

Equality analysis

Title: Directive 2011/24/EU on the application of patients' rights in cross-border healthcare

Relevant line in [DH Business Plan 2011-2015](#):

What are the intended outcomes of this work?

Transposition of the Directive aims to ensure the application in UK law and policy of the provisions of the Directive:

- Clarification of established case law on patients' right to access healthcare elsewhere in the EEA;
- Setting out the grounds on which patients can claim reimbursement, from their home health system, for the costs related to such care;
- Equal application of patients' rights for all EU citizens;
- Improved information and better clarity on the rules that apply;
- EU-wide cooperation in a number of areas regarding healthcare.

Who will be affected?

Patients, healthcare providers, national health authorities

Evidence

What evidence have you considered?

Background

An EU citizen has the right to freedom of movement and the freedom to obtain services across the European Community. The essence of the right to freedom of movement is that the EU is seen as a single community of Member States, where land borders assume less importance. Citizens of the EU have the right to travel, live and work in any Member State. From a health perspective, European citizens may seek publicly funded healthcare abroad within Europe in various circumstances – as tourists requiring urgent care; when living and working abroad; or in limited circumstances by travelling especially to receive care. These reciprocal arrangements are enshrined in European legislation (Regulation (EEC) 1408/71, - now Regulation 883/2004 following amendment).

With 27 different Member States, these freedoms are not always uniformly applied. The European Court of Justice (ECJ) exists to arbitrate in cases where the existing national laws and practices conflict with the underlying principles of the internal market. In the last 15 years, there have been more than a dozen high profile cases in which the right to cross-border healthcare has been challenged in the court. From these, key rulings have been made on different aspects of patient mobility and the rules surrounding reimbursement of costs (including one in 2006 against the UK in the case of *Yvonne Watts v Bedford PCT*, which the UK lost).

In the case of cross-border healthcare, with so many ad hoc judgements being made in the courts and so many grey areas existing within and between countries, it became clear that a Directive was needed to clarify the law and the rights of citizens across the EU. This new primary legislation brought together existing rights under previous treaties, best practice in providing access to these rights, and the judgements and case law of the ECJ. With a new generation of Europeans seeing national frontiers as increasingly irrelevant, the Directive is positioned as an effort to give patients greater freedom in choosing where they obtain their treatment.

The Directive became law in April 2011 and must be implemented by all Member States within 30 months – therefore by 25 October 2013.

The EU Directive on cross-border healthcare

At the June 2006 Health Council, the Council of Health Ministers agreed the following set of overarching values that underpin the delivery of health services throughout the EU:

- Universality (that is, no-one is barred from access to healthcare);
- Access to good quality care;
- Equity (equal access for all regardless of ethnicity, gender, age, social status or ability to pay);
- Solidarity (the link between the financing of national health services and accessibility to all).

The new Directive on cross-border healthcare means that for a citizen seeking to exercise their fundamental rights, the rules and processes involved should now be simpler and much more straightforward. Citizens should have a much clearer idea of what they are entitled to, and what restrictions their own country can put on these rights.

The Directive creates a framework for cross-border healthcare, rather than a detailed set of rules and in a number of areas decisions on how to achieve the obligations set forward by the Directive are left to Member States. What the Directive does is clarify citizens' rights to access healthcare in another Member State and sets out the grounds on which they can claim reimbursement of the costs of treatment from their home health system (or insurer). It formalises the way in which citizens can take advantage of those rights, incorporating the case law established in the ECJ, to make the system more transparent and easier to access. The Directive also sets out a number of areas for EU-wide cooperation in healthcare.

In some cases, prior authorisation may be required before a patient accesses treatment in another Member State. This may be the case for services that need significant levels of planning and manpower and either involve overnight accommodation in hospital of at least one night or requires the use of highly specialised and cost intensive medical infrastructure or medical equipment, such as PET-CT imaging. Prior authorisation may also be applied to treatments that present a particular risk for the patient or the population or treatment provided by a healthcare provider that in a particular case would give rise to serious and specific concerns about the quality or safety of care.

The Directive does not challenge the right of Member States to define which medical services they choose to provide through its system. If a Member State does not offer the right for patients to get a particular treatment at national level, the directive does not create any new entitlement for patients to receive this treatment abroad and to be reimbursed. Similarly, the purpose of the Directive is not to foster or promote cross-border healthcare but to facilitate access to healthcare services in another Member State when it proves to be useful and necessary for citizens.

Who will be affected?

Research has shown that the numbers and types of EEA citizens who have travelled or intend to travel overseas for healthcare treatment are generally unknown. Very limited data is available now about how many people actually receive healthcare outside their country of residence. It is not clear how many people are even aware of the possibilities to receive healthcare abroad. Neither is much information available about the numbers and types of people that may actually be willing to receive medical treatment abroad and under which circumstances. This situation will change in the future on the back of Community-wide implementation of this Directive as the European Commission and Member States start to do much more to capture relevant data and better monitor cross-border flows. However, we start from a very low knowledge base.

