Department of Health

UK Implementation of Directive 2011/24/EU - One Year On

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Actions Undertaken and Progress Achieved

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- Five territory implementation of the Directive in the UK – Five different healthcare systems and five separate healthcare budgets
- Factor in differing needs in each territory – for example, two territories share borders with another EU Member State, three do not
- In order that each system was properly represented, we set up five National Contact Points, one in each territory
- In England, transposition of the Directive was conducted in the context of major NHS reforms and restructuring:
    - Centralisation of European NHS functions in England as a result of those reforms - S2 and Directive applications in England are now managed by one team
    - This has resulted in greater consistency and expertise in how European healthcare applications are managed

Actions Undertaken and Progress Achieved

- Systems of prior-authorisation and reimbursement were already in place in the UK in response to the '*Watts'* judgement in 2006
- However, we recognise that those systems did not go far enough
- Used the implementation of the Directive as a way of strengthening our systems across the UK, both for prior-authorisation and for reimbursement, as well as strengthening the legislation that underpins them
- As a result of our devolved systems, each territory had to enact the relevant Regulations transposing the Directive in its territory, including setting up their own National Contact Point
- Improved and increased public-facing information for patients, as well as more streamlined and clearer systems for managing requests for prior-authorisation and for reimbursement

Current and Future Challenges

EU-level Challenges

- Directive 2011/24/EU vs Regulation (EC) No 883/2004:
    - Concerns about the EHIC being undermined: need to consider the possibility of the EHIC being refused by providers in favour of receiving direct payments under the Directive
    - Confusion for patients between the two planned treatment routes (S2 Route vs Directive)
- Concerns about invoice fraud as a result of the Directive, for example, the supporting medical information and whether that corresponds to the treatments provided
- Beginning to observe the emergence of third party interests seeking to act as facilitators for patients wanting cross-border healthcare – and potentially profiting from a patient's reimbursement
- Some concerns around emerging providers actively marketing services in other Member States

UK Challenges

- Demand for cross-border healthcare currently low – NHS is a universal service, free at the point of delivery – UK NHS patients are accustomed to receiving all their care needs close to home
- Current low-level of awareness in the UK of cross-border healthcare, including among clinicians
- Behaviour may start to change for a number of reasons:
    - Increased awareness of the Directive and what it means for patients'
    - If we start to see the level of investment in NHS services decrease
    - If NHS waiting times start to rise
- Balance to strike between protecting patients' rights and protecting our health systems
- Maintaining strong relationships across devolved healthcare systems

Fostering Collaboration Among Member States

Future Collaboration

- Already beginning to see collaboration between Member States on the operation of the Directive
- Particularly useful when seeking to compare common experiences:
    - Concerns around emerging providers targeting patients – initial discussions between Member States have already proved useful
    - Concerns about ‘third party agents’ - discussing actions different Member States are taking to protect their systems against potential fraudulent behaviour
- Collaboration on ways to counter invoice fraud
- Different Committees (eg Cross-border Committee and NCP Forum) helping to create a network of cross-border policy experts across Europe

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