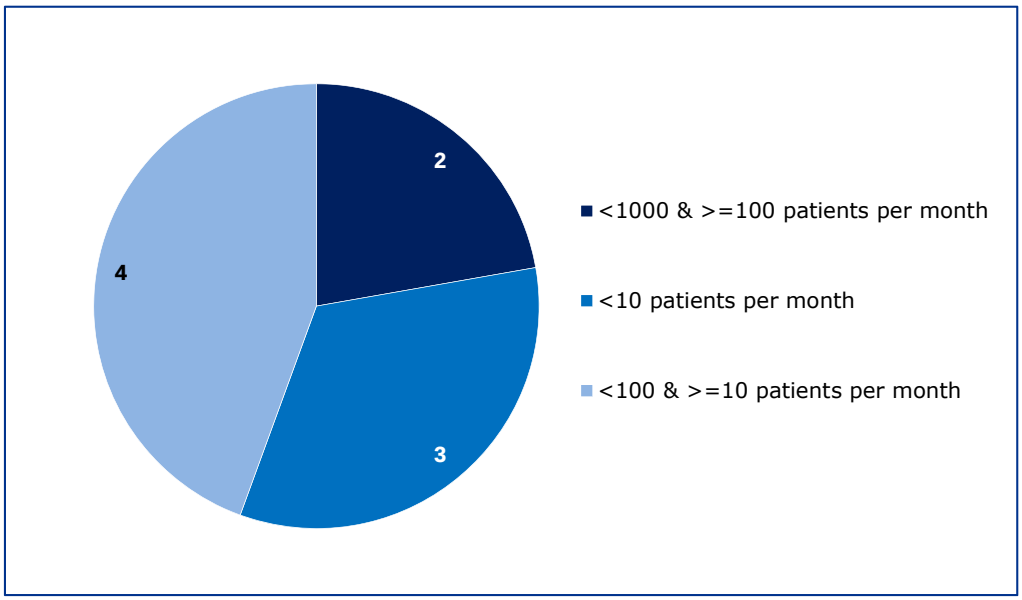


Depending on the Member States, these activities were carried out over different time periods between September 2013 and October 2014.

The NCPs also gave their opinion regarding patients' awareness about the Directive and the existence of the NCPs. In spite of the communication campaigns, this is considered to be "low" by eight out of nine of them.

With regard to the frequency of patients asking for information, the following chart shows that seven NCPs out of nine receive less than 99 requests per month, and no NCPs receive more than 1000 requests.

Figure 30 - Average frequency of patients requesting information from the NCP



This chart, based on monthly results, suggests that NCPs receive an average of almost five requests per day. In order to deal with these requests, the NCPs are structured in different ways, employing between one to three FTEs.

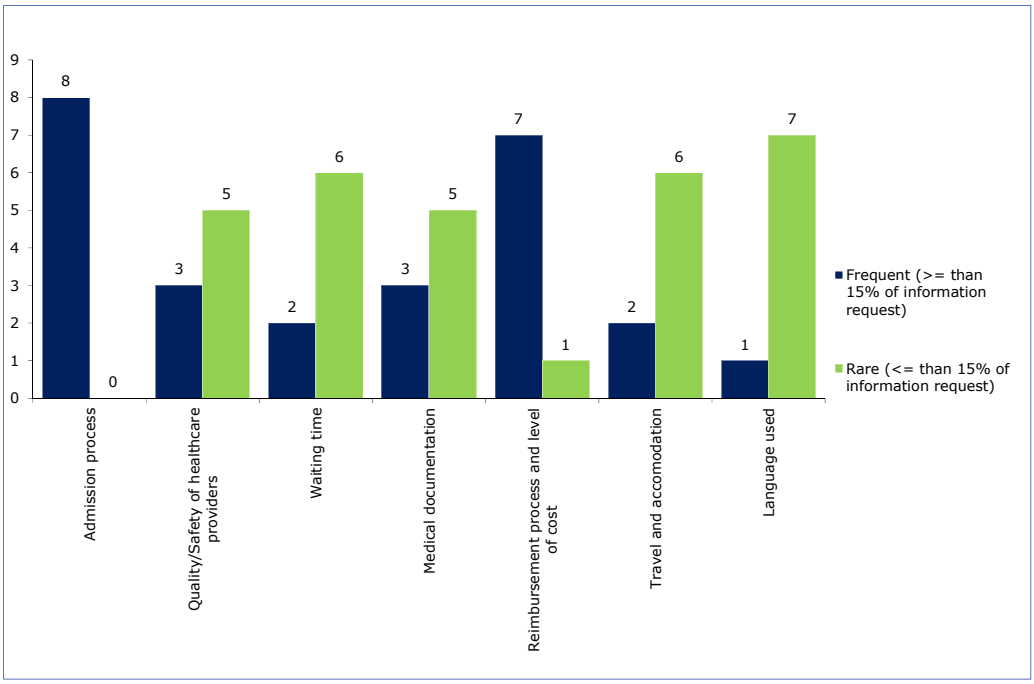
Five of the eight NCPs that answered the question have established a dedicated office and in two other countries the activities are carried out by the departments responsible for international relations. Only one out of the five NCPs that have established a dedicated office has one employee working 70% of his/her time, while four have between two and three employees working full time for the NCP. It is worth highlighting that, given the lack of activity, one NCP informed us that it plans to decrease its dedicated work-force.

The NCPs were asked whether they monitor the number of national patients using healthcare abroad, with regards to the EU Directive 24/2011. It appears that half (five out of ten) of the NCPs monitor it. For instance, one NCP explained that since the adoption of the Directive, 27 national patients have gone abroad through its provisions.

It was also asked if a system is in place to monitor the number of foreign patients by providers of private and/or public national healthcare. One NCP explained that it takes into consideration both private and public institutions and another one stated that monitoring is carried out by another institution. All the others (six out of eight) explained that such monitoring system does not exist.

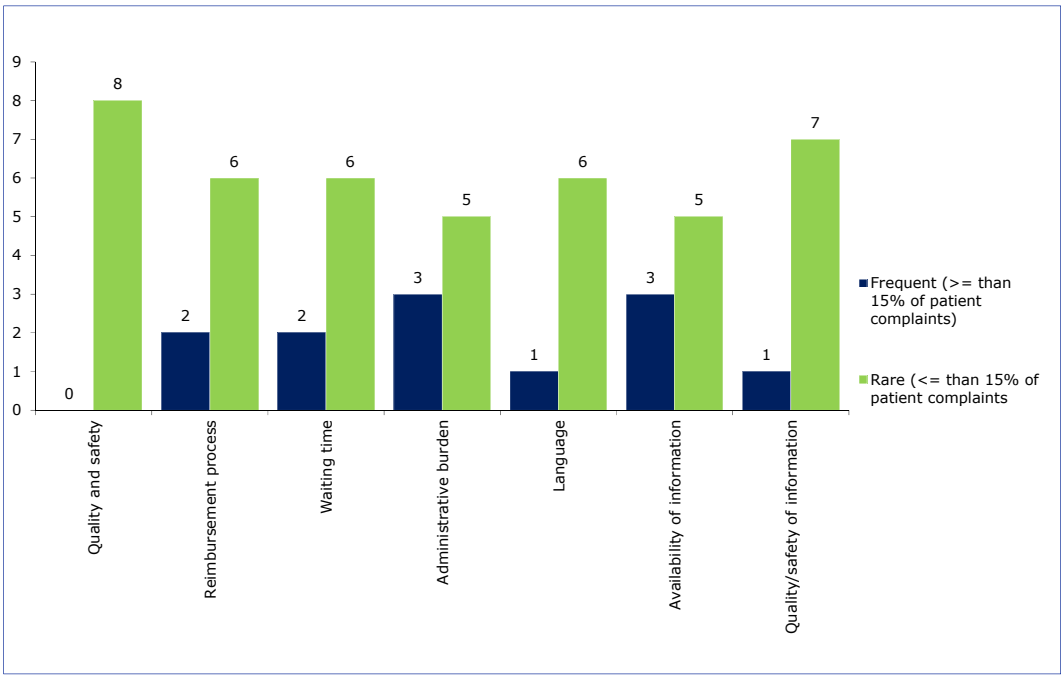
As not every Member State has a monitoring system, the NCPs stated that at the moment, only limited data are available on patient flows based on the Directive. Therefore, when asked for general conclusions about the origin of the patients, the NCPs commented that they usually come from EU countries using other international agreements or using the EHIC (European Health Insurance Card). Insufficient data are available on preferred destinations for NCPs to give an evidence-based answer. The NCPs were asked what kind of requests they typically receive from patients, i.e. which are the most common topics patients are interested in. The results are presented in the following table:

Figure 31 - NCP estimates of type of requests received



The topics that patients ask about more frequently are "admission process" and "reimbursement process and cost". Language used is a frequently asked topic for one country only. NCPs were asked to evaluate the frequency of patient complaints; the results are presented in the following table:

Figure 32 - NCP estimates of the frequency of patient complaints by topic



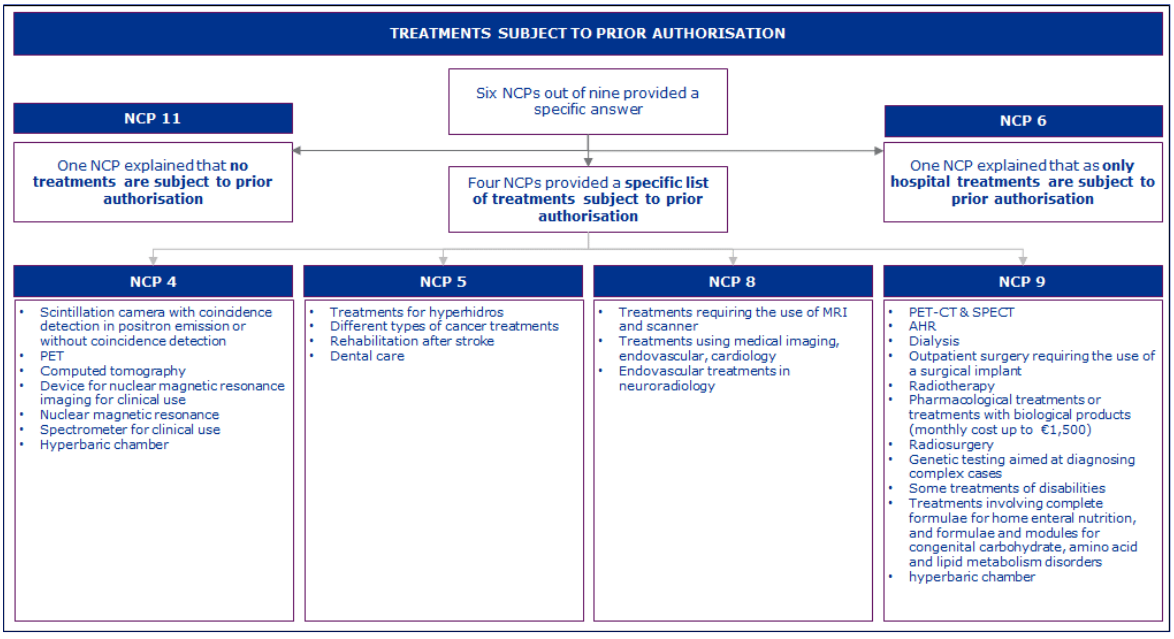
Patient complaints are frequently related to "Administrative burden", "Reimbursement process" and "Waiting time" issues.

Reimbursement process is a frequently asked topic and also the topic to which most complaints relate. These results suggests that this is an area that requires further improvement. The reimbursement and prior authorisation processes are described in detail in the following section.

Reimbursement and prior authorisation: Article 8 of the Directive 2011/24/EU states that, given certain conditions[74], patients need prior authorisation from their Member State of affiliation. These conditions are not always clearly defined by Member States, which only sometimes provide detailed information on the treatments for which patients should request prior authorisation. In this regard, the NCPs were asked if they publish a list/categories of treatments to which patients could refer. We found that three respondents referred patients to the list/categories included in the Directive and made no reference to further lists.