The most comprehensive research undertaken to answer some of these unknowns is the 2007 Euro Flashbarometer survey, commissioned by DG Sanco – *“Cross-border Healthcare in the EU”*. The survey covered all 27 EU Member States on a randomly selected sample of 27,200 individuals of at least 15 years of age (on average – just over 1000 individuals per Member State).

The findings suggest that 70% of the EU27 population tend to believe that costs of healthcare treatment received elsewhere will be reimbursed for them by their national health authority or insurance fund. 4% of Europeans received medical treatment in another EU Member State over the 12 months to June 2007; cross-border patient mobility is most significant in Luxembourg, where every fifth citizen (20%) sought healthcare outside the country's borders.

3% of UK citizens received medical treatment in another EU Member State in the previous 12 months to June 2007. This is not broken down into types of treatment or socio-economic groupings (though will include a large cohort seeking emergency treatment, covered separately by the European Health Insurance Card); and so does not help to clarify whom this impact assessment will represent. There is some data available which shows the socio-demographic groupings of EU citizens receiving medical treatment in another Member State (see table at Annex A).

For the UK, currently, the numbers of people travelling overseas specifically for treatment are low. We know, for example, that around 1500 people travel each year under the arrangements enshrined in Article 22 of Regulation (EEC) 1408/71 (now superseded by Regulation 883/2004) – and although subsequent case law has demonstrated that individuals can exercise additional rights under what is now the Directive, and seek reimbursement from the NHS in such cases, we are not aware that a significant number of people have used this route. Where they do, we know little about their reasons for doing so, nor very much about the types of treatment they receive or the costs involved.

This impact assessment will be attempting to set out the potential impacts on equality issues across the socio-economic groups (where possible), and the common demographic groupings; including gender, race, age, and disability. Where this is not possible, mitigating actions will detail how the impact will be assessed through the consultation and engagement processes. A full list of the data sources used in this document is shown at Annex B.

Summary of analysis

The Directive is very clear on, and conforms with previous Directives around the principle of 'equal treatment between persons irrespective of racial or ethnic origin':

"The Directive applies in conformity with the Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin. That Directive prevents people in the European Union from being discriminated against on grounds of race and ethnic origin and is also applicable to all persons, in relation to social protection, including social security and healthcare. Therefore, the principle of equal treatment enshrined in Directive 2000/43/EC which means that there shall be no direct or indirect discrimination based on racial or ethnic origin shall remain in place and is not affected by the provisions of this Directive."

"...and in order to avoid unsustainable impacts of healthcare, it is important to ensure that patients from within and outside domestic systems are treated in a non-discriminatory manner.....Moreover, according to the general principles of equity and non-discrimination, patients should in no way be discriminated against on the basis of their sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation. Furthermore, as this Directive respects the fundamental rights and observes the principles recognised in particular by the Charter of Fundamental Rights of the European Union, it has to be implemented and applied with due respect for the rights to equality before the law and the principle of non-discrimination, in accordance with the general principles of law as enshrined in Articles 20 and 21 of the Charter."

It is evident there are a significant number of gaps in the evidence base for this assessment, together with mitigating actions to resolve any negative impact on equality within certain groups. The assumed rationale for this is a lack of available data; and the data that has been made available is more generic in its presentation, and less specific. Where evidence is available, in some instances there is a lack of follow-through in consideration, i.e. the issue is initially discussed and not followed up – or in some cases, suggestions to address the issue are made; which have not been enacted by the Commission in its final negotiations. What must be borne in mind is that the Directive is a framework and, in some Articles, 'how' the obligations are to be implemented is left open to Member States to agree.

Key issues

One of the most evident potential inequalities arising from the Directive is the assumption that patients will pay up-front for their healthcare treatment within the EEA. One of the main principles of the Directive is that a patient, where appropriate, has the right to seek healthcare treatment elsewhere within the EEA and then seek reimbursement of the equivalent cost of that treatment had the healthcare been provided in the home territory. In the UK, this means that a patient seeking healthcare overseas

can claim reimbursement for the cost of the treatment had it been provided to the patient under the National Health Service (NHS).

Other notable inequalities include awareness of the Directive itself, and how to seek/access treatment abroad within the EEA. There is evidence that shows that the older population are more aware of the Directive and their right to seek overseas healthcare treatment than are their younger counterparts; however, in contradiction – the younger generation (where they are aware of the Directive) are more cognisant of how to seek and access such treatment. The reason for this could be the ability to utilise technology more easily (e.g. the internet).

