

Health care across borders:

Implications of the EU Directive on cross-border health care for the English NHS

Elisabetta Zanon

Summary: The EU Directive on patients' rights in cross-border health care, agreed in March 2011, extends the reach and choice of patients beyond their traditional, national borders. Adapting to the rights and demands of the 'European patient' will be a challenge for health care organisations, forcing them to think differently about how they plan, finance and provide health care. The Directive, however, offers opportunities too for those providers with the expertise and the resources to adapt to a more European market. This article looks at the implications of the Directive for the English National Health Service (NHS).

Key words: cross-border health care, patient mobility, NHS, patients' rights, entitlements, England

The way health care in Europe is planned and the range of providers that patients have access to could look very different in the years to come with the implementation of the EU Directive on cross-border health care.¹ The Directive, which clarifies the rights of patients to receive health care in other EU member states, was adopted in March 2011 after a lengthy EU decision-making process. The legislation will have to be implemented nationally by October 2013 and will have the effect of extending patient choice beyond national borders with significant implications for both English National Health Service (NHS) commissioners (the NHS equivalent of an 'insurer' in the context of cross-border health care) and providers.

The NHS European Office engaged throughout the EU decision-making process to ensure the rules struck the right balance between the increasing mobility of our citizens and patients on the one hand and the member states' responsibility for

the organisation, management and funding of their health care systems on the other. We undertook a wide consultation process with the aim of assessing the potential implications for the NHS,² followed this with a briefing putting forward NHS views on the proposals³ and, more recently, summarised in a new publication the implications for the NHS of the agreed Directive.⁴

The extent of our involvement was dictated by the symbolic nature of the Directive and the genuinely uncertain consequences the Directive could have. While the implications of the Directive discussed in this article are an early reading of the situation and the true impact on our health care system is still largely unknown, adapting to these new challenges and taking advantage of the coming opportunities is in our own hands.

What the Directive says

It is important to note that the Directive speaks with the voice of the patients – it is their rights it clarifies. Its underpinning rationale is that it should be as easy as possible for patients to have access to health care abroad, subject to the same conditions that apply to accessing health care at home. The legislation confirms that it is always the home health system that decides what

health care is available to its citizens, regardless of whether they are treated at home or abroad. In the case of the NHS therefore, patients will be required to have their eligibility to health care assessed by a general practitioner. This provision is particularly important to the NHS which, unlike social insurance systems, does not have a 'basket' of health care to which all patients are entitled, but instead makes decisions on eligibility locally, taking into account the circumstances of individual patients.

From the perspective of our health care system, the Directive has been generally welcomed, owing to the fact that it provides clarity for those in charge of planning care. Importantly, it allows EU member states the option of introducing prior authorisation for patients seeking care abroad, applicable to health care which is subject to planning requirements and which involves at least one night in hospital, or which requires the use of highly specialised and cost-intensive medical equipment. Authorisation can only be refused in limited circumstances and decisions have to be taken in an objective and non-discriminatory manner, for example when a patient could be exposed to a high safety risk that cannot be regarded as acceptable.

*Elisabetta Zanon is Director, NHS European Office, Brussels, Belgium.
Email: elisabetta.zanon@nhsconfed.org.*

Further information on the role and work of the NHS European Office can be found at www.nhsconfed.org/europe

HEALTH POLICY DEVELOPMENTS

Authorisation cannot be refused when a patient is experiencing 'undue delay' in receiving treatment and while there is no formal definition of what constitutes 'undue delay', judgements must be based on a clinical assessment of what is a medically acceptable period for the individual clinical circumstances of the patient.

The Directive clarifies that commissioners are not required to pay more than the cost of a patient's treatment if provided by the NHS and there is no requirement to pay travel, accommodation or other expenses that would not be covered if treatment were provided by the NHS.

One of the biggest issues concerning cross-border health care is how domestic costs are determined. The Directive states that each country should have a transparent mechanism for calculating the reimbursement a patient is entitled to, but the detail of this is left for the country to determine.

