the voice of the NHS in Europe

NHS European Office

briefing

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Healthcare in Europe

NHS views on the European Commission's proposals on cross-border healthcare

Key points

- Overall, NHS organisations do not expect a large increase in the volume of cross-border healthcare as a result of the European proposals.
- Some NHS providers are interested in developing opportunities to offer healthcare to European patients.
- Patients should be supported to make informed choices about the best healthcare options for them; where they decide to receive planned healthcare in another EU country, they should be supported to do so with clear information about the conditions that will apply.
- NHS organisations support the use of prior authorisation systems, in particular, to ensure patients have the information they need to make informed choices about cross-border healthcare.
- Information on quality and safety systems will be a key element of patient information, but these matters should remain the responsibility of the appropriate national authorities.
- It is crucial that local and regional decision-making processes about what treatment a patient can receive, can continue.
- The European measures must be proportionate and should not impose complex or burdensome requirements that result in resources being diverted from patient care.
- NHS organisations would welcome more guidance on the rules which apply to accessing healthcare abroad and their application in the context of the NHS.

Discussions are ongoing in Europe to decide new rules that should apply to patients seeking healthcare in other European countries at the expense of their home system. The NHS European Office carried out a consultation exercise to assess potential implications of the proposed legislation for the NHS. This *Briefing* summarises NHS views on some key aspects of the EU proposals.

Introduction

In July 2008, the European Commission published proposals for a directive on the application of patients' rights in cross-border healthcare. The proposals followed a series of cases in the European Court of Justice (ECJ), where individuals have sought reimbursement for healthcare received in another EU country, and which have established that, in certain

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circumstances, patients have the right to access cross-border healthcare.

There are a number of uncertainties around the case law which make it difficult to implement in practice. The draft directive seeks to clarify the present situation (see box on page 6) and to put in place measures to support the provision of cross-border healthcare, for the benefit of both patients and those managing health services.

The proposals are now before the European Parliament and the Council of Ministers (the health ministers from the national governments), who must agree on a text before it can become law. The legislative process offers opportunities to feed into these discussions and the NHS European Office is working closely with EU decision-makers with a view to influencing potential changes to the proposals.

In order to inform this work, the NHS European Office undertook a major consultation process[1] to assess the potential implications for the NHS of the proposals. The consultation ran for a period of three months and input was received from a full range of NHS organisations as well as a variety of other stakeholders from the UK healthcare community. This *Briefing* summarises NHS views on some of the key issues arising from the proposals.

1. *A European health service? The European Commission's proposals on cross-border healthcare.* The NHS Confederation, August 2008.

NHS views on the proposals

Potential impact on the NHS

Historically, relatively few NHS patients have sought healthcare in another EU country despite the long-standing existence of a mechanism to do so (the E112 referral process). Most patients prefer to receive healthcare as close to home as possible. The NHS did not, therefore, anticipate a large expansion in the volume of cross-border healthcare, either to or from the UK, within the framework of the draft directive.

In light of this, the NHS view was that systems established to provide for and facilitate cross-border healthcare should not be disproportionate in scale and cost to the level of cross-border activity. The objective of legislation should be to provide clarity about the rules relating to cross-border healthcare so that interested patients are able to make informed decisions within a framework that respects the organisation and structures of different health systems.

Some NHS providers said they would be interested in exploring opportunities to provide more services to EU patients, in particular in areas of specialist expertise. In such cases, extra capacity would be planned so that additional patients could be treated to the benefit of, and not the detriment of, NHS patients.

However, concerns were raised about potential impacts on a small number of highly specialised services, where expertise and/or capacity are limited. Some NHS organisations felt that, in some circumstances, for example, organ transplants, there could be a need to give UK-resident patients higher priority than incoming patients from other countries or to be able to refuse to accept an incoming patient for treatment.

These were very much exceptional examples and, for the vast majority of services, the NHS view was that incoming EU patients would be accommodated and treated on an equal basis to local patients.

Information on cross-border healthcare

The point that emerged most consistently from NHS organisations was the need for patients to be able to obtain good quality information about their options, including treatment abroad, in a way that enables them to make informed decisions about their healthcare.

Patients need to be aware of the circumstances that will apply before they make a decision about whether to access cross-border healthcare. For example, different standards of quality and safety may apply and clinical practices may differ. Patients will also need to consider arrangements for any after-care required and what will happen if anything goes wrong.

NHS organisations thought that the idea of a network of national contact points may be a useful approach for providing general information about cross-border healthcare and exchanging information about different countries' systems. However, it is important to be clear that these contact points cannot give personal advice on the best care, or act as advocates, for individual patients.

A patient's own clinician will often be best placed to help them make choices about their care, although it is important to be realistic about the amount of information they will be able to provide on healthcare options abroad. Alongside this, patients may need to contact their commissioner/insurer for information on their entitlements. In view of this, there was overwhelming support across the NHS for putting in place a process for patients to consult their local NHS before obtaining cross-border healthcare.