One of the key objectives in meeting this information gap is to ensure that citizens are made fully aware of their rights and entitlements in accessing cross-border healthcare. This is an important obligation at Article 5 of the Directive and is something that will be addressed as part of the UK's implementation plans – including monitoring of how many are accessing cross-border healthcare and any potential discrimination in the system that might have the unintended effect of disallowing or disadvantaging some groups to access their rights.

Overall demand

We consider that it is important not to overplay the impact of this Directive. There is a lot for an individual patient to think about before they take the decision to seek healthcare in another EU country – for example, a different language & culture, different professional and safety standards and outcome indicators, accommodation, travel and subsistence costs, assurance on care pathway(s), avenues to obtain appropriate redress etc. The patient would need to do their own due diligence to assure themselves that the financial and other considerations associated with cross-border healthcare outweigh staying within their own health system.

It is therefore likely that relatively few patients will seek healthcare in another EU country unless they perceive that by doing so they can access something 'better' than they would get at home under the NHS. The Directive does not allow patients to be reimbursed for treatments in other countries that they would not have been entitled to at home, so 'better' in this sense is most likely to relate to reduced waiting times, standards of quality and safety, and issues such as cleanliness and being able to access renowned specialists in a particular field.

Overall, for most treatment types, implementation of the Directive is not expected to result in an increased uptake of cross-border healthcare. Indeed, the Directive gives primacy to Regulation 883/2004 – i.e. where cross-border healthcare is requested and the requirement for prior authorisation applies, then Regulation 883/2004 route should be considered first, unless the patient specifically requests otherwise. However, in certain situations, the disadvantages of cross-border healthcare will be less relevant:

- a. **Patients with links to another EU country:** these patients will be familiar with the language, culture and health system of another country to which they are likely to travel on a regular basis. Crucially, for some treatments, they might indeed prefer treatment in their country of origin (for example, to be closer to friends and family).
- b. **Low risk treatments/treatments not subject to prior authorisation:** many of the concerns about dealing with a foreign health system in a foreign language will be much less relevant for ambulatory treatments – i.e. treatments with little risk of complications or treatments for less severe conditions. In some cases, patients could even consider some ambulatory treatment as part of their holidays abroad. This may be a consideration for low risk, low impact dental services for example.

Given the above, there is no reason to expect the Directive to lead to a substantial increase in travel for treatment across the board and notably for complicated treatments requiring hospitalisation. However, the proposed measures may significantly affect patients belonging to specific groups (e.g. EU migrants) or looking for specific types of treatment which are low risk, not subject to prior authorisation and exhibit a degree of variation in local entitlements within the NHS (e.g. dentistry).

The potential for Directive rights becoming the preserve of better off citizens able to "queue jump" domestic waiting lists is discussed later on in this document.

Disability (includes learning disability, long term conditions)

In the context of cross-border healthcare, there are clear obligations on Member States to ensure that patients/citizens are provided with information about cross-border healthcare services. This is about making information on rights and entitlements publicly available and easily accessible, as well as the conditions that will apply to reimbursement and procedures for appeal and redress if patients consider that their rights have not been respected.

Member States are required to designate one or more National Contact Points (NCP) to assist in this aim. The NCP will act as a conduit or information point, providing a wide range of information and/or links to the required information (for example, via professional/registration bodies & regulators etc). The ambition here is for Member States to work more closely together in the interests of patients and the information given by NCPs on quality of healthcare, patient safety and procedures to follow will help patients make an informed choice on the healthcare they seek.

One of the specific requirements on NCPs is to ensure that information is “...*easily accessible, available by electronic means and in formats accessible to people with disabilities*”. In delivering its responsibilities, the NCP(s) will need to have regard to the requirements and expectations of the Equality Act 2010. This (UK-wide) legislation makes it illegal to discriminate against disabled people in the provision of healthcare. All service providers have a duty to advance disability equality and are required to make reasonable adjustments to the way they deliver healthcare and to the physical features of their premises to meet the needs of disabled people. NHS organisations, excluding GP practices, also have a duty to produce a disability equality scheme to demonstrate and report on how they will tackle disability equality and how they will consult with disabled people within service design.

In the Act, a person has a disability if:

- they have a physical or mental impairment
- the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities

There are additional provisions relating to people with progressive conditions. People with HIV, cancer or multiple sclerosis are protected by the Act from the point of diagnosis. People with some visual impairments are automatically deemed to be disabled.

Obvious requirements on the NCP and NHS bodies are providing different options for those who are visually impaired and people with hearing loss. The Directive uses the word “format” and clearly envisages formats accessible to people with disabilities. For example, a person with visual impairment may find it more difficult to access information via the internet and may ask instead for information in Braille or a telephone line. There are special IT formats to make it easier for people with visual impairment.