For NHS health care which is not covered by a tariff – currently around 60% of care – defining levels of reimbursement could be tricky given prices are subject to negotiation and geographical variations. Furthermore, NHS tariffs may cover a package of care, rather than just one procedure, which means costs may need to be 'unbundled' if a patient receives a different package of care abroad. With regards to matters of quality, safety and liability of care, responsibility rests with the country where the health care is provided. This means that standards set by the UK regulatory bodies will not apply to treatment provided abroad and NHS hospitals treating patients from other EU countries will do so to NHS standards.

What will be the main implications for NHS organisations?

It is unlikely that there will be a large increase in the numbers of UK patients travelling abroad. Currently, the numbers are small – it has been estimated that only around 1,000 UK NHS patients a year go abroad for care. But commissioners should be mindful that one of the reasons given by patients for travelling abroad is the opportunity to receive treatment more quickly. So in the event that NHS waiting times increase in the coming years, we could see larger numbers of patients looking to access health care abroad funded by the NHS.

Neither is the Directive expected to have a major impact on NHS budgets, with patients in principle reimbursed for costs

no higher than NHS treatment. But commissioners will need to bear in mind that authorisation cannot be refused in cases of 'undue delay'.

On a positive note, the legislation will end the current uncertainty about the rights of NHS patients considering travelling abroad and how commissioners handle requests from them. With the NHS expected to move to a system of greater local variation under ongoing NHS reforms, a key issue will be for commissioners to have a clear 'list' of the types of health care they do and do not provide. This will be crucial for minimising uncertainty for commissioners and patients, and for reducing the possibility of legal challenge from patients who want to access treatments that are not routinely available on the NHS.

Looking at the impact on providers, it is possible that the NHS could see an increase in requests from overseas patients for access to treatment in some clinical areas, especially for those NHS trusts that provide highly specialised care and have an international reputation. In such cases it is essential that sufficient capacity is planned for, so that additional patients can be treated to the benefit rather than the detriment of NHS patients.

It is important to emphasise, however, that European patients must not automatically be classed as private patients as this would be discriminatory and contrary to EU law. Providers will instead have to offer these patients the option to be classed as either 'paying' NHS patients or private patients, with only the latter being subject to private fees.

One issue for providers seeking more overseas patients is the fact that NHS tariffs are often higher than the prices of other EU countries. Patients will only be reimbursed up to the cost of health care in their own country and would have to cover the difference personally wherever NHS care is more expensive.

There are real opportunities for those trusts with specialist expertise, especially in the diagnosis and treatment of rare diseases, which are expected to emerge from the establishment of 'European reference networks'. The Directive states that these networks will concentrate knowledge in medical areas where expertise is rare and this could have a positive impact on participating NHS trusts in terms of international reputation, collaboration and improved patient care.

What will happen next?

The Directive is due to be fully implemented by October 2013. The implementation will take place in parallel to a vast programme of NHS reforms in England, raising many questions about how the rules will be implemented on the ground and which organisations will be responsible for its different provisions.

It will be during the transposition into national law that key issues regarding the practical implementation of the Directive will be decided, such as:

- decisions around how the process of prior authorisation will work in practice;
- how to ensure that patients can access detailed information on their entitlements to health care;
- how many contact points for cross-border health care will be established across the country and which organisations will be responsible for this function;
- which data on cross-border health care will have to be collected; and
- how the cost of cross-border health care will be calculated, in particular for those procedures which are not subject to tariffs.

Further to this, work will continue to be conducted at EU level to develop a number of provisions in the Directive, such as the concept of 'European reference networks', and to put forward guidelines to support member states with the implementation of the Directive.

Despite the EU Directive now being agreed, it is clear that a number of important decisions on the application of the rules have still to be taken and that our work to engage and influence them will continue over the next couple of years.

REFERENCES

1. Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare. *Official Journal of the European Union*, Brussels, 2011. Available at: <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF>
2. NHS European Office. *A European Health Service? The European Commission's Proposals on Cross-Border Healthcare*. Brussels: NHS Confederation, 2008.