Prior authorisation

The NHS view was that, where a patient had made a genuinely informed choice to seek cross-border healthcare, they should be supported to do so. However, some concerns were raised about whether patients would, in reality, be able to make such informed decisions about suitable providers in other countries.

For example, in the UK, all providers of NHS healthcare are required to provide healthcare according to NHS standards and conditions including, for example, taking into account relevant clinical guidelines.

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By contrast, in a cross-border situation, a patient can access treatment from any healthcare provider – private or state/public sector – and without reference to issues such as compliance with quality and safety standards and clinical guidelines. NHS organisations were concerned that this implied a greater degree of risk in cross-border healthcare, of which patients may not even be aware.

Although they did not support the idea of common EU standards in healthcare quality and safety, fearing this could lead to duplication, confusion and might even risk a 'lowest common denominator' approach, NHS organisations felt that information on quality and safety systems would be crucial. They were also concerned that patients might need help to interpret the data, as differences in the way health services are managed and organised and data collected may mean that they are not easily comparable.

NHS organisations felt the logical way of achieving this was to put in place prior authorisation systems. Such systems were not viewed as a barrier to cross-border healthcare, as it was expected that authorisation would generally be granted, with refusals only in exceptional circumstances (for example, if there was a risk to wider public health associated with the patient travelling for treatment).

On the contrary, many NHS organisations viewed such systems as being essential to protecting patients' interests by ensuring that they understand the conditions that apply to cross-border healthcare before they make a decision about their treatment.

The NHS view was that the provisions in the draft directive, which envisage that prior authorisation systems could only be used in exceptional circumstances, were inadequate. In particular, the distinction between hospital and non-hospital care is a false one, as the degree of risk and resource-intensiveness of healthcare can depend as much on the individual circumstances of the patient as the degree of complexity of the treatment itself. In addition, the need to plan services and manage financial resources applies equally to healthcare provided in hospitals and in other settings.

NHS organisations felt that the simplest and clearest approach to prior authorisation systems would be for each country to develop its own list of healthcare for which prior authorisation is required, whilst ensuring that prior authorisation systems are clear, user-friendly and responsive.

Conditions for accessing healthcare

The NHS supported the principle that the right to reimbursement towards the costs of healthcare received in another EU country should be limited

to treatment that the patient's home health system has agreed to fund.

In relation to this, many NHS organisations highlighted the fact that the NHS has no defined list of healthcare for which all patients are eligible. Access to specialist care in the NHS is by referral from primary care, and decisions about an individual's care are usually taken by their NHS clinician, taking into account relevant clinical guidelines and with reference to local commissioners' guidance on local priorities, which aim to balance individuals' particular health needs against the needs and priorities of the wider local population.

The legal framework must recognise the legitimacy of local priority-setting and allow for the 'gatekeeper function' and local decision-making processes to continue.

NHS organisations noted that if NHS patients have sought treatment abroad without a needs assessment from an NHS clinician, it may be extremely difficult to determine retrospectively whether treatment would have been available under the NHS and, therefore, whether the patient is eligible for a reimbursement.

Limiting the right to travel for treatment

NHS organisations considered that, where it has been established that a patient is eligible to receive a particular treatment, the fact that healthcare could be provided locally should not in itself be a reason to prevent the patient from seeking treatment abroad.

However, the NHS view was that in certain exceptional circumstances it might be appropriate to restrict a patient's right to travel to obtain healthcare. Examples given included patients with a highly contagious and dangerous infectious disease and patients requiring care in a secure psychiatric facility.

Some NHS organisations also presented the view that limiting the right to travel for treatment may be necessary in certain low volume, highly specialised services where a small reduction in caseload could threaten service viability. For example, clinicians may need a minimum caseload in order to maintain their levels of expertise in treating very rare or highly complex conditions. The strong view was that any patient refused access to treatment abroad should be able to obtain a clear explanation of how and why the decision had been reached.

The draft directive appears to give little scope to healthcare providers to refuse to accept incoming patients, and NHS organisations felt it was important to be clear that nothing in the draft directive interferes with the right of a provider to refuse to accept a patient for planned treatment if the provider deems it clinically inappropriate to treat that patient, or the provider is unable, for example for reasons of limited capacity or expertise, to provide adequate or appropriate treatment to that patient.

Costs, mechanisms and levels of reimbursement

NHS organisations felt it was very important that all parties were clear

'Many NHS organisations viewed prior authorisation systems as being essential to protecting patients' interests'

about costs and levels of reimbursement in cross-border healthcare. Where it has been established that a patient is eligible to receive a particular treatment, and they elect to receive that treatment abroad, most NHS organisations agreed that reimbursement should be limited to the amount that the same treatment would have cost the home system.