However, accessibility is not just about the visually impaired; it involves thinking about a full range of disabilities including people with dyslexia, limited movement or learning difficulties. Accessible formats can also benefit other groups including people with changing abilities due, for example, to ageing. Much will depend on overall demand but these issues will need to be considered fully by the national authorities delivering functions on cross-border healthcare.

Concerns have also been raised regarding the possible effect of the Directive on those persons with a disability in other areas – for example, air travel:

Access to Air Travel, Airport and airline services for Disabled People (Liaison Group of UK Airport Consultative Committees)

“...ultimately, the directive could introduce inequalities...or extra costs incurred by people with disabilities...” (Cross-border healthcare in Europe: clarifying patients’ rights: BMJ 12 Feb 2011 Vol. 342)

Under European law, disabled people and other people with reduced mobility have legal rights to assistance when travelling by air. Regulation (EC) No 1107/2006 sets out two essential goals: first, preventing unfair treatment, that is refusal of carriage on the basis of reduced mobility and, second,

guaranteeing the provision, free of charge, of the assistance that passengers with reduced mobility need to have for air travel.

The following services should be available at all European airports for persons with a sensory, physical or learning disability which affects mobility when using transport:

- Facilities to summon assistance at designated arrival points, such as at terminal entrances, at transport interchanges and in car parks
- Assistance to reach check-in
- Help with registration at check-in
- Assistance with moving through the airport, including to toilets if required
- Help with getting on and off the plane
- Free carriage of medical equipment and up to two items of mobility equipment
- A briefing for you and any escort or companion on emergency procedures and the layout of the cabin
- Help with stowing and retrieving baggage on the plane
- Assistance with moving to the toilet on the plane (some planes will have an on-board wheelchair)
- Someone to meet you off the plane and help you reach connecting flights or get to the next part of your journey

There is detailed information about this on the DirectGov website as well as that of the Equality and Human Rights Commission.

Additionally, Article 7 of the Cross-border Healthcare Directive allows Member States to reimburse the full costs of healthcare plus “other related costs”, such as accommodation, travel and other expenditure that may be incurred by persons with a disability (e.g. in respect of an accompanying carer). However, the Directive recognises that this may happen in accordance with national legislation and does not therefore create any new entitlements in these areas. Each of the UK territories has arrangements in place for the consideration of travel costs and those of accompanying carers and although accommodation costs are not generally provided for, these could be considered on an exceptions basis.

Consultation question: What further assistance is required to make cross-border healthcare a reality to those people with a disability, learning disability or long-term condition?

Gender

As with other areas, we have found very little evidence of potential impact on sex/gender from the obligations contained in the Directive and therefore we assume there is no necessity to intervene or redirect policies so that they work towards gender equality. The findings from the Euro Flashbarometer survey suggest:

‘Women (51%) are much more likely than men (42%) to be concerned about the cost implications of such an endeavour [receiving medical treatment abroad]’

‘Also, males are less likely to be bothered by this factor (45%) than females (55%) [likely to be deterred from using medical services abroad].’

A DH-commissioned study* (hereafter “the York Report”) examined the perceived advantages and disadvantages of travelling abroad for treatment and concluded:

“We examined the demographic make-up of those individuals who stated avoidance of long waiting lists to be an advantage of receiving planned healthcare abroad funded by the NHS..... Very little difference was found across genders in this cross tabulation.”

*Cross-border Healthcare and Patient Mobility: Data and Evidence Gathering – Final Report August 2010 (York Health Economics Consortium)

Race

Evidence in this area is mixed and, in the main inconclusive. Black and minority ethnic (BME) groups generally have worse health and health outcomes than the overall population, although some BME groups fare much worse than others, and patterns vary from one health condition to the next. Evidence suggests that the poorer socio-economic position of BME groups is the main factor driving ethnic health inequalities.

Generally, research shows that the majority of people in the UK would prefer not to consider going abroad for non-urgent treatment in the future. Both social class and age have a significant impact upon people's willingness to consider going to another EU country for treatment. Resistance to going abroad for treatment increases consistently with age, and those aged 65 or more are significantly less likely to consider having NHS-funded treatment in another EU country in the future than younger age-groups. Those in the lower social grades are also less likely to consider this than those in the top social grades. In addition, patients may be less likely to wish to access cross-border healthcare if they have to pay for it upfront and claim back the costs. However, the scope for growth in the longer term as understanding of new rights and procedures develops cannot be predicted.

More widely, the information we have collected on patient and public attitudes to cross-border healthcare raises some further important issues. The Euro Flashbarometer survey found that:

"...61% mentioned that they do not have enough information about treatments available abroad, while 49% said they would not travel abroad for medical treatment because of language barriers..."

"....Besides English language countries, we also find that some Slavic language countries (and Latvia) are among the first six countries where the proportion of those refusing treatment abroad on account of language reasons is high..."