Available at: <http://www.nhsconfed.org/NationalAndInternational/NHSEuropeanOffice/OurWork/Pages/CrossBorderHealthcare.aspx>

3. NHS European Office. *Healthcare in Europe. NHS Views on the European Commission's Proposals on Cross-border*

Healthcare. Brussels: NHS Confederation, 2009. Available at: <http://www.nhsconfed.org/NationalAndInternational/NHSEuropeanOffice/OurWork/Pages/CrossBorderHealthcare.aspx>

4. NHS European Office. *Patient Choice Beyond Borders. Implications of the EU*

Directive on Cross-border Healthcare for NHS Commissioners and Providers. Brussels: NHS Confederation, 2011. Available at: <http://www.nhsconfed.org/NationalAndInternational/NHSEuropeanOffice/OurWork/Pages/CrossBorderHealthcare.aspx>

Towards fairer care funding in England

David McDaid

The question of how to fund long-term care (LTC) services in England has long vexed policy makers. The system has always been a complex mix of substantial out of pocket payments for personal care, supplemented by means tested support. It remains difficult for the public to understand and has been accused of being unfair: thrifty individuals who make provision for old age or save to pass on assets to their children lose out. The lack of any meaningful private LTC insurance means there is no mechanism to mitigate the risk of catastrophic costs should someone need care and support.

Recognition of inequities, whilst mindful of need for a sustainable system of public support, has been the spur for several reports and reviews commissioned by government, as well as by independent bodies since 1998. For differing reasons none led to major change.

July 2011 saw publication of the latest report from the independent Commission on Funding of Care and Support.¹ This was established by the Coalition government in July 2010 to review funding for care and support in England. In particular it was asked for recommendations on partnership funding between individuals and the state for care. It also considered how people could protect their assets, including homes, against care costs.

*David McDaid is Senior Research Fellow, LSE Health and Social Care and European Observatory on Health Systems and Policies, London School of Economics and Political Science.
Email: d.mcdaid@lse.ac.uk*

Chaired by economist Andrew Dilnot, alongside former Labour Health Minister Lord Warner and Care Quality Commission Chair, Dame Williams, recommendations include national criteria for care to eliminate discrepancies in care entitlements between local authorities. Individual contributions towards costs of social and LTC needs should be capped between £25,000 and £50,000. Other than £10,000 per annum for accommodation and food, all other costs would be met by the state. Theoretically this cap could stimulate development of LTC insurance products. The Commission also recommended that the mean-tested threshold for care support be increased from £23,250 to £100,000. Full implementation, assuming a £35,000 contribution cap, would cost £1.7 billion (0.25% of public expenditure) rising to £3.6 billion by 2025. Overall, the package would mean no-one should spend more than 30% of their wealth on care needs.

Reaction

Government reaction to the report has been muted. Health Minister Andrew Lansley welcomed the report in Parliament, but made reference to significant cost implications "which the government will need to consider against other funding priorities and calls on constrained resources... we have to consider carefully the additional costs to the taxpayer of the Commission's proposals against other funding priorities". This reaction might also reflect political nervousness that the recommendations could be viewed as a way for homeowners, i.e. those in higher socioeconomic groups, to benefit finan-

cially at a time when deep cuts are being made across the welfare state.

Reaction has been more upbeat from non-governmental organisations, with many calling for continued momentum to publish a White Paper setting out governmental plans by Easter 2012. The Association of British Insurers see the proposals as a way of reducing uncertainties which have made the development of LTC insurance difficult.

Perhaps most critically, there have also been renewed calls for the political parties to put aside differences to work together. This previously has been difficult to achieve. Prior to the general election in 2010, LTC became a politically charged issue, with efforts to build cross-party consensus failing amid accusations by the then opposition Conservatives that government plans to reclaim some of the costs of LTC from the estates of individuals after death would amount to nothing short of a 'Death Tax'. Encouragingly, there have been calls since the publication of the Commission's report by politicians in all parties for a mature apolitical debate on the issue. It remains to be seen whether this will help facilitate the development of a LTC funding model acceptable to the public, that all the political parties are willing to be held accountable for.

REFERENCES

1. *Fairer Care Funding. Report of the Commission on Funding of Care and Support*. London: Department of Health, 2011. Available at <https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf>