The European Commission published proposals on patients’ rights to cross-border health care in July 20081 with a view to “help patients in getting the health care they need, and help Member States ensure the accessibility, quality and financial sustainability of their health systems and the well-being of their citizens.”2 However, a mechanism for patients to obtain planned treatment in another EU country at the expense of their home health care system already exists under longstanding EU regulations on the coordination of social security schemes3 (the ‘E112 referral’). Department of Health figures show that very few patients from England, Scotland and Wales have been treated under these arrangements.4 Data on patient flows between Northern Ireland and the Republic of Ireland also indicates low levels of cross-border activity.5 So why is a new directive on cross-border health care needed, and will it really make any difference to the NHS?

Why is it needed?
The draft directive follows a succession of cases in the European Courts of Justice (ECJ), where individuals have sought reimbursement for health care received in another EU country at the expense of their home health care system already exists under longstanding EU regulations on the coordination of social security schemes3 (the ‘E112 referral’). Department of Health figures show that very few patients from England, Scotland and Wales have been treated under these arrangements.4 Data on patient flows between Northern Ireland and the Republic of Ireland also indicates low levels of cross-border activity.5 So why is a new directive on cross-border health care needed, and will it really make any difference to the NHS?

Will it make any difference to the NHS?
The NHS European Office undertook a major consultation process with the aim of assessing the potential implications for the UK National Health Service (NHS) of the proposals set out in the draft directive.6 Whilst it is impossible to predict how patterns of cross-border health care will change in the future, overall, most NHS organisations did not anticipate a large expansion in the volume of cross-border health care, either to or from the UK, within the framework of the draft directive.

In general, the NHS view was that cross-border patient flows arising from a future directive would not have a significant impact on the NHS’ ability to manage and deliver health services for the UK population, particularly in comparison to the impacts of wider phenomena such as demographic change and migration patterns. The absence of large cross-border patient flows does not, however, mean that these proposals would have no impact on the NHS. The draft directive is intended to fully respect national governments’ responsibilities for the organisation, management and funding of health care. However, the consultation identified a number of areas where there is the potential for confusion and/or conflict between the current proposals and present NHS policy. This article discusses two areas where the draft directive’s proposed approach does not reconcile easily with existing NHS arrangements.

Entitlements
The draft directive aims to ensure that patients can access the same health care entitlements in other EU countries as at home. The principle is simple but the reality is more complex, in particular in systems like the NHS that do not have defined lists of care to which patients are automatically entitled.

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, where relevant taking into account, or with reference to, local commissioners’ (the NHS equivalent to an ‘insurer’ in the context of cross-border health care) guidance on low priority treatments.

In light of this, NHS organisations noted that if a patient sought treatment abroad without a needs assessment from their local NHS, it may be extremely difficult to determine retrospectively whether treatment would have been available under the draft directive’s proposed approach.

Key words: Cross-Border Health Care, NHS, Patient Mobility, Entitlements, UK

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Summary: In July 2008, the European Commission brought forward proposals for an EU Directive on patients’ rights in cross-border health care. The NHS European Office carried out a consultation exercise to assess potential implications of the proposed legislation for the UK National Health Service (NHS). This article discusses the outcomes from the consultation and considers how proposed provisions on cross-border health care could have consequences in two areas of domestic health policy.

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the NHS, and therefore, whether the patient is eligible for a reimbursement.

A further complexity arises because of the difficulty in determining what constitutes the same treatment in another health care system, for example because differences in clinical practice may exist. The draft directive attempts to overcome this by defining the right to reimbursement with reference to the costs which would have been paid had the “same or similar” health care been provided within the patient’s home system.

The NHS view was that such an approach could be interpreted as contradicting the principle that entitlement is limited to that which patients can receive at home. A patient might seek a treatment in another country that their home system does not fund and argue that they should be reimbursed because it is ‘similar’ to a treatment they were receiving at home. Such a system could lead to numerous disputes between ‘cross-border’ patients and their home health care systems. It could also result in patients who cannot, or do not wish to, access cross-border health care, being unfairly disadvantaged.