Following this theme, the House of Lords EU Committee in its report commented:

"It is clear that language may prove to be a barrier in the delivery of cross-border healthcare and that this may impact on a patient's choice to travel. We therefore consider that patients must be made aware of any language issues and costs before they seek cross-border healthcare. Language barriers could prove particularly critical in the areas of giving consent and ensuring continuity of care and patient safety. We recommend that the responsibility for addressing the language barrier is decided by the home Member State."

The York Report, in analysing the public survey suggests the following:

"...We also found relatively low levels of knowledge in minority groups. 36% of Black individuals and 42% of Asian individuals in the sample reported awareness in comparison to 63% of white individuals. When considering the higher proportion of white individuals in the sample compared to BME, the level of reported knowledge is relatively low in ethnic groups."

"A further cross tabulation was conducted on the ethnicity and gender of participants who told us they had considered receiving planned healthcare abroad. The results were not typical of the stratified sample, with higher percentages in Black (18%), Asian (11%) and other minorities (15%) being more likely to consider going abroad for planned healthcare compared to White respondents (4%). Therefore, consideration of planned healthcare abroad was much higher in participants from non-white backgrounds."

"It was also found that knowledge of healthcare abroad appeared to be limited among people from different ethnic backgrounds. However, high frequencies were reported of individuals from ethnic backgrounds whom had previously considered healthcare. Therefore, although awareness is recorded to be low among individuals from ethnic backgrounds, willingness to travel abroad and receive planned healthcare is high."

This Equality Analysis assesses the impacts of transposing EU Directive 2011/24/EU rather than the

impacts of the Directive itself. For instance, patients' rights to accessing cross-border health care result directly from the Directive and, indeed, the Treaty. These patient rights (and the consequential impacts of them being granted) are not contingent on any domestic transposition and are not affected by the proposed measures. Accordingly, the Directive does not in our view create socio-economic inequities that do not already exist.

However, in mitigating the concerns set out above, it is clear that people from minority and hard to reach groups and communities may need information to be delivered in a way that is personalised to meet their individual needs and preferences.

To a large extent, we believe that the solution to this is in the scope of the National Contact Point(s) (NCPs - Art.6 Directive requirement). All patients need reliable and understandable information on cross-border healthcare. In order to enable patients to make use of their rights in relation to cross-border healthcare, national contact points will be set up to provide information on rights, procedures and access to healthcare services. The ambition is for Member States to work more closely together in the interest of patients and the information given by national contact points on quality of healthcare, patient safety and procedures to follow will help patients make an informed choice on the healthcare they seek.

The NCP will act as a central repository of information and expertise on cross-border issues, providing accurate information to patients in a range of different formats. However, at the same time it must be remembered that the purpose of the Directive is not to foster or promote cross-border healthcare but to facilitate access when it proves to be useful and necessary (for citizens). This, the NCP will fulfil an information rather than a promotion function.

While the Directive does not specifically require information to be made available to people in different languages, in the UK there is again a need to consider the Equality Act 2010. Under the Act, public bodies are required to consider accessibility options for protected groups so, depending on demand, there may be justification in such measures in relation to citizens seeking access to cross-border healthcare. The NCP – under the auspices of the NHS Commissioning Board – will lead this work.

Age

This is another area where evidence suggests a mixed picture. The Patient Liaison Group from the Royal College of Surgeons suggested that patients may wish to travel if there are unmet healthcare needs in the UK, but did not think older people would want to travel. The York Report, in its analysis of the public survey, went further:

“...Results indicate that middle-aged people are more aware of the service, but younger people have greater access to information and are more willing to travel; (As this age group is less likely to require extensive treatment, this further supports the notion that numbers requesting healthcare abroad will not dramatically increase;)”

“62% (n=624) were aware of being able to receive planned healthcare abroad funded by the NHS. However, of these 624 individuals, less than half (n=257) were aware of where to go for advice on this service....”

“we found that awareness of planned healthcare abroad is more prevalent within middle aged and elderly people as opposed to younger individuals, which reflects age characteristics of travel abroad respondents.”

“We examined the demographic make-up of those individuals who stated avoidance of long waiting lists to be an advantage of receiving planned healthcare abroad funded by the NHS. The highest frequencies of this perception were reported in the middle-aged bands; 52% of individuals aged 35-44, 50% of individuals aged 45-54 and 54% of individuals aged 55-64 shared this perception....”

“These findings indicate awareness of planned healthcare (and patient mobility) increases with age, as 73% of 270 individuals aged 55-64 and 61% of 270 individuals aged 45-54 were aware of planned healthcare abroad in comparison to 27% of 22 individuals aged 18-24 in the sample. However, in terms of accessing information regarding healthcare abroad, a high proportion of younger individuals (in 18-24

and 25-34 age bands) reported the internet to be their first port of call. Although this is reflective of the younger generations inauguration and familiarity with technology and the digital age, there is a lot of comprehensive information regarding NHS funded healthcare abroad, therefore the younger individuals report a more fruitful method of accessing information, as opposed to the middle aged groups who reported a doctor as the first port of call.”

Therefore, it is indicated that middle-aged [white] groups are more aware of NHS funded healthcare abroad, yet younger individuals have a greater grasp of accessing comprehensive information on the service.”

Again, there is a balance to be struck between providing the correct level of information to people and avoiding straying into active promotion of cross-border healthcare.

Consultation questions:

- To what extent do you think that these proposals will have an affect on equality with respect to race and age?
- What more could be done to advance equality of opportunity?

Gender reassignment (including transgender)

No impact identified.

Sexual orientation

No impact identified.

Religion or belief

No impact identified.

Pregnancy and maternity

No impact identified.

Carers

No impact identified.

Other identified groups

Income related inequality

The NHS has worked hard in recent years to reduce its waiting times for medical treatment. However, under the Directive patients waiting for treatment might choose to go abroad in order to receive treatment sooner - especially so if the concept of “undue delay” applies in an individual’s case. The ECJ has defined undue delay as a waiting time that *“exceeds the period which is acceptable in the light of an objective medical assessment”*. This means that such judgments should be based on individual medical assessments, not merely on arbitrary time-based targets such as 18-weeks. Evidence of undue delay may be provided by a home clinician, or, under the rules on mutual recognition of professional qualifications, by a clinician registered in another EU Member State.

If “undue delay” is applicable to a patient’s individual circumstances, then, self-evidently a patient willing to travel will be better off by receiving treatment more quickly in another Member State. However, in doing so, he/she also jumps the queue – i.e. he/she receives treatment in the time that is necessary according to the condition, rather than on the basis of a managed waiting list and is then reimbursed for that treatment in good time.

The acts of application, determining whether prior authorisation and undue delay apply, and subsequent reimbursement of patient costs use up NHS financial resources. Since the NHS budget is assumed fixed, this means that those resources cannot be used for other treatments/patients, so there may need to be a reshuffling of treatment priorities which clearly will favour patients who are capable of going abroad for their treatment. Aside from the associated “on costs” to the NHS, this presents issues of equity in the system – i.e. those capable of travelling are unlikely to be those with the most severe

conditions; they are also likely to be socio-economically in the better off groups. Thus, the Directive has the potential to create distortions in the NHS when patients exercise their rights in going abroad for treatment.

The ability of an individual to pay for their (cross-border) treatment up front is therefore a key issue with this Directive. As was debated in the House of Lords Grand Committee (Monday 8 June 2009):

“The Committee had a major concern about equity, echoing many of our witnesses, especially those representing patient groups. A system where a patient had to pay up front for their care only to be reimbursed at a later date would exclude those without the necessary financial resources from using cross-border treatment. The European Parliament, like the committee, appeared to suggest that there be a system of state-to-state payments, but the UK Government seem to see any system as open to fraud and impacting on patients who cannot or will not travel for healthcare. How will the principle of equity ensure that all groups have equal access, whether or not they travel abroad for their care?”

In a similar vein, the Kings Fund, in their submission *“Patient Mobility in the European Union”* added:

“...First, there is the issue of awareness of the option to seek treatment abroad. Second, there are the financial implications for those who might want treatment but who cannot afford the travel costs or any additional premiums they may have to pay if the treatment is more expensive than the NHS equivalent...”

Additionally, the NHS Confederation and the Patient Liaison Group suggested that:

“...vulnerable patients and those from lower socio-economic groups might require extra help or support in making the decision about whether to use cross-border healthcare.”

These points are all well made and were central to the process of negotiation on the Directive. The solution that has been arrived at is to allow the NHS Commissioning Board (which will be discharging EU patient mobility and cross-border healthcare responsibilities from 1 April 2013) to agree to make payment directly to overseas providers on behalf of the patient following treatment – in effect acting as a third party – since this is allowable under the Directive. However, it is critical in doing this that it does not invoke the NHS duty of care, as the Commissioning Board will never be formally commissioning the treatment; they would simply be assisting the patient in exercising his or her individual rights.

This would not be the arrangement of general preference - we would expect most patients to pay the provider directly at the point of treatment and then seek reimbursement on return home but it should be a tool available to the Commissioning Board where patients would otherwise struggle to meet the cost of treatment up-front because of their financial circumstances. This would therefore be something that would be decided on a case-by-case basis.

Consultation questions:

- Do you agree that the Commissioning Board should be able to make payments direct to overseas providers, where this would be beneficial for patients in difficult financial circumstances?
- If so, what safeguards would you like to see put in place?
- To what extent do you think that these proposals will have a positive or an adverse impact on equity? What else could be done to manage any adverse impact?
- Are there any other potential impacts that are not identified?

Patient inflow

A common misconception is that the Directive will allow foreign patients to queue jump domestic waiting lists. This is not the case. It is true that healthcare providers must not discriminate against patients from another Member State – however, providers are not obliged to provide or prioritise care for non-resident EU citizens where this would negatively affect the treatment of domestic citizens with similar levels of need. Measures must be limited to what is necessary and proportionate and must not be a means of arbitrary discrimination. In principle, the strongest grounds for refusing a non-UK patient are lack of

service capacity.

Similarly, providers must also apply the same scale of fees to patients from another Member State as they charge to domestic patients and they must provide information to help a patient make an informed choice, including on prices and clear invoices. Member States should also ensure that systems of professional liability insurance or similar are in place for healthcare providers.

Area inequality

A further issue of concern has been the potential for inequalities to exist from area to area. The mechanisms by which requests for cross-border healthcare and reimbursement of costs are currently dealt with operate at local level by Primary Care Trusts in England (and by Health Boards in Wales, Scotland and Northern Ireland). This is a highly decentralised system, which is given to inconsistency of application of the law.

Evidence from the York Report shows that the decision-making that takes place at a local level on enquiries or applications relating to cross-border healthcare falls well short of the obligations set out in the Directive. To citizens, patients and those involved in health service administration, entitlements and procedures and how to make use of them are not transparent.

Therefore, in implementing the Directive we propose to centralise decision-making on cross-border healthcare within the NHS Commissioning Board. This will ensure critical mass of expertise and much greater consistency in decision making and limits the risk of getting things wrong, thereby disadvantaging patients.

Engagement and involvement

Was this work subject to the requirements of the cross-government [Code of Practice on Consultation](#)?

Yes.

How have you engaged stakeholders in gathering evidence or testing the evidence available?

We will be testing the evidence we have via public consultation on Directive implementation.

How have you engaged stakeholders in testing the policy or programme proposals?

Previous consultations and engagement include the following:

The European Commission's original proposal for a Directive

The Government consulted on the first draft of the Directive when this was first published in 2008. This consultation set out the rationale for the Commission's intervention in this area; the measures being proposed to make cross-border healthcare a success for European citizens and respondents were requested to contribute views to inform negotiations on the Directive.

The consultation documentation (including a partial impact assessment) is available to download from the Department of Health website at the following link:

http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_089029

2010 Interim Regulations, Directions & Guidance

Subsequently, in 2009, the Government ran a limited consultation on the scope and application of a set of interim regulations and accompanying directions and guidance.

This limited consultation sought to build on the full public consultation carried out in 2008/09 on the draft Directive and requested views from within the NHS on the establishment of prior authorisation and reimbursement arrangements in respect of applications from patients to access cross-border healthcare under the provisions of Article 49 of the Treaty. These came into force in April 2010.

The consultation documentation is available to download from the Department of Health website at the

following link:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107296

House of Lords European Committee

The House of Lords European Union Committee published a Report on the European Commission proposal for a Directive on 24th February 2009 - *'Healthcare across EU borders: a safe framework'*.

This report sought to identify key issues that must be addressed by the Directive, and suggested how some of the challenges might be resolved. The Government's response to the recommendations and conclusions within the report is available to download from the Department of Health website at the following link:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098392

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

See above.

Summary of Analysis

In terms of overall impact, from the surveys we have done on patient choice the vast majority of people tell us that they prefer to receive their care as close to home as possible – and patients in England are already able to choose services from any hospital provider that meets NHS standards and costs.

The current scale of patient mobility is very low, based on available data. We do not expect that this will change significantly as a result of the Directive – in the context of the millions of people who are being treated by the NHS, we expect the numbers who seek healthcare in another Member State will remain as a very small proportion of overall demand.

It is very difficult to predict how many people may in the future decide to seek healthcare overseas as a result of the newly adopted Directive. It is possible that the Directive may have the effect of raising the profile of cross-border healthcare. However, in the short to medium term, it will take time for the Directive to bed in, for the rules to be understood and for the message to get out to the public. One of the things that may dissuade people will be the complexity of putting in place all the necessary arrangements - getting the right information, knowing who to trust, dealing in different languages, booking travel and aftercare packages, etc. Immediate impact (on all groups) is therefore judged to be low.

Eliminate discrimination, harassment and victimisation

None identified.

Advance equality of opportunity *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

None identified.

Promote good relations between groups

None identified.

What is the overall impact?

As stated, and in the absence of evidence to the contrary, our view is that the overall impact of the Cross-border Healthcare Directive is likely to be neutral in many respects – i.e. the Directive does not in

our view create socio-economic inequities that do not already exist. The one area of concern is income-related inequality, where action is being taken to mitigate the potential effects.

Addressing the impact on equalities

We will be in a better position to consider any potential adjustments after consultation.