On the other hand, some more proactive National Contact Points provided a non-exhaustive list that identifies the following categories of treatment as being cost-intensive, thus requiring prior authorisation:

Figure 33 - Treatments subject to prior authorisation



[74] Art.8: "Healthcare that may be subject to prior authorisation shall be limited to healthcare which:

(a) 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:

(i) involves overnight hospital accommodation of the patient in question for at least one night; or

(ii) requires use of highly specialised and cost-intensive medical infrastructure or medical equipment;

(b) involves treatments presenting a particular risk for the patient or the population; or

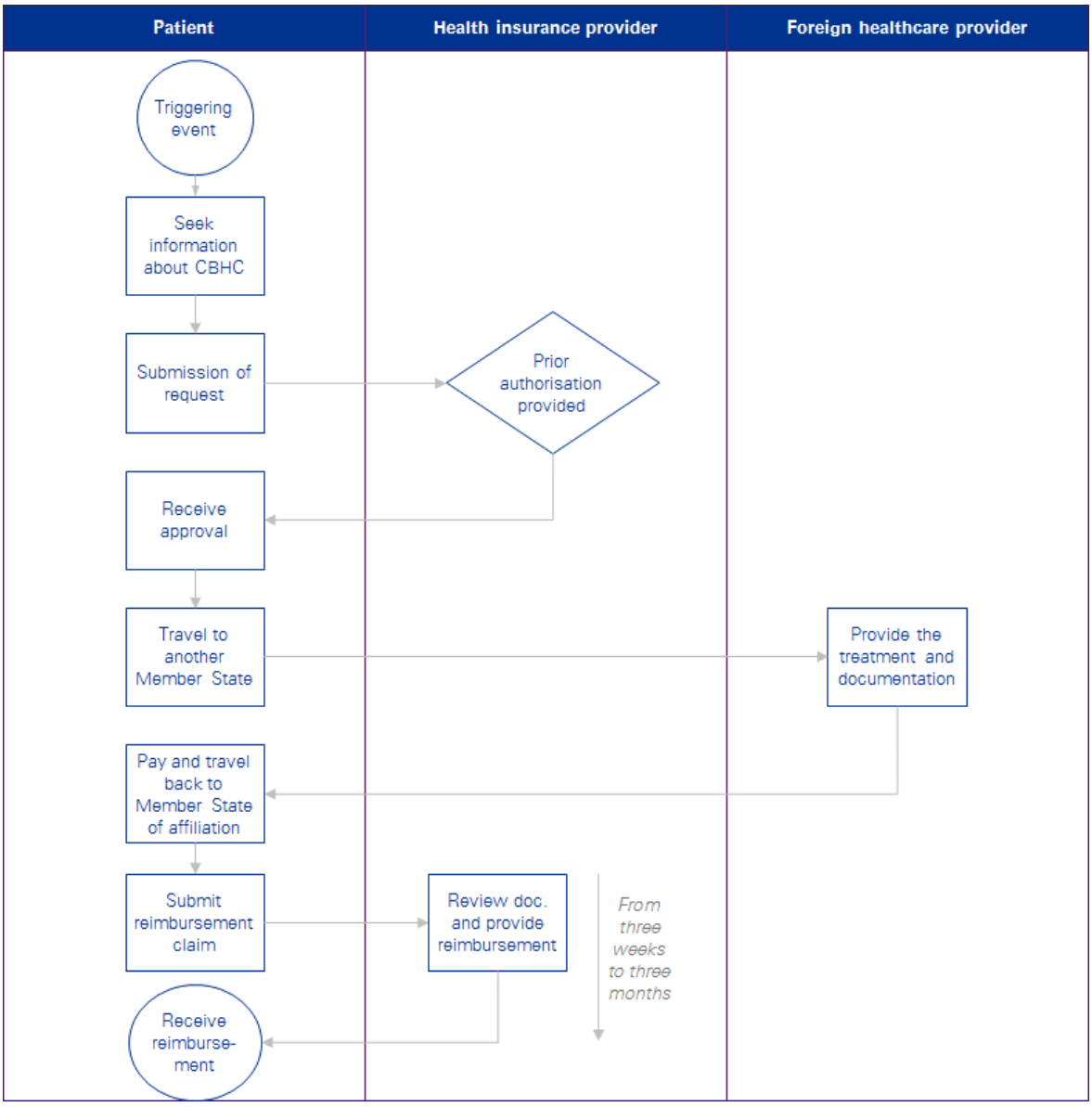
(c) is provided by a healthcare provider that, on a case-by-case basis, could give rise to serious and specific concerns relating to the quality or safety of the care, with the exception of healthcare which is subject to Union legislation ensuring a minimum level of safety and quality throughout the Union."

Countries that still do not provide lists explained that national authorities are preparing a Ministerial Decree to provide the list of treatments subject to prior authorisation.

The time limit in which the prior authorisation requests must be dealt with varies between Member States, ranging from two weeks to three months.

The NCPs described the process of reimbursement for treatment received abroad. Although differences exist, the process can be summarised as shown in the following chart:

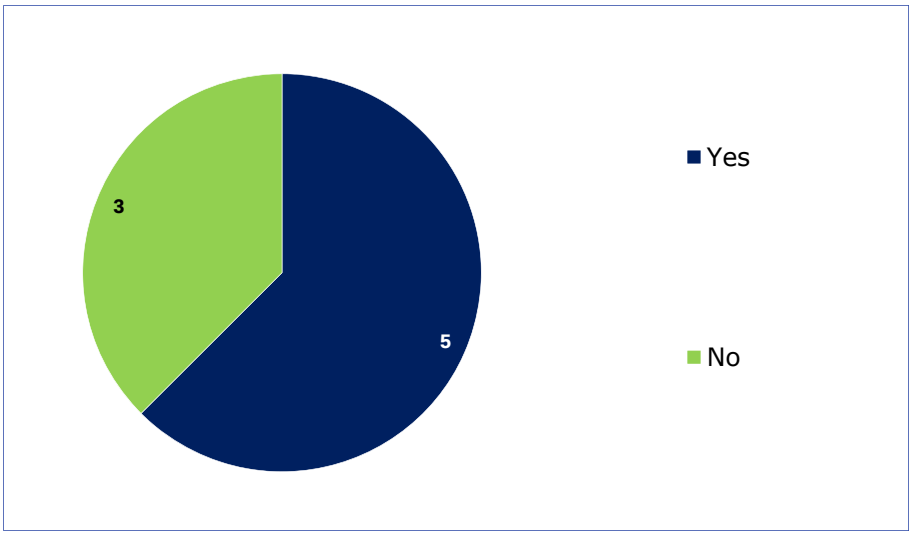
Figure 34 - Reimbursement process of a patient



The general process is: filling in the forms (prior authorisation or any other), presenting the medical expert examination to the parties in charge of the authorisation (health insurance provider) for their decision and finally requesting reimbursement once the treatment has been performed.

With regard to tariffs, NCPs were asked if there are national tariffs to which patients could refer.

Figure 35 - Presence of a national tariff scheme for treatments



Five NCPs answered positively, providing the corresponding web links (although not all of them redirect exactly to a tariff scheme), while others explained why the national tariffs are not provided. The main reasons are that regional tariffs are applied. Three NCPs explained that other domestic reimbursement rules are also applied, such as:

- Mixed systems with a percentage calculated via the national DRG system and a percentage calculated by the respective regional health fund.

It was also asked if there is a possibility for covering additional, indirect costs incurred by patients (e.g. accommodation, travel, etc.). Some NCPs said that these costs might be covered given the following (depending on the NCP):

- invoice and confirmation of payment; or
- cost-effectiveness; in a national healthcare system, the cost-effectiveness rule establishes that the cost of the treatment should not exceed the domestic cost by more than 30%.

Under Directive 2011/24/EU, patients are required to pay upfront for care. This is in contrast to the provisions of Regulation no. 883/2004[75], which states that Member States shall pay the costs of treatment directly. NCPs were asked if paying upfront can cause any difficulty for patients, and if so, whether other methods of payment were available. Five out of the nine NCPs stated that it is not an issue, while the remaining four believe it is a barrier.

[75] Regulation (EC) no 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems.

NCPs were asked what documentation should be submitted by the patient in order to be reimbursed; seven NCPs provided an answer. The following figure presents the answers provided by them:

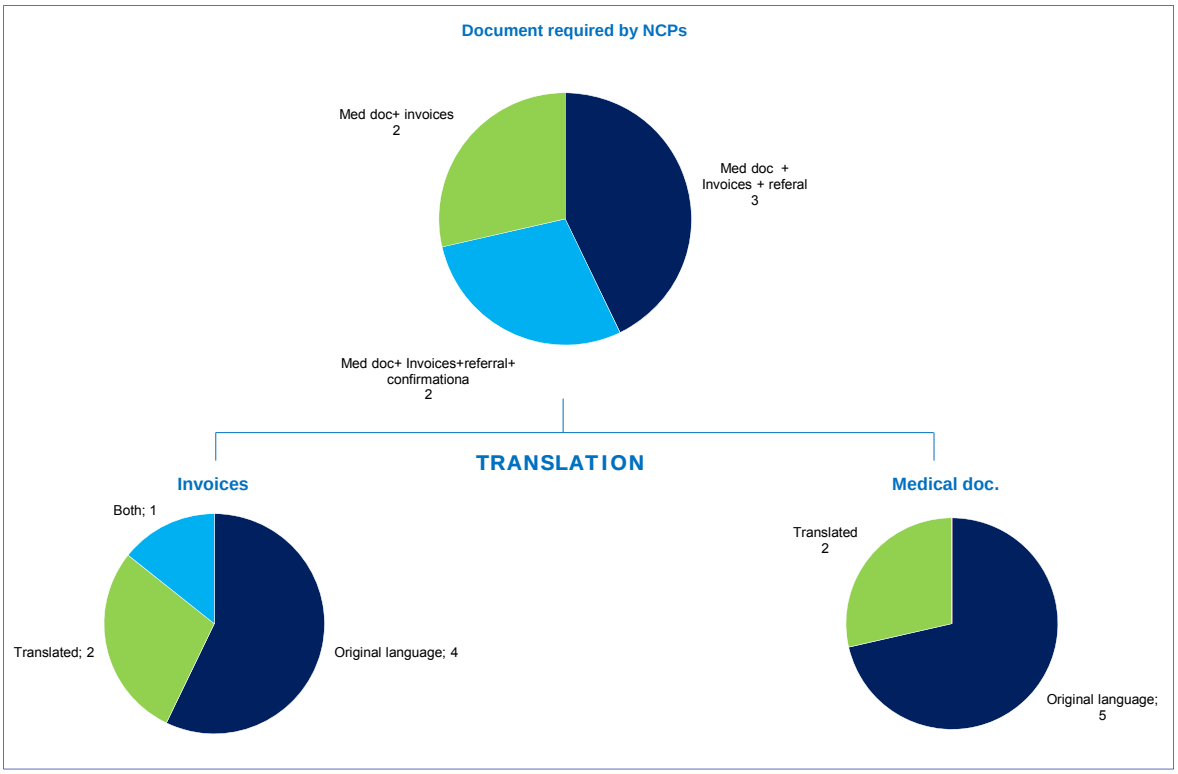
Table 19 - Documentation to be submitted in order to be reimbursed

National Contact Point	Medical docs.		Invoices		Referral note from a national HCP	Other
	Original language	Translated	Original language	Translated		
NCP 1						
NCP 2						
NCP 3						
NCP 4						
NCP 5						
NCP 6						
NCP 7						
NCP 8						
NCP 9						
NCP 10						
NCP 11						
NCP 12						
TOTAL	**5**	**2**	**5**	**3**	**5**	**2**

Legend

- Answer not available
- Yes
- Answer not selected

Figure 36 - Documentation to be submitted in order to be reimbursed



Three NCPs stated that the medical documents, the invoices and the referral are required, two replied that a confirmation of payment is also required, while another two said that the medical documents and invoices are sufficient.

Regarding the invoices, four NCPs said that no translation is needed while another two said only a translated invoice can be accepted. Yet another said that both documents are required.

Regarding medical documents, two NCPs said that translation is required.