It was noted that in practice this is likely to present challenges for the NHS, relating to both incoming and outgoing patients. Although the NHS in England operates a system of tariffs for healthcare, not all treatments are subject to tariff and, for those that are, prices are factored to take account of local costs, so there is not, in reality, a standard price for any treatment. Furthermore, a tariff may cover a package of care, rather than a single procedure, and therefore costs may need to be 'unbundled' if a patient receives a different package of care in another EU country.

Whilst some NHS organisations suggested that treatment costs might be paid directly from the patient's commissioner/insurer to providers in certain cases, removing the need for patients to pay upfront, there was no support for this to be a universal requirement. Indeed, because patients are able to 'top-up' their cross-border healthcare with additional treatments or services that would not be funded

'Patients who decide to seek treatment in another EU country should not be advantaged over patients who are unable or unwilling to do so'

at home, and because some systems require patients to make a co-payment, it emerged that paying the provider directly could, in practice, be extremely complicated and less transparent for patients.

Furthermore, many NHS organisations felt that payments from patients to providers would avoid potential difficulties with large scale and potentially bureaucratic systems for processing and securing payments between healthcare systems, and reduce difficulties associated with following up debtors from other countries where monies are outstanding at the conclusion of treatment.

Health inequalities and cross-border healthcare

The issue of equity is challenging and there was no clear consensus amongst NHS organisations as to what impact the proposals would have on inequalities. A range of issues – such as the state of an individual's health, geographical factors, family and work commitments, how articulate and well-informed a patient is, the ability to speak another language, as well as their financial position – will all affect an individual's ability to seek treatment abroad.

In general, the NHS view was that rights to access cross-border healthcare should be well publicised, so that patients were aware of the options. However, where treatment could be provided in a timely manner in the UK and patients are deciding for personal reasons to seek treatment in another EU country, the view was that they should not gain a special advantage over patients who are unable or unwilling to do so. They should, therefore, as a general rule, be responsible for costs which would not be incurred if they received NHS-funded treatment in the UK.

Many NHS organisations felt that, where there was a particular need, NHS commissioners should have flexibility to make special arrangements on an individual basis to cover costs of treatment abroad upfront and/or pay additional costs if care was more expensive. The existing 'E112 referral' mechanism could be useful in such circumstances.

What happens when things go wrong: issues of liability and redress

A number of NHS organisations had experience of treating patients experiencing complications following unsuccessful or incompetently undertaken treatment abroad. Whilst the number of patients affected overall is likely to be small, NHS organisations felt that this further supported the need for a system of prior authorisation, which could help equip patients with the information they need in order to be able to choose the best treatment for them and a safe and high-quality healthcare provider.

In this context, it is important that local NHS organisations and clinicians are able to help patients make a decision about where to receive cross-border healthcare without liability being conferred upon them if something goes wrong.

The NHS supported the position set out in the proposals that it is the systems of the country where healthcare is provided that apply in terms of liability and redress when things go wrong. However, concerns were raised about the draft directive's narrow focus on compensation rather than wider redress (which can include a range of steps such as regulatory action, changes in practices and action to rectify a problem).

Next steps

Discussions at EU level on the proposals will continue over a number of months and the NHS European Office will continue to work closely with EU decision-makers to ensure that NHS concerns receive proper consideration. There are likely to be further opportunities to contribute to this work as the proposals develop throughout the legislative process.

In the meantime, the current legal framework, based on ECJ case law, will continue to apply and NHS organisations need to be able to respond appropriately to patients who may be interested in receiving treatment abroad or coming to the UK for the purpose of receiving healthcare.

For further information or to submit views or comments, please contact:
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The current rules

- NHS patients are entitled, subject to some conditions, to receive care in another EU country and NHS commissioners should have a system in place to deal with requests for treatment abroad. Usually, the patient will need to pay for their treatment up front and then claim a reimbursement from their NHS commissioner.
- If undue delay applies to NHS care, a request for treatment abroad cannot be refused.
- Patients can only receive reimbursements for treatment that their commissioner funds.
- Prior authorisation systems can be used, but can only be compulsory in certain circumstances, usually for hospital or specialised care. Where prior authorisation is not compulsory, patients can ask for refunds of costs of planned treatment already received in another EU country.
- These rules all relate to planned care. They do not affect the existing European Health Insurance Card (EHIC) provisions, which provide for EU visitors to another EU country to receive emergency or immediately necessary treatment under the same conditions as local patients.

More information on the current rules can be found on the NHS European Office website at **www.nhsconfed.org/europe**

The NHS European Office

The NHS European Office has been established to represent NHS organisations in England to EU decision-makers. The office is funded by the Strategic Health Authorities and is part of the NHS Confederation.

EU policy and legislation have an increasing impact on the NHS as a provider and commissioner of services, as a business and as a major employer in the EU.

Our work includes:

- monitoring EU developments which have an impact on the NHS
- informing NHS organisations of EU affairs
- promoting the priorities and interests of the NHS to European institutions
- advising NHS organisations of EU funding opportunities.

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