Action planning for improvement

We will be in a better position to consider any potential adjustments after consultation.

For the record

Name of person who carried out this assessment: Rob Dickman

Date assessment completed:

Name of responsible Director/Director General: Richard Douglas

Date assessment was signed:

Medical treatment received in another Member State, by socio-demographics

Q: Have you, yourself received any medical treatment in another EU Member State in the last 12 months? (May 2007)

	Total N	% Yes	% No	% DK/NA
EU27	27228	3.6	96	0.4
SEX				
Male	13172	3.9	95.6	0.5
Female	14056	3.3	96.3	0.4
AGE				
15 - 24	4069	5.2	94.5	0.4
25 - 39	6939	4.0	95.5	0.5
40 - 54	7444	3.0	96.9	0.1
55+	8633	3.1	96.3	0.6
EDUCATION (end of)				
Until 15 years of age	4602	2.8	96.5	0.7
16 - 20	11532	3.5	96.2	0.3
20+	7331	3.9	95.8	0.3
Still in education	3139	4.6	95.1	0.2
LOCALITY TYPE				
Metropolitan area	5640	4.9	94.7	0.4
Other towns	10602	3.4	96.1	0.5
Rural areas	10897	3.1	96.5	0.4
OCCUPATION				
Self-employed	2504	4	96	0
Employee	8915	3.2	96.5	0.3
Manual worker	2369	4	95.4	0.6
Not working	13354	3.7	95.8	0.5

Sources of evidence

- i) Consultation on the European Commission's proposals for a Directive on the application of patients' rights in cross-border healthcare – 8 Oct 2008
- ii) International Medical Travel Association's response to the DH Consultation 2008
- iii) The European Commission's proposals for a Directive on the application of patients' rights in cross-border healthcare: UK Government's response to consultation
- iv) Cross-border Healthcare and Patient Mobility: Data and Evidence Gathering – final Report August 2010 (York Health Economics Consortium)
- v) House of Lords: European Union Committee 4th Report of Session 2008-09 – *“Healthcare across EU borders: A safe framework”*
- vi) Summary of main issues raised by respondents to the House of Lords inquiry
- vii) House of Lords: Grand Committee Monday 8 June 2009 (Moved by Baroness Howarth of Breckland)
- viii) Impact Assessment for the Health Bill (NHS Constitution) 1 May 2009
- ix) Cross-border healthcare in Europe: clarifying patients' rights: BMJ 12 Feb 2011 Vol. 432
- x) Access to Air Travel for Disabled People: Liaison Group of UK Airport Consultative Committees www.ukaccs.info/rights.htm
- xi) DirectGov – Airport and airline services for disabled travellers <http://www.direct.gov.uk/en/DisabledPeople/TravelHolidaysAndBreaks/GettingThere/index/htm>
- xii) The King's Fund: Patient mobility in the European Union
- xiii) Euro Flashbarometer survey: Cross-border health services in the EU – Analytical report (The Gallup Organisation June 2007)
- xiv) Proposal for a DIRECTIVE OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the application of patients' rights in cross-border healthcare 020708
- xv) Accompanying document to the Proposal for a DIRECTIVE OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the application of patients' rights in cross-border healthcare IMPACT ASSESSMENT
- xvi) Is greater patient choice consistent with equity? The case of the English NHS: Anna Dixon, Julian Le Grand (The King's Fund)

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their Directorate
Involvement, communication and engagement	<p>In terms of making information on rights and entitlements publicly available, we will need to consider which communication channels we use for UK citizens. In England, NHS Choices is central to how DH puts messages out to the general population and here we package Regulation 883/2004 and the Directive together in a comprehensive section on patient mobility and healthcare abroad:</p> <p>http://www.nhs.uk/NHSEngland/Healthcareabroad/plannedtreatment/Pages/introduction.aspx</p> <p>This will be revamped quite considerably to take account of the implementation of the Directive and to give greater emphasis on individual rights and the processes that are in place. The Commissioning Board and NCP will also have an online presence from which information on the procedures and processes to follow can be publicised. These bodies will also need to consider the requirements of the Equality Act 2010 and in particular, how information is made widely available and in appropriate formats.</p> <p>We will also develop approaches to reach CCGs, provider trusts, GPs and other primary care sources, within a comprehensive information and engagement strategy to ensure that all parts of the health system respond effectively and appropriately to patient requests.</p>		<p>Rob Dickman PS&F</p> <p>Plus colleagues in NHSCB/NCP (once established)</p>
Data collection and evidencing	<p>Post consultation</p>		<p>Rob Dickman PS&F</p>
Analysis of evidence and assessment	<p>Post consultation</p>		<p>Rob Dickman PS&F</p>

Monitoring, evaluating and reviewing	Post consultation		Rob Dickman PS&F
---	-------------------	--	------------------