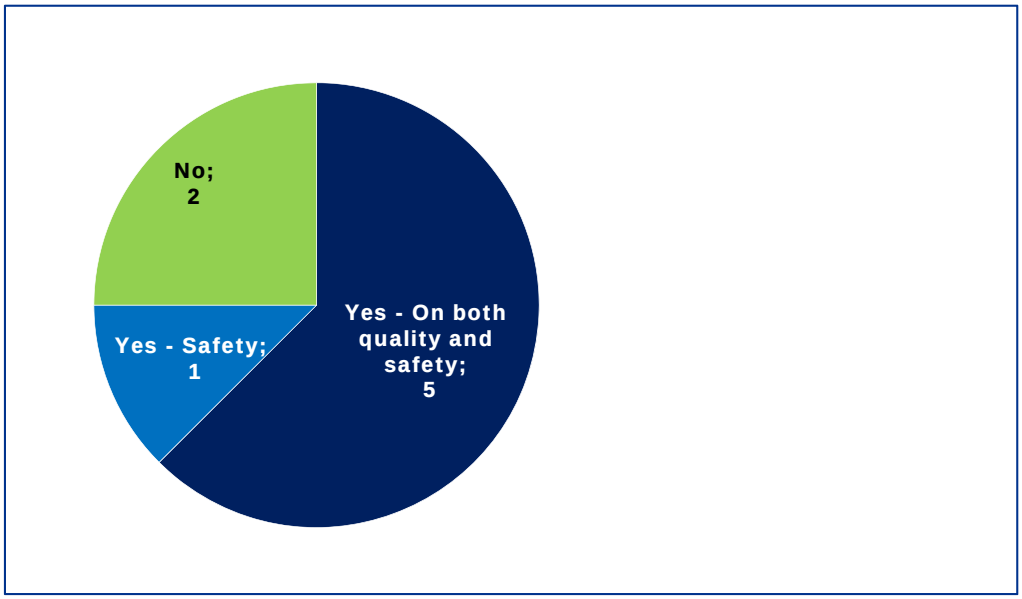
Quality and safety - Most of the NCPs (seven out of eight) confirmed that they provide information on the quality and safety of national healthcare systems. Some of them also provided the web link to find such information in more detail, while others deal with these issues at a general level only.

Regarding quality and safety patients usually require the following information:

- quality of the healthcare provider;
- laws to be applied in the event of any harm;
- information on the "best" healthcare provider;
- national legislation;
- standards in connection with the treatments needed.

It was then asked whether NCPs provide quality and safety information on specific healthcare providers. The results are presented in the following chart:

Figure 37 - NCPs providing quality and safety information for specific HCPs



Five NCPs out of eight provided information regarding the quality and safety of the country's HCPs.

Following these questions about quality and safety, the NCPs were asked:

- whether national patients request information from their NCP on how to proceed in the event of any harm arising from healthcare received abroad;
- if foreign patients request information from foreign NCPs on how to proceed in the event of any harm arising from healthcare received in the Member State of treatment.

Figure 39 - NCPs receiving questions from national patients on the procedure to be followed in the event of any harm arising from healthcare received abroad

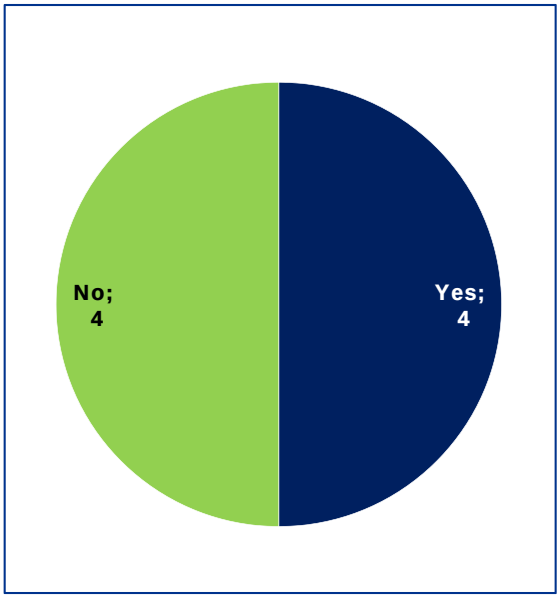
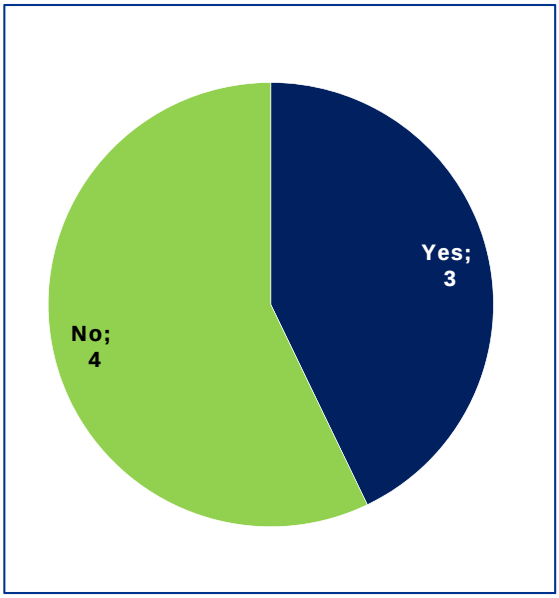


Figure 38 - NCPs receiving questions from foreign patients requesting information on the procedure to be followed in the event of any harm arising from healthcare received in a national hospital

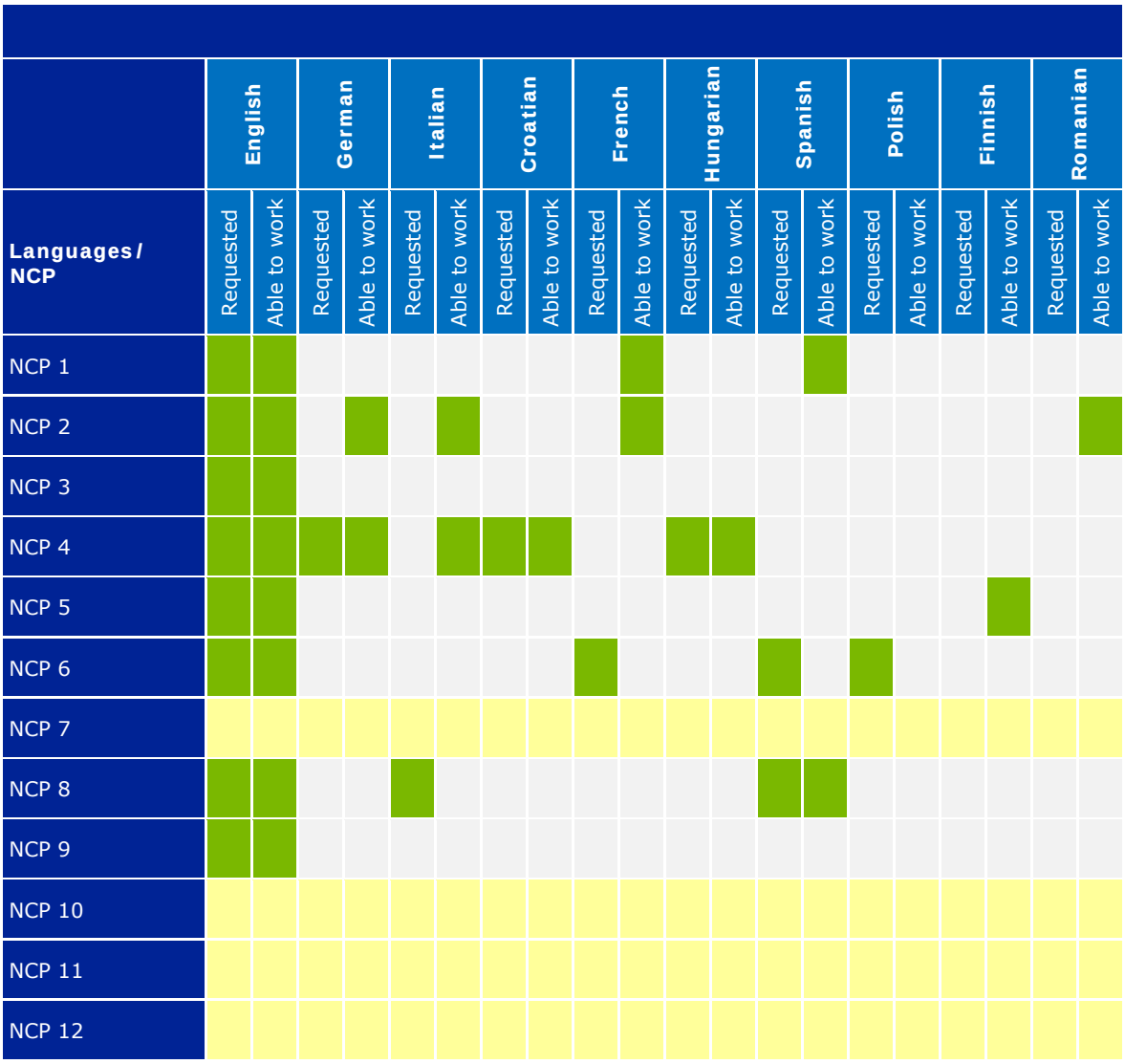


It was asked which national-level entity handles complaints from patients in the event of harm. The NCPs identified various entities in accordance with national legislation, as follows:

- the ombudsman;
- the courts;
- authorities for patients' rights;
- the Health and Social Care inspectorate;
- the Ministry of Health.

Language used - With regard to the most commonly used language by inbound patients and those spoken by NCPs, the NCPs indicated that they have all received English requests and that they are able to answer these questions. The following table summarises the comparison between the language used by inbound patients and the second languages used by NCPs:

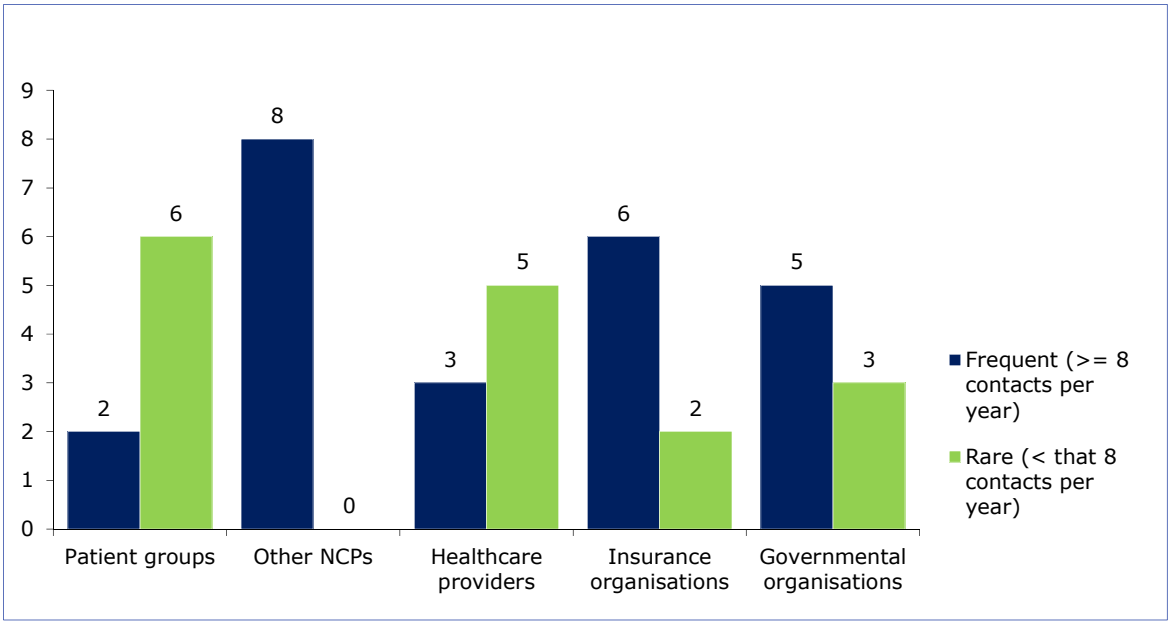
Table 20 - Languages used by inbound patients other than the NCP's national language vs Second languages in which NCPs are able to work



The above chart enables the identification of mismatches between foreign languages in which incoming requests to NCPs are drafted, and languages in which the same NCPs are able to work. In particular, NCP 4 receives requests in four different foreign languages, but is able to work with all these languages. On the contrary, NCP 6 receives requests in four foreign languages, but is only able to process English queries (as a second language). This leads to the risk that a number of requests will be left unanswered.

Cooperation with stakeholders - The NCPs identified the stakeholders with whom they cooperate with regards to the Directive 2011/24/EU, summarised in the following chart:

Figure 40 - NCPs' level of cooperation with stakeholders (N=8)



All NCPs stated that they have more than 8 contacts per year with other NCPs, they also added that they are determined to improve cooperation with "regional" NCPs and with the Member States where significant patient flow is detected. The level of cooperation with patient groups is considered to be rare for six NCPs out eight.

On the other hand, others stated that the involvement of patient groups is one of their professional goals and is currently not emphasised adequately.

EU Directive 24/2011 vs Regulation (EC) No. 883/2004 – NCPs explained that they received enquiries about the relevant provisions of Regulation (EC) No 883/2004. Nevertheless, only five out of eight NCPs stated that they provide information about those provisions. This is due to the organisational differences between NCPs, as some of them were created solely for the purpose of informing patients about the provisions of the Directive, while others aim more generally to inform patients about cross-border healthcare provisions. Four of the nine NCPs interviewed that provide information both on the Directive and on the Regulation, experienced difficulties in communicating the differences between those legal instruments. The main reason identified by the respondents is that it is difficult to explain the differences between the function and features of prior authorisation in the two legal frameworks.

ANNEX 4

Pseudo Patient Investigation

The first scenario

The results for Scenario 1 are presented in the following table:

Table 21 - Status of the NCPs contacted – Scenario 1

Contacts and answers				
NCP	Submitted		Answered	
	E-mail	Phone call	E-mail	Phone call
NCP 1		Not available		Not available
NCP 2			No	
NCP 3		Not available		Not available
NCP 4				
NCP 5				
NCP 6				
NCP 7				
NCP 8		Not available[1]		
NCP 9				No
NCP 10				
NCP 11		Not available		Not available
NCP 12				
Total	**12**	**9**	**11**	**8**
%	**100%**	**100%**	**92%**	**89%**

Of the 12 NCPs, only NCP2 did not answer the e-mail sent by the Pseudo patient. This was due to the fact that it gave the answers directly on the phone.

Considering that NCP 1, NCP 3, NCP 11 and NCP 8 do not have an available phone number, only NCP9 did not answer the phone call. The purpose of this table is to show whether it is feasible for patients to contact their National Contact Point. As can be seen in the above chart, the 12 NCPs replied to the pseudo patients using at least one of the two channels used for contacting them (e-mail and phone).

By merging the information gathered through the two channels it is possible to have an overview of the answers the Pseudo patients received:

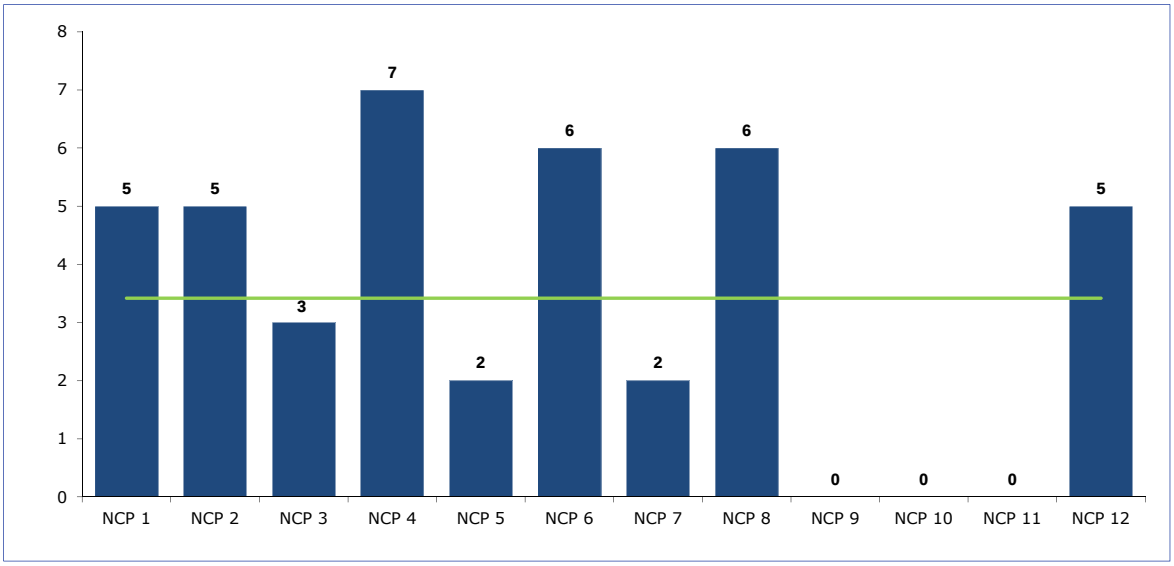
Table 22 - Summary of Scenario 1

Questions	Answers	NCP1	NCP2	NCP3	NCP4	NCP5	NCP6	NCP7	NCP8	NCP9	NCP 10	NCP 11	NCP 12	Total	
														%	Units
Was it explained whether the treatment requires prior authorisation?	YES													33 %	4
	NO													67 %	8
	N/A													0 %	0
Was the amount being reimbursed for a specific treatment clearly defined?	YES													67 %	8
	NO													33 %	4
	N/A													0 %	0
Was it explained which documents are needed in order to address a reimbursement claim?	YES													50 %	6
	NO													50 %	6
	N/A													0 %	0
Was it explained in which language the medical prescription should be written, in order to be understood in another MS?	YES													33 %	4
	NO													67 %	8
	N/A													0 %	0
Was it explained in which language the invoices should be written, in order to get the reimbursement?	YES													50 %	6
	NO													50 %	6
	N/A													0 %	0
Are there any formalities imposing burdens on patients seeking cross-border healthcare?	YES													8 %	1
	NO													92 %	11
	N/A													0 %	0
Was it explained which documents patients need, in order to receive follow-up treatment in their home country?	YES													33 %	4
	NO													67 %	8
	N/A													0 %	0
Did the National Contact Point provide any other information?	YES													67 %	8
	NO													33 %	4
	N/A													0 %	0
Total	%	56 %	56 %	33 %	78 %	22 %	67 %	22 %	67 %	0 %	0 %	0 %	56 %		
	Units	5	5	3	7	2	6	2	6	0	0	0	5		

The guidelines describing the questions asked, the text of the e-mails and the templates Pseudo patients filled in are presented in "Annex 1 – Methodology". As can be seen in the above chart, although they received the e-mails and/or the phone calls, some NCPs did not address any of the points the pseudo patient was interested in.

The following figure shows the NCPs average results for information provided:

Figure 41 - NCPs answers in the first scenario



The second scenario

As for Scenario 1, the following table shows whether the NCPs answered the e-mails and/or the phone calls of the pseudo patient for the second scenario: the outbound patients seeking an MRI scan on knees in a foreign Member State.

Table 23 - Status of the NCPs contacted - Scenario 2

Contacts and answers				
NCP	Submitted		Answered	
	E-mail	Phone call	E-mail	Phone call
NCP 1		Not available		Not available
NCP 2				
NCP 3		Not available		Not available
NCP 4		No		No
NCP 5				
NCP 6				
NCP 7				
NCP 8		Not available		
NCP 9				No
NCP 10				
NCP 11		Not available		Not available
NCP 12				
Total	12	7	12	6
%	100%	88%	100%	75%

As above mentioned, NCP 1, NCP 3, NCP 11 and NCP 8 do not have an available phone number[76]. In Scenario 2, NCP 4 and NCP 9 did not answer the phone call while all the 12 NCPs answered the e-mails. Some of the questions of Scenario 2 were the same as those asked in the first scenario although in this case the requests were made for a different treatment and thus resulted in different answers. The following table provides an overview of the answers the received:

Table 24 - Summary of Scenario 2

Questions	Answers	NCP 1	NCP 2	NCP 3	NCP 4	NCP 5	NCP 6	NCP7	NCP8	NCP9	NCP 10	NCP 11	NCP 12	Total	
														%	units
Was it explained whether the treatment	YES													58%	7
	NO													42%	5

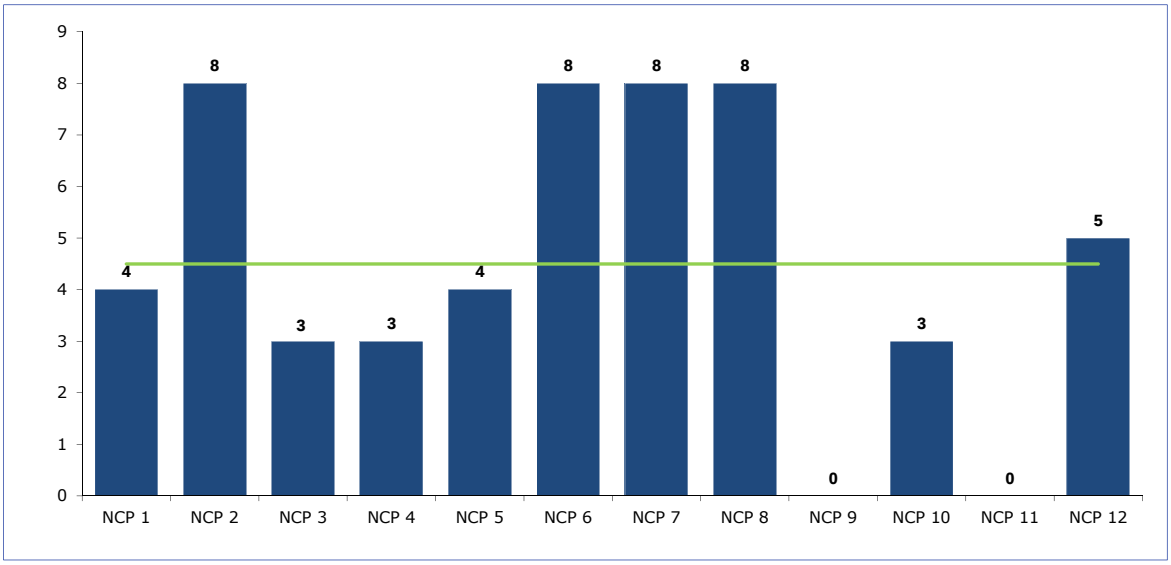
[76] NCP8 provided a phone number as a response to the e-mail sent by the pseudo patient.

Questions	Answers	NCP 1	NCP 2	NCP 3	NCP 4	NCP 5	NCP 6	NCP7	NCP8	NCP9	NCP 10	NCP 11	NCP 12	Total	
														%	units
requires prior authorisation?	N/A													0 %	0
Was it explained which documents are needed to request prior authorisation?	YES													58 %	7
	NO													42 %	5
	N/A													0 %	0
Was the time-limit defined for a prior authorisation request?	YES													33 %	4
	NO													67 %	8
	N/A													0 %	0
Was the amount to be reimbursed for the specific treatment clearly defined?	YES													83 %	10
	NO													17 %	2
	N/A													0 %	0
Was the procedure to be followed in case of claim for the reimbursement explained?	YES													50 %	6
	NO													50 %	6
	N/A													0 %	0
Was it explained in which language the medical prescription has to be in order to be understood in another MS?	YES													33 %	4
	NO													67 %	8
	N/A													0 %	0
Was it explained in which language the invoices have to be in order to get the reimbursement?	YES													42 %	5
	NO													58 %	7
	N/A													0 %	0
Was it explained which documents are needed to get follow-up treatment once the patient travels back home?	YES													17 %	2
	NO													83 %	10
	N/A													0 %	0
Did the National Contact Point provide any other information?	YES													75 %	9
	NO													25 %	3
	N/A													0 %	0
Total	%	40 %	80 %	30 %	30 %	40 %	80 %	80 %	80 %	0 %	30 %	0 %	50 %		
	Units	4	8	3	3	4	8	8	8	0	3	0	5		

Again in this case, although they received the e-mails and/or the phone calls, NCP 9 and NCP 11 did not address any of the points the pseudo patient was interested in.

The following figure shows the NCPs average results for information provided:

Figure 42 - NCPs answers in the second scenario



The third scenario

The third scenario, the inbound patient seeking a hip replacement operation in a foreign Member State, changes perspective. It is no longer about a fictional patient calling the National Contact Point of its own country to have information on being treated abroad but a fictional patient that calls the National Contact Point of the country in which he/she wants to be treated.

The following table shows whether the NCPs answered the e-mails and/or the phone calls of the Pseudo patient:

Table 25 - Status of the NCPs contacted – Scenario 3

Contacts and answers				
NCP	Submitted		Answered	
	E-mail	Phone call	E-mail	Phone call
NCP 1		Not available	No	Not available
NCP 2				
NCP 3		Not available		Not available
NCP 4				
NCP 5				
NCP 6				
NCP 7				
NCP 8		Not available	No	Not available
NCP 9			No	No
NCP 10				
NCP 11		Not available		Not available
NCP 12			No	
Total	11	8	7	7
%	92%	100%	64%	88%

The team of pseudo patients, in order to craft the guideline used for the exercise, made a pilot phone call to NCP 6. Therefore, as the methodological procedure was to first contact the NCPs via e-mail and then by phone call, the Pseudo patient did not send any e-mail to NCP 6.

The table above shows that NCP 1, NCP 8 and NCP 9 did not answer the e-mail; however, they did in the other two scenarios.

In Scenario 3 the questions asked were different from those asked in the first two scenarios, as the latter focused more on quality and safety information on healthcare providers of the same country of the NCP contacted.

The answers to the pseudo patient investigation activities may be summarised as following:

Table 26 - Summary of Scenario 3

Questions	Answers	NCP 1	NCP 2	NCP 3	NCP 4	NCP 5	NCP 6	NCP 7	NCP 8	NCP 9	NCP 10	NCP 11	NCP 12	Total	
														%	units
Was information about quality of healthcare providers in the MS of treatment given?	YES													8%	1
	NO													67%	8
	N/A													25%	3
Was information about the authorisation to seek healthcare in a specific healthcare provider given?	YES													58%	7
	NO													17%	2
	N/A													25%	3
Were the authorisation criteria to provide treatments under the Directive 24/2011 of healthcare providers given?	YES													0%	0
	NO													75%	9
	N/A													25%	3
Were the quality and safety criteria to be met for the authorisation described?	YES													0%	0
	NO													75%	9
	N/A													25%	3
Is the patients' right to be treated as national citizens in foreign healthcare providers ensured?	YES													25%	3
	NO													50%	6
	N/A													25%	3
Was it explained whether hospitals require additional documents to treat patients (under the Directive 24/2011)?	YES													8%	1
	NO													67%	8
	N/A													25%	3
Was it explained which tariffs are de facto applied by the hospitals?	YES													33%	4
	NO													42%	5
	N/A													25%	3

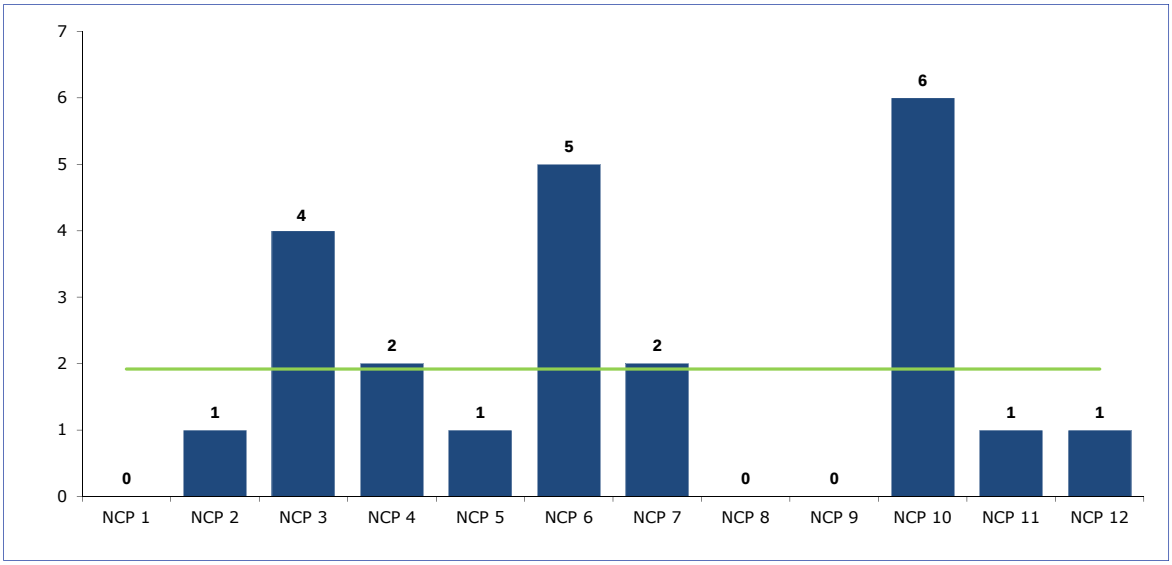
Questions	Answers	NCP 1	NCP 2	NCP 3	NCP 4	NCP 5	NCP 6	NCP 7	NCP 8	NCP 9	NCP 10	NCP 11	NCP 12	Total	
														%	units
Was the competent entity in the event of any harm clearly defined?	YES													25%	3
	NO													50%	6
	N/A													25%	3
Was the procedure to be followed in the event of any harm explained?	YES													17%	2
	NO													58%	7
	N/A													25%	3
Was it explained which obligations healthcare providers of MSs have regarding medical invoices?	YES													17%	2
	NO													58%	7
	N/A													25%	3
Total	%	n/a	9%	36%	18%	9%	45%	18%	n/a	n/a	55%	9%	9%		
	Units	n/a	1	4	2	1	5	2	n/a	n/a	6	1	1		

As mentioned above, NCP 1, NCP 8 and NCP 9 did not answer the e-mail/phone call and are therefore not taken into account. None of the NCPs provided an answer to the following questions:

- Were the authorisation criteria to provide treatments under the Directive 24/2011 of healthcare providers given?
- Were the quality and safety criteria to be met for the authorisation described?

The following figure shows the NCPs average results for information provided:

Figure 43 - NCPs answers in the third scenario



The response rate to the questions of Scenario 3 was lower, which supposedly indicates that information on quality and safety (typically requested in English in Scenario 3) are more difficult to obtain.

Key findings

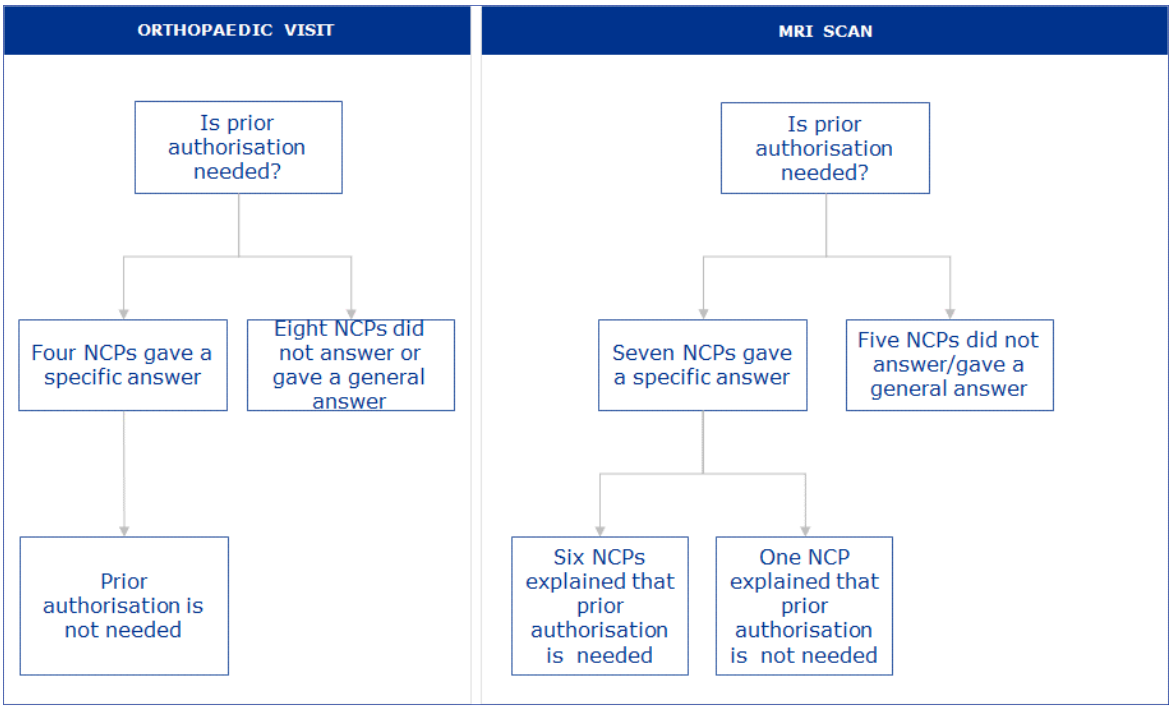
In this section the key findings of the pseudo patient investigation are presented. The results are divided by topic, independent of the scenario through which those data were gathered.

Prior authorisation: the aim of the questions was to determine whether the NCPs are able to provide specific information on the features of the prior authorisation request, on the documents needed and on the relative timing of processing (of the prior authorisation).

As previously described, the first two scenarios differ in the treatment the patients need to undergo abroad. The orthopaedic visit is a quite common treatment that is not among the cases for which the Directive[77] requires prior authorisation. Conversely, the MRI scan is a treatment that Member States could consider as cost-intensive, thus subject to prior authorisation. The following chart shows how the NCPs answered these questions:

[77] Art.8: "Healthcare that may be subject to prior authorisation shall be limited to healthcare which:
(a) 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:
(i) involves overnight hospital accommodation of the patient in question for at least one night; or
(ii) requires use of highly specialised and cost-intensive medical infrastructure or medical equipment;
(b) involves treatments presenting a particular risk for the patient or the population; or
(c) 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."

Figure 44 - Need for prior authorisation



All NCPs that provided specific answers on whether prior authorisation is needed for the orthopaedic visit answered correctly. The same can be said for the NCPs answering for the MRI scan, where the only divergent answer was provided by the country in which only hospital treatments are subject to prior authorisation.

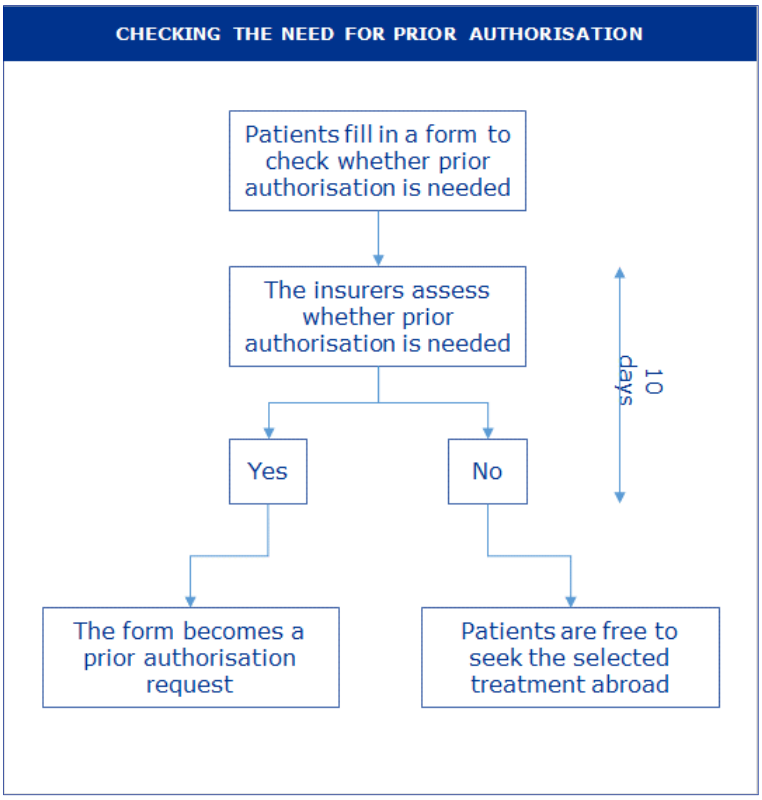
The time to receive prior authorisation varies, depending on the country, from a minimum of 15 days to a month.

The investigation activity showed that generally the documentation to be delivered in order to obtain prior authorisation is the medical prescription[78] of a national institution, sometimes together with an application form.

In two NCPs, in order to ascertain whether the treatment is subject to prior authorisation, patients have to submit a written request to their health insurance provider. This request must contain the diagnostic/therapeutic data and the name of the treatment that patients need, as well as the venue and the name of the healthcare provider by which the patients want to be treated. This process is shown in the following graph:

[78] Six NCPs out of twelve explained that the medical prescription is needed.

Figure 45 - Application form to check the need for prior authorisation



Reimbursement: in order to assess whether the information given to patients on reimbursement is clear and comprehensive, the pseudo patients asked questions about the amount to be reimbursed, the refund procedure to be followed and the language in which the invoices have to be translated to be recognised by the health insurance providers.

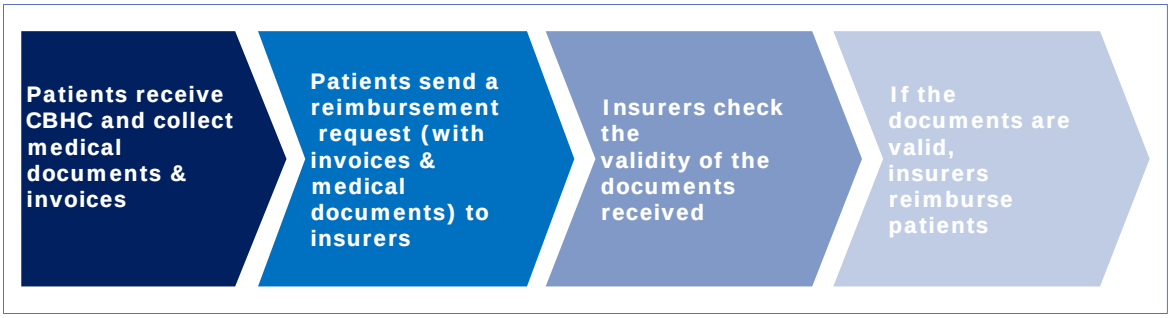
The NCPs were not able to provide information on the specific amount to be reimbursed for either the orthopaedic visit or the MRI scan. However, pursuant to the Directive[79], the NCPs explained that the amount to be reimbursed shall be equal to national or local tariffs.

Only two cases are exceptions, as in one Member State reimbursement amounts to 80% of the tariff applied nationally while in another, the reimbursement procedure could provide a refund increased by up to 30% of the national rate to compensate the difference from that of the other Member States.

Regarding the reimbursement procedure to be followed, the NCPs provided different answers in the different scenarios. However, from the answers it is possible to conclude that the procedure patients have to follow is as the following chart shows:

[79] Art.7: "The costs of cross-border healthcare shall be reimbursed or paid directly by the Member State of affiliation up to the level of costs that would have been assumed by the Member State of affiliation, had this healthcare been provided in its territory without exceeding the actual costs of healthcare received."

Figure 46 - The reimbursement procedure



In the answers NCPs provided on the refund procedure, it was also often explained that patients have to contact their own health insurance provider in order to obtain all the information needed.

In both scenarios, the information on the language in which invoices shall be presented for reimbursement is unclear and inconsistent. Only two NCPs gave the same answer in both scenarios, indicating to patients that the submission of the invoices must be accompanied by a translation.

Follow up treatments: as regards follow up treatments and continuity of care, only one NCP provided information for both the first and second scenarios. It was explained that continuity of care in the Member State of affiliation is ensured as long as patients provide the treatment-related documents.

Quality and safety: the information collated in this section was gathered from the NCP answers for Scenario 3. The patient was requesting information from a foreign NCP for a hip replacement operation to be provided by a hospital in that Member State. More specifically, in this scenario the NCPs replied to questions on the quality of healthcare providers and on the authorisations that these providers have under the Directive for the treatment required by patients.

Only one NCP provided information on the quality of national healthcare providers. The employee helped the Pseudo patient by telephone to find and understand the evaluative criteria applied.

Conversely, no NCPs gave information on the authorisation criteria allowing healthcare providers to treat patients under the Directive. However, seven NCPs answered that the hospital selected by the Pseudo patient was authorised to treat patients under the Directive.

As regards the case of harm arising from treatments, the NCPs indicated different entities[80] to be contacted in this event, largely owing to juridical differences among Member States. Although, often patients bear the burden of proof, they can bring a lawsuit to seek damages. The ombudsman was also indicated as being the institution set up by some Member States to solve these problems more effectively.

[80] E.g. Ombudsman, court, arbitration boards.

Being treated in a foreign MS: the questions in this section were aimed at finding out what are the procedures that patients have to follow to be treated abroad. More specifically, it was asked:

- the language in which medical prescription must be made to be accepted abroad;
- the additional documents to be provided;
- the obligations hospitals have in providing invoices;
- the cost that patients have to pay for treatment.

As regards the language, answers vary a lot among the countries. In some cases it is stated that medical documents must be translated, while in others, that the original document is sufficient. Two NCPs made explicit reference to the EU Directive 2012/52/EU of 20 December 2012, which encoded at European level the minimum required information. However, these rules relate to drugs and medical devices prescriptions.

Surprisingly, in one case, foreign patients also have to ascertain their national medical prescription by being examined by a national specialist.

Pursuant to the Directive[81] the NCPs confirmed that foreign patients have the same rights as national patients and explained that hospitals do not have any obligation to provide invoices in a language other than their national one.

As regards the tariff scheme that hospitals apply to European patients under the Directive, it was generally explained that fees are equivalent to those national citizens would pay if they wanted to receive the treatment as private individuals.

[81] Art.7: "Member States may adopt provisions in accordance with the TFEU aimed at ensuring that patients enjoy the same rights when receiving cross-border healthcare as they would have enjoyed if they had received healthcare in a comparable situation in the Member State of affiliation."

ANNEX 5

Stakeholder interviews

Key findings

Phone and face-to-face interviews were conducted with all the main stakeholders who gave their availability following an initial mapping exercise, with particular regard to the healthcare insurance providers and patient groups. Stakeholders who were not available for an interview completed a structured online questionnaire tailored to relevant topics for their organisation.

From a selection of almost 120 stakeholders we conducted 59 interviews over four weeks.

A set of interviews was conducted on different categories, specified in the following paragraphs.

Health insurance providers

Knowledge of the Directive 2011/24/EU: we interviewed twenty-two health insurance providers and almost all of them stated that they provide information on both the Directive and the Regulation 883/2004. Almost all of the twenty-two HIP respondents received requests for information from patients about the possibility of receiving treatment abroad under the Directive. Most of them highlighted the point that citizens are aware of treatments to which they are entitled under their benefit baskets, since in some countries competent offices communicate the necessary information; otherwise they can obtain such information through online searches or by consulting doctors. Since patients cannot always know the differences between EU policies, insurers often decide on their own which rules are the most favourable for patients. Whether patients know or do not know which treatments are subject to prior authorisation is a matter that differs significantly among Member States. Most health insurance providers explained that patients do not really know about it. Two HIPs explained that in their countries no treatments are subject to prior authorisation, while others said that patients are knowledgeable about it, but most of the time they request prior authorisation even when it is not strictly necessary.

Prior authorisation and reimbursement: health insurance providers described the prior authorisation and reimbursement process for patients who receive treatment abroad:

- Inpatients ask permission before undergoing the treatment by submitting a referral letter and a treatment plan.
- The health insurance provider takes into consideration whether the treatment is covered by his/her insurance plan.
- For care which does not require prior authorisation, patients must send a claim with all the relevant documents following treatment and the health insurance provider considers whether the treatment is covered. The patient is then reimbursed if it is.

Prior authorisation is normally given within one and three months and with taking into account the urgency of the treatment. Most health insurance providers did not identify any additional burden for patients to access cross-border healthcare. In one case only the HIP requires a formal application designed to determine whether the treatments requested by patients are subject to prior authorisation and in this case the application takes ten days to be processed.

In ten out of nineteen of cases, the HIPs stated that the amount that foreign patients have to pay for treatments is in line with the national tariffs; in other cases, the country has different tariffs which vary by regional/local council level or whether or not physicians/specialists are affiliated with the HIP.

Therefore, the tariffs applied depends on the regional/local council/healthcare provider to which patients are referred and is that applicable to non-affiliated physicians/specialists (where this rule exists).

In order to request reimbursement patients must submit certain documents that depend on the Member State considered. Health insurance providers were then asked to indicate the documents they need to reimburse patients. The primary finding is that the documents mainly required by the HIPs are the medical documentation and invoices.

It should be noted that thirteen out of the twenty-one health insurance providers interviewed require the original medical documentation and only six of them require a translation. Sixteen out of twenty-one HIPs require the invoice in its original language, while six require a translation of the same invoice. Eight HIPs also require a referral from a national healthcare provider.

The results are presented in the following table:

Table 27 - Documents to be submitted for reimbursement

Health insurance provider	Medical documentation		Invoices		Referral note from a national HCP	Other
	Original language	Translated	Original language	Translated		
HIP A	■		■			
HIP B	■		■			
HIP C		■		■	■	
IP D	■			■		■
HIP E	■	■	■		■	
HIP F	■	■	■	■	■	■
HIP G	■	■				
HIP H						
HIP I			■		■	■
HIP J		■	■	■		
HIP K			■			
HIP L	■		■			
HIP M	■		■	■		
HIP N	■		■			
HIP O	■		■			
HIP P	■		■		■	
HIP Q			■		■	■
HIP R			■		■	
HIP S		■		■	■	
HIP T	■		■			
HIP U	■		■			■

Health insurance provider	Medical documentation		Invoices		Referral note from a national HCP	Other
	Original language	Translated	Original language	Translated		
TOTAL:	**13**	**6**	**16**	**6**	**8**	**5**

Legend

- Answer not available
- Yes
- Answer not selected

Furthermore, the documents that health insurers indicate they need are set out below, depending on the individual HIP:

- identity documents;
- copies of prescriptions;
- confirmation of payment;
- application form.

We point out the anomaly that some HIPs have not indicated whether they require the invoice or medical documentation either in their original format or with translation.

Reimbursement practices in Member States - as illustrated in the following table - have a waiting time for reimbursement ranging nationally from seven to 90-180 days and under the Directive from 21 to 90-150 days.

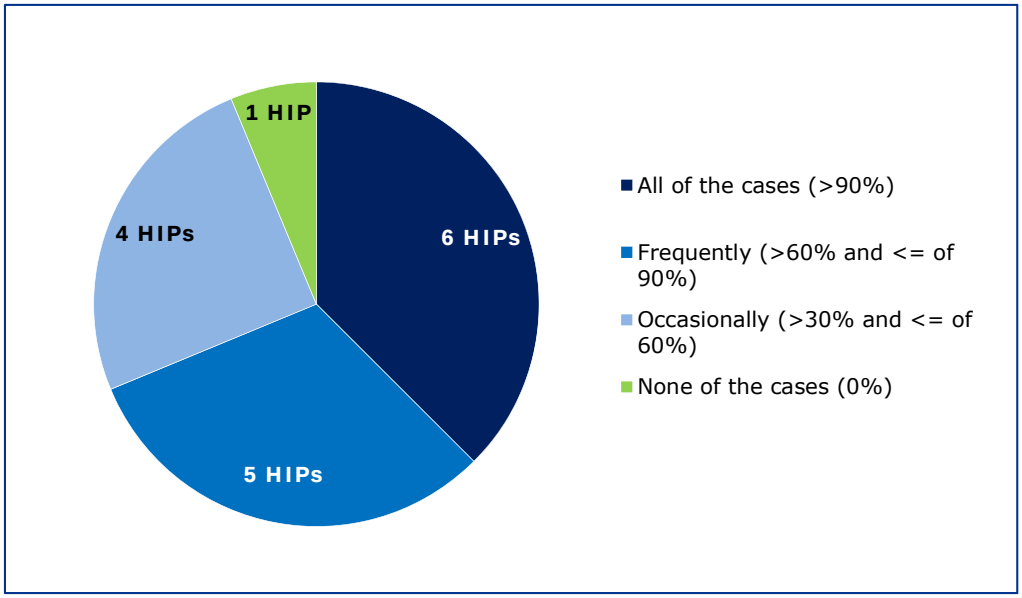
Table 28 - Time needed for reimbursement

HIPs	Nationally	Directive
HIP A	n/a	30 days
HIP B	n/a	30-90 days
HIP C	n/a	n/a
HIP D	n/a	21 days
HIP E	7 days	Depends on cases
HIP F	n/a	n/a
HIP G	n/a	n/a
HIP H	28-42 days	n/a
HIP I	n/a	n/a
HIP J	90-180 days	90-150 days
HIP K	n/a	90 days
HIP L	60 days	60-90 days

HIPs	Nationally	Directive
HIP M	n/a	n/a
HIP N	n/a	n/a
HIP O	n/a	45 days
HIP P	10 days	30 days
HIP Q	n/a	n/a
HIP R	2-3 days	2-3 days
HIP S	30 days	30 days
HIP T	n/a	30 days
HIP U	n/a	30 days

Eleven HIPs out of 16 can understand and process invoices from foreign healthcare providers in all cases (or at least frequently), and that only one stated that there are difficulties in understanding these. One HIP also stated that the administrative procedures and process for a cross-border case is not an easy task, as it has four people dedicated solely to it.

Figure 47 - HIPs ease in processing foreign documentation



Eight out of the fifteen HIPs that answered the question state they incur administrative costs related to cross-border healthcare, mainly represented by the translation of invoices and bank transaction fees.

Three HIPs stated that, in some cases, patients can incur additional costs for the administrative services related to prior authorisation and reimbursement processes, for example, for the translation of the documents required.

Since the reimbursement process might require interaction with other MSs, it was asked whether cooperation agreements are in place with foreign healthcare providers. Such agreements seem to be an essential element in the management of CBHC but only six out of fourteen Hips stated they have some cooperation agreements with, where specified, foreign healthcare providers in Belgium, Germany, Spain and the Netherlands. Although these agreements exist, it was not specified whether the HIPs recommend these hospitals to patients.

Quality/safety: the HIPs explained that, depending on the country, the quality and safety systems applied are:

- ISO (International organisation for standardisation);
- JCI (Joint commission international);
- information on licensing of services;
- health services protocols;
- authorisations to provide care based on national or regional standards.

One of the HIPs explained that providing information on quality and safety to patients is too complicated, and thus not all of them provide this information. The HIP stated that the complexity in making decisions on the quality/safety of providers chosen by patients in order to grant them the authorisation to be treated is reduced when there are cooperation agreements in place with such HCPs.

On follow-up treatment all of them stated that it is guaranteed, claiming that health insurance policy and European law enforce obligations on that.

Waiting time: HIPs are neither responsible for assessing the waiting time of individual patients nor for informing patients on it. In some cases HIPs identified independent medical experts as the competent parties in assessing justified waiting times relating to patients' clinical conditions. Another HIP simply stated that not allowing patients to go abroad - based on waiting times - implies so much responsibility that they do not reject a prior authorisation request on this basis, and only two of them carry out a search for a national HCP which could perform the requested treatment in a reasonable period of time. Moreover, four HIPs state that the waiting times are not a problem in their country.

Patients generally gather information on the internet or by calling the person in charge for such information (not specifying who the person is). Waiting time is generally individually assessed for all treatments, although in certain countries there are national guidelines for specific treatments.

In other cases the maximum waiting times are standardised and one of the insurers defined the following modalities:

- seven days for general practitioners;
- 90 days for specialists;
- 90 days for treatments.

Healthcare providers

Knowledge of the Directive 2011/24/EU: of the six healthcare providers we interviewed, only three were aware of the Directive, and two of them launched an institutional communication campaign to the members of their organisation via:

- the internal magazine;
- the online magazine.

It was mentioned that they already had some patients asking to be treated under the Directive. Healthcare providers give information on the treatment options they provide through their website or when they are directly asked.

Prior authorisation and reimbursement: patients who ask to be treated under the Directive 2011/24/EU are usually requested to provide the same information/documentation as other patients, but healthcare providers specified that there is still lack of information on this matter. However, some patients ask for more documents, such as medical records and invoices. Only one HCP declares having received a request for a translation of invoices.

Healthcare providers monitor both national and cross-border patients, checking and registering their nationality. Three out of five HCPs state they monitor the number of foreign patients treated and differentiate patients who arrange appointments in order to be treated (planned care) and patients treated in emergencies. The healthcare providers interviewed mainly apply public tariffs (national or regional) while costs for additional services are applied separately. Only one answered that they apply the tariffs applicable to a private patient.

The available tools to pay for patients are:

- Cash;
- ATM (point of sale) payment;
- Bank transfer;
- Credit card payment.

Because of national rules, in one country payments in cash cannot exceed a fixed amount (e.g. €1,000). If harmful treatments occur, patients can refer (both for private and public hospitals) to the complaints department of the hospital, which provides information on the procedure to follow. Some of the healthcare providers, especially in areas frequented by tourists, have agreements with some specialists (paediatricians or GPs) for the treatment of cross-border patients. The healthcare providers interviewed identified the NHS (UK) and the German healthcare system as the best practices in the communication and coordination of activities to promote their providers and healthcare

offer. With regard to the successful best practices, the TEN4HEALTH[82] project and the HoNCAB[83] project are identified as being the most effective.

Quality and safety: the HCPs interviewed mainly measure quality and safety through the criteria for authorisation and accreditation. The additional ones are ISO 9000 or Joint commission certifications. The data are available on the websites of the providers or through the service charter given to patients. Four out of six healthcare providers interviewed are obliged to guarantee continuity of care.

Trade unions and trade union confederations

Knowledge of the Directive 2011/24/EU: we interviewed four trade unions. They stated that in their opinion patients are not informed or are poorly informed about the Directive and the benefits arising from it. One of the trade unions interviewed stated it did not undertake any communication campaigns and nor did anyone else, to their knowledge.

They stated that, from their point of view, National Contact Points provide sufficient information to patients and that, in some countries, they do not have a role in receiving complaints with regard to incorrect reimbursement, while in others they do, but at local level only. In one case they identified the healthcare cooperation agreements between France, Germany, and Belgium as best practice regarding the process of cross-border healthcare.

Patient groups

Knowledge of the Directive 2011/24/EU: we interviewed six patient groups. The majority of them (four out of six) believe that patients are not generally informed about the Directive 2011/24/EU. Communication campaigns were undertaken but it was more generally on cross-border healthcare. This trend changed only recently, partly thanks to the regional conferences organised by the European Patients Forum. Furthermore, it was also reported that even when patients know which category of treatments are subject to prior authorisation, they are not in a position to understand to which category the treatment they are requesting belongs to.

Three out of six patient groups explained that patients usually contact them after having contacted the National Contact Point in order to obtain more detailed information on their rights; on the one hand, this shows the importance of patient groups' supporting role vis-a-vis patients, while on the other, it suggests the need to improve the information service offered by the NCPs. The respondents identified the Slovenia-Italy and Belgium-Netherlands borders as the areas in which cross-border healthcare is most common and therefore the areas in which information is better disseminated.

[82] TEN4Health was a project (2007-2009) that contributed to improve healthcare provision for a mobile European Union. Started by leading public health insurance providers, the TEN4Health service package assures access by citizens to healthcare in participating Member States' hospitals, based on a secure web service and its integration into developing European eHealth infrastructure networks. The TEN4Health service package fundamentally contributed to the ubiquitous acceptance of the European Health Insurance Card and prepared for the later introduction of its eCard version. It greatly enhanced and extended its utility by integrating efficient support for electronic post-processing at European Union level.

[83] HoNCAB was a project (2008-2013) whose main objective was to obtain a better understanding of the financial and organisational requirements that may arise as a result of a patient receiving healthcare outside the Member State of affiliation, thus preparing hospitals for the new conditions applying after the entry into force of the EU's rules on patients' rights in cross-border healthcare (Directive 2011/24/EU). The project also set up a pilot network of hospitals, with the aim to share between Member States practical experiences, problems and solutions related to cross-border care.

Prior authorisation and reimbursement: the financial aspect of the Directive was referred to as being one of the most critical barriers for the implementation of the Directive, as people living in countries with a low GDP often cannot afford healthcare treatments in foreign Member States, especially as they are reimbursed only to the level of national tariffs. They go on by highlighting the different basket of treatments as another big barrier to overcome.

Patient groups explained that the competent party to be contacted in the event of any harm and the relevant procedure to follow are available on the web (often on the Ministry of Health website), although they did not specify its contents.

Patients commonly seek healthcare abroad for three main reasons:

- waiting time;
- treatments not available in the patient's country;
- quality reasons.

As far as quality is concerned, patients request information on:

- treatment-related equipment for Medical Services;
- medical qualification;
- special therapy personnel;
- total number of cases for the treatments provided by the hospital.

But they commonly refrain from using cross-border care because of:

- issues with the reimbursement process;
- issues with the prior authorisation process;
- administrative issues;
- language issues;
- additional costs (e.g. travel and accommodation).

Patient groups did not identify the recognition of prescriptions for follow-up treatment as a barrier: only one of them explained that physicians agreed to provide further care on the condition that the treatment patients received abroad was medically relevant. In one case, a patient group stated that follow-up treatment can only be provided nationally in the case of emergencies.

Waiting time: in five out of six cases, patients are informed/or can be informed of their own waiting time by contacting the HIP, although the information is not always accurate. Certain countries define the maximum waiting times by law (thus patients know them) but in practice they are often not reliable. Patients, however, usually do not express complaints on waiting time or reimbursement issues.

Patient ombudsman

Knowledge of the Directive 2011/24/EU: we interviewed eight patient ombudsmen. The interview process highlighted, that they are the most aware about the Directive 2011/24/EU.

Prior authorisation and reimbursement: Four of them have never received complaints from cross-border patients in their country on this matter. One of them stated that patients have expressed complaints with regard to the following topics:

- quality of healthcare;
- information on cost prior to treatment;
- difficulties regarding access to patient files.

The person in charge of complaints related to the refusal of prior authorisation varies from country to country. Amongst those commonly in charge are:

Table 29 - Institution to be contacted in case of complaints for prior authorisation

Interview subjects	Institution to be contacted
PO A	National centre for patient's rights and documentation
PO B	Medical officer of the health insurance fund
	Competent labour court in appeal
PO C	National Contact Point
	Commissioner for Health
PO D	National Contact Point
	Customer care unit within the ministry for energy and health
PO E	Health Insurance Complaints and Disputes Foundation
	Health Insurance Disputes Committee
PO F	Health Insurance Complaints and Disputes Foundation

As for complaints due to any harm patients incurred:

Table 30 - Institution to be contacted in the event of any harm following treatment

Interview subjects	Institution to be contacted
PO A	National centre for patient's rights and documentation
PO B	Competent mediation service for patient's rights
	Provincial medical commission (the provider is not working according to the legal framework)
	Provincial council of the order of physicians (complaints with the behaviour of the healthcare provider)

Interview subjects	**Institution to be contacted**
	Inspection and monitoring services of the communities and Regions (hygiene motivations or financial compensation for received harm)
	Court (provider guilty for professional negligence)
PO C	National Contact Point
	Commissioner for Health
PO D	National Contact Point
	Customer care unit within the ministry for energy and health
PO E	Health Insurance Complaints and Disputes Foundation
	Ministry of Health, Welfare and Sport
PO F	Healthcare inspectorate

With regard to complaints on incorrect reimbursement following a previously-agreed amount for treatment provided by a foreign healthcare provider, patients can refer to:

Table 31 - Institution to be contacted in case of complaints on reimbursement

Institution to be contacted in case of complaints on reimbursement	
Interview subjects	**Institution to be contacted**
PO A	National centre for patient's rights and documentation
PO B	Health insurance fund
	Competent labour court in appeal
PO C	National Contact Point
	Commissioner for Health
PO D	National Contact Point
	Customer care unit within the ministry for energy and health
PO E	Health Insurance Disputes Committee
PO F	National Health Care Institute

A comparison of the above tables shows:

- the National Contact Points are indicated as possible interlocutors by only two patient ombudsmen for the three types of complaints;
- three out of six patient ombudsmen always indicated the same interlocutors for the three different scenarios, while the remaining three indicated a different interlocutor, depending on the complaint case histories;
- patient ombudsmen which belong to the same country sometimes indicated different interlocutors for the same complaint, thus highlighting a lack of clarity with respect to the organisation involved for each type of claim, giving rise to

the possibility of not providing the correct answer to the patient looking for guidance.

Frontline healthcare prescriber organisations

Knowledge of the Directive 2011/24/EU: we interviewed six frontline healthcare prescriber organisations. Three of them were not aware of the Directive 2011/24/EU. In their opinion neither the National Contact Point nor any other organisation undertook an effective communication campaign on cross-border healthcare. In one case, a frontline healthcare prescriber organisation explained that even though the National Contact Point provided information, the channels were not specified. They stated that currently only a few patients ask explicitly if they can go abroad by using the Directive 2011/24/EU.

Prior authorisation and reimbursement: Three frontline healthcare prescribers have obligations in the event they want to write prescriptions for cross-border use, as imposed by the European Directives. Nonetheless, only one of them received guidelines (the Regulation) on this matter from the authorities or from the National Contact Point.

With regard to follow-up treatment, due to legal/ethical reasons, GPs have to continue or take over treatment provided to patients by other institutions, although they point out they do not do it when the policy strongly differs from their own guidelines. In order to do so, they need a medical dossier with sufficient data to continue the treatment and, in one case:

- details regarding the treatment;
- discharge condition in detail;
- recommendations regarding the rehabilitation plan.

Only one of the frontline healthcare prescriber organisations interviewed made recommendations on foreign healthcare providers. Frontline healthcare prescribers explained that it is due to geographical reasons that cross-border care is more common in some border regions, and thus cooperation agreements exist (these agreements also existed before the Directive). No further details on such cooperation agreements were provided.

Frontline healthcare prescribers cooperate to promote cross-border care (although cooperation does not only occur in this regard). One organisation pointed out that meetings are organised to train GPs on taking over patients (e.g. e-invoices, electronic dossier for patients and interoperability systems).

Waiting time: In three of the countries where frontline healthcare prescribers were interviewed, waiting times are individually assessed for all treatments, and for one of them only certain treatments have standardised waiting times, while all others are assessed case by case. Only one country of the frontline healthcare prescribers interviewed have standardised waiting times for all treatments. In the first two cases the GP's role is to estimate waiting times on the basis of the urgency of the condition.

For information on treatments that cannot be provided in a medically justifiable time-frame the organisations interviewed referred to health insurance. In one case, the organisation interviewed explained that, when this situation occurs, patients are entitled to choose another hospital nationwide or abroad.

Authorities

Knowledge of the Directive 2011/24/EU: we interviewed six authorities. Three of them assert that various activities have been carried out to promote the Directive, such as coordination meetings with main stakeholders, articles in the press, national groups constituted by regional experts and large-scale professional press conferences.

Prior authorisation and reimbursement: Three of the authorities interviewed assert that the list of treatments subject to prior authorisation is not available, thus highlighting a particular gap in the implementation of the Directive into national law.

Three authorities identify upfront payment as being a possible limitation to the use of CBHC, and in one case there is an excess clause to request the reimbursement for treatment carried out abroad of around € 14. It was also pointed out that only patients able to pay for the cost of treatment upfront are able to access the CBHC, however, this category is also the one most likely to benefit from the national HCPs as private citizens.

All the authorities believe that HCP and the administrative offices involved are ready to receive inbound cross-border patients. In no case, however, were they able to highlight best practices in the application of the Directive because of the short timeframe since its implementation.

The authorities do not currently take into account the inflow and outflow of CBHC patients for the strategic healthcare planning for their countries, although in some cases the issue has been discussed but postponed for the time being. Moreover, only two authorities out of six claim to have a monitoring system for outbound patients under the Directive, and just one authority claims to have a monitoring system for inbound patients.

Audit/Health inspectorate bodies

The audit bodies interviewed did not give any direct answer regarding the Directive, but assessed its potential positively and the opportunities and rights granted by it to the patients.

ANNEX 6

List of NCPs as provided by EC

NATIONAL CONTACT POINTS

AUSTRIA

Gesundheit Österreich GmbH
Website: https://www.gesundheit.gv.at/Portal.Node/ghp/public/content/kontaktstelle-patientenmobilitaet.html
Email: patientenmobilitaet@goeg.at

BELGIUM

Website: www.crossborderhealthcare.be
Email: information@crossborderhealthcare.be,

BULGARIA

National Health Insurance Fund
Website: www.nhif.bg
Email: crossbordercare@nhif.bg

CROATIA

Croatian Health Insurance Fund
Website: www.hzzo.hr
Email address: ncp-croatia@hzzo.hr

CYPRUS

Ministry of Health
Website: www.moh.gov.cy/cbh
Email: ncpcrossborderhealthcare@moh.gov.cy

CZECH REPUBLIC

Centre for International Reimbursements
Website: www.cmu.cz
E-mail: info@cmu.cz.

DENMARK

National Agency for Patient Rights and Complaints (Patientombuddet)
Website: https://www.patientombuddet.dk/Klage-_og_sagstyper/International_Sygesikring/Nationalt_kontaktpunkt_for%20_behandling%20_i%20_EU_EOES.aspx
E-mail: pob@patientombuddet.dk

ESTONIA

Ministry of Social Affairs of Estonia
Website: http://kontaktpunkt.sm.ee
Email: kontaktp@sm.ee

FINLAND

Kela
Website: http://www.kela.fi/yhteyspiste
Email: yhteyspiste@kela.fi

FRANCE

Ministère des affaires sociales et de la santé
Website: http://www.sante.gouv.fr/soins-de-sante-transfrontaliers-point-de-contact-national-pcn.html
Email **: europe-info-patients@sante.gouv.fr**

GERMANY

Deutsche Verbindungsstelle Krankenversicherung - Ausland (DVKA
Website: www.eu-patienten.de
Email: info@eu-patienten.de

GREECE

EOPYY– National organization for health care services, provision, division of international affairs, National Contact Points GR Department
Website: www.eopyy.gov.gr
Email: **ncp_gr@eopyy.gov.gr**

HUNGARY

National Center for Patients' Rights and Documentation
1. for EU citizens that intend to use Hungarian healthcare
Website: www.patientsrights.hu,
Email: contact@patientsrights.hu

2. for Hungarian citizens seeking healthcare in EU
Website: www.eubetegjog.hu
Email: info@eubetegjog.hu

IRELAND

Cross-Border Healthcare Directive Department
Website: http://hse.ie/eng/services/list/1/schemes/cbd/CBD.html
Email: Crossborderdirective@hse.ie

ITALY

Ministry of Health, Directorate-General for health planning
Website: http://www.salute.gov.it/portale/temi/p2_4.jsp?lingua=english&area=healthcareUE
Email: *http://www.salute.gov.it/portale/temi/p_sendMailNCP_ENG.jsp*

LATVIA

National Health Service
Website: www.vmnvd.gov.lv
Email: nvd@vmnvd.gov.lv

LITHUANIA

State Health Care Accreditation Agency under the Ministry of Health
Website for NCP where patients could find the information in one place**:**
www.lncp.lt
Website: http://www.vaspvt.gov.lt/en
Email: vaspvt@vaspvt.gov.lt
National Health Insurance Fund under the Ministry of Health
Website: http://www.vlk.lt/vlk/en/
E-mail: vlk@vlk.lt

LUXEMBURG

Ministry of Health
for EU citizens intending to use Luxembourg healthcare
Contact Person: Mike Schwebag
Email: mike.schwebag@ms.etat.lu

Ministry of Social Security (Caisse nationale de santé)
for persons insured in Luxembourg seeking healthcare in the EU
Website:www.cns.lu
Email: cns@secu.lu

MALTA

Ministry for Health
Website:
https://ehealth.gov.mt/HealthPortal/chief_medical_officer/cross_border_healthcare/information.aspx
Email: crossborderhealth@gov.mt

NETHERLANDS

Netherlands NCP Cross-border Healthcare
Website: www.cbhc.nl

POLAND

National Health Fund
Email: Iwona.Grabowska@nfz.gov.pl

PORTUGAL

The Central Administration of the Health System
Website: http://diretiva.min-saude.pt/home-2/
Email: diretiva.pcn@acss.min-saude.pt

ROMANIA

National Health Insurance House
E-mail: pnc@casan.ro
Website: www.cnas-pnc.ro

SLOVAKIA

Healthcare Surveillance Authority
Website: www.udzs-sk.sk
Email: web@udzs-sk.sk

SLOVENIA

Health Insurance Institute of Slovenia (HIIS)
Website: http://www.nkt-z.si/wps/portal/nktz/home
Email: kontakt@nkt-z.si

SPAIN

Ministry of Health, Social Services and Equity
Website: http://www.msssi.gob.es/pnc/home.htm
Email: oiac@msssi.es

SWEDEN

Försäkringskassan
Website: www.forsakringskassan.se
Email: kundcenter@forsakringskassan.se, huvudkontoret@forsakringskassan.se
Socialstyrelsen
Website: www.socialstyrelsen.se
Email: info@socialstyrelsen.se

UNITED KINGDOM

NHS
Website: www.nhs.uk/nationalcontactpoint

ICELAND

Icelandic Health Insurance- International Department
Website: http://www.sjukra.is/english
Email:international@sjukra.is

NORWAY

The Norwegian Health Economics Administration
Website:
Email: post@helfo.no
Website: http://www.helfo.no/omhelfo/Sider/about-helfo.aspx#.UxedxSm9Kc0

For the purposes of pseudo patient investigation, the NCPs of the following Member States have been contacted:

Table 32 - Contact details of NCPs

Countries	**Mail address**	**Phone number**
Austria	patientenmobilitaet@goeg.at	Contact channel not available
Belgium	information@crossborderhealthcare.be	+32 (0)2/290 28 44
France	europe-info-patients@sante.gouv.fr	Contact channel not available
Germany	info@eu-patienten.de	+49 2289530800
Hungary	**Inbound**: info@patientsrights.hu **Outbound**: info@eubetegjog.hu	**Inbound**: 06-80-620-600 **Outbound**: +36-20-999-0025
Italy	Contact form: http://www.salute.gov.it/portale/temi/p_sendMailNCP_ENG.jsp?lingua=english	Contact channel not available
Lithuania	**State Health Care Accreditation Agency under the Ministry of Health**: contact.point@vaspvt.gov.lt **National Health insurance Fund**: vlk@vlk.lt	**State Health Care Accreditation Agency under the Ministry of Health**: +370 5 261 5177 **National Health insurance Fund**: +370 5 268 5110
Malta	crossborderhealth@gov.mt	0035 621220501
Netherlands	Contact form at: http://www.cbhc.nl/services/contact	Contact channel not available
Slovenia	kontakt@nkt-z.si	(00 386) 01 / 30 77 222
Spain	oiac@msssi.es	901 400 100
Sweden	**Inbound**: socialstyrelsen@socialstyrelsen.se **Outbound**: kundcenter@forsakringskassan.se	**Inbound**: (+46) (0)75 247 30 00 **Outbound**: 0771-524 524

ANNEX 7

Evaluative questions

Reimbursement

Dissemination of information

1) Have patients been informed in their MS of affiliation the existence and contact details of the National Contact Point?

2) Having requested information from the National Contact Point have patients received sufficient information on the possibility of accessing cross-border care and on their entitlements and the corresponding level of reimbursement?

3) What are the geographical disparities regarding patient information in relation to cross-border care and reimbursement practices? Is relevant information made only available at certain source points so that patients encounter problems to access it or is information made liberally available?

4) Do patients request prior authorisation, not only for hospital inpatient care (Art.8), but also for ambulatory care, as a tool to clarify reimbursement conditions? Do patients contact insurers prior to seeking cross-border care? If so, is the supply of information neutral?

5) What is the level of co-operation between different NCPs with regards to information on quality and safety of cross-border care and invoicing?

Processes and outputs

6) Have patients been correctly reimbursed following the use of cross-border care? To what extent are national authorities in MSs monitoring whether healthcare providers comply with their duties under Art. 4.2 (supply of information, including on treatment options, and quality standards)?

7) Do MSs competent authorities have mechanisms to track the number of foreign patients using healthcare in their country?

8) In what way and to what extent are different contextual issues of:

   - Language;
   - Invoicing;
   - Patient confidentiality;

   Affecting/impeding reimbursement processes? Which obligations for translation of invoices are in place in the different MSs?

9) *On invoicing*: Are insurers just as ready to adapt to reimbursement claims for healthcare received from a health-care provider not based in their own system?

10) *On pricing*: Which domestic tariffs schedules are de facto being applied? Is it the agreed tariffs between health insurers and providers or those for private patients, which are applied by providers who do not adhere to the collectively agreed tariffs? Are there other tariffs being used?

11) *On non-intended effects*: Who in practice bears the responsibility for accessing planned healthcare investigations treatment across borders in a) finding

relevant intelligence on potential treatments/outpatient care, b) bearing the burden of proof in demonstrating to insurers that the treatment/investigation has been carried out, c) bearing the responsibility to submit the correct documentation, including accurate translations of medical records and accurate invoices?

Administrative burdens

12) What are the administrative burdens regarding administration of the reimbursement processes in relation to cross-border care such as: National Contact Points, transaction costs, invoicing costs, costs associated with patient outflow and inflow?

Benchmarking/Best practices

13) Is there an established benchmark/best practice in the MS regarding reimbursement such as: reimbursement will occur within the same number of days as for internal procedures or such days augmented by a fixum? (National deadline + x days) and how does it compare with cross-border healthcare processes?

14) How efficient are the reimbursement processes in different Member States in relation to a) established individual national benchmarks, or b) in relation to benchmarks established in the transnationally operating private health insurance sector?

15) What are the most recent up to date tools regarding payment systems and reimbursement of health care?

Quality and safety

Dissemination of information

16) To what extent are patients in the MS informed about the quality and safety of cross-border healthcare before and after their choice, including information on where to seek help in case of harm? How easy was it to find information (availability) and how accessible was it to a non-specialist audience (accessibility)? What determines patients' first choice of a provider situated outside their home country?

17) Has the provision of information by the MS of affiliation been impartial in regards to the patient's options for treatment?

18) What information in terms of quality and safety does the patient consider useful in relation to cross-border healthcare?

19) How many patients in the MS refrain from using cross-border care as a result of poor information in relation to requests from the NCP?

Quality and safety, processes and outputs

20) What is the level of patient-oriented cooperation between health professionals and health organisations in relation to cross-border care?

Sustainability

21) To what extent are patients able to receive follow-up treatment, including recognition of prescriptions in their MS of affiliation after usage of cross-border healthcare?

Administrative burdens

22) What are the administrative burdens on MSs in relation to the number of patients who benefit from cross-border care, regarding quality and safety; how do these issues affect the operations of cross-border care?

Benchmarking/Best practices

23) Is there a reference standard on how to address issues of language barriers/interoperability/continuity?

Waiting time

24) What is the definition of waiting times/undue delay in different MSs?

25) What are the waiting times in different Member States regarding healthcare? Are patients informed about their own waiting time?

26) What are the practices regarding undue delay in different Member States (Individual assessment vs. standardised waiting times)?

27) What are the entitlements in different MS regarding waiting times in relation to healthcare?

28) Are there any best practices or benchmarks in relation to processes regarding different issues of undue delay in the MS?

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