These problems could be avoided by clarifying the draft proposals, with regard to the limit on entitlements and also by recognising different mechanisms for determining eligibility in the text. Even with such clarifications, NHS organisations will need to ensure that patients can easily access information about processes used to determine eligibility, and that decisions about entitlements are reached and communicated to them clearly and promptly. This is likely to pose a particular challenge in relation to cases where patients apply for a treatment not usually funded or challenge a decision not to fund a treatment, when a longer timescale may be needed for a decision to be made.

There is currently significant variation in the way local NHS organisations reach and review decisions about entitlements. In the context of work to define an NHS Constitution, a statement of the NHS’ core values and patients’ rights and responsibilities, there are moves towards improved standards and greater transparency in local decision-making, which will be important in the context of cross-border health care.

**Patient choice**

Under the policy known as ‘patient choice’, NHS patients in England referred for specialist care are able to choose to be seen by any NHS provider that provides appropriate treatment. Many English NHS organisations viewed the proposals on cross-border health care to some degree as an extension of ‘patient choice’. The NHS view was, therefore, that where it has been established that a patient is eligible to receive a particular treatment, the fact that health care could be provided locally should not, alone, be a reason to prevent the patient from seeking treatment abroad.

However, one key difference between patient choice in England and cross-border health care is that patient choice is limited to providers contracted to the NHS. This includes a range of independent and third sector providers (for example, charitable or voluntary sector organisations), but crucially, all are required to provide health care according to NHS standards and conditions, including, for example, taking into account relevant clinical guidelines.

By contrast, in a cross-border situation, a patient can access treatment from any health care 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 health care, of which patients may not even be aware.

NHS organisations considered that, in order to reduce such risks, it would be essential to ensure that patients considering cross-border health care obtain clear information on the conditions that apply before they seek treatment abroad. As this will need to include personalised information on a patient’s individual needs and entitlements, the NHS view was that there should be a process for patients to consult their local NHS before obtaining cross-border health care.

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 health care, 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). These systems were also seen as an important way of protecting patients’ interests. By providing clarity on matters, such as what specific treatment their clinician recommends for them, what reimbursements they will be eligible for and what costs they will have to meet themselves, arrangements for any after-care needed and what will happen if anything goes wrong, such systems would enable patients to make an informed choice about the best health care option for them.

The NHS view was that the draft directive was short-sighted as it did not recognise the potential benefits to patients of prior authorisation systems, and in proposing that prior authorisation systems could only be used in exceptional circumstances. NHS organisations felt that the simplest and clearest approach to prior authorisation systems would be for each country to develop its own list of health care for which prior authorisation is required, whilst ensuring that prior authorisation systems are clear, user-friendly and responsive.

As levels of cross-border health care to and from the UK have, to date, generally been relatively low, few local NHS organisations currently have the knowledge and expertise to be able to advise patients interested in cross-border health care. The development of systems to support and facilitate cross-border health care will therefore have resource implications.

The NHS view was that prior authorisation and information systems would be a necessary investment. However, it is essential that information and data collection requirements remain proportionate, and the NHS view has been that the focus should be on enabling patients to make informed choices, for example by highlighting what questions they might ask of a potential health care provider. It is important to avoid a situation where potential cross-border patients are entitled to more information and support than domestic patients seeking care at home.

**Conclusions**

The NHS European Office’s consultation on the European Commission’s proposals on patients’ rights in cross-border health care found that NHS organisations did not fear a large amount of cross-border health care as a result of potential new legislation in this area. However, there were concerns about potential clashes between the proposals and domestic policies, and these issues should receive full consideration.

Ultimately, the extent to which the cross-border proposals will impact on the NHS and its patients will depend on the final shape of the directive if and when it is...
adopted, and how it is then implemented at national level. The NHS European Office will continue to work with NHS organisations to further assess the draft directive as the legislative process continues, and to inform EU policymakers of potential implications for domestic health care systems.

REFERENCES


