

# Cross-border healthcare

Accessing medical treatment in other EU countries:  
Consumer attitudes and experiences



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**Disclaimer:**

This document has been prepared for ANEC. However, the opinions expressed herein are those of the authors and do not necessarily reflect the views of ANEC.

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### Abbreviations:

- ANEC – European Consumer Voice in Standardisation
- CEN – European Committee for Standardisation
- EC – European Commission
- ECC – European Consumer Centre
- EEC-Net – European Consumer Centre Network
- EHIC – European Health Insurance Card
- EPF - European Patients Forum
- ERNs – European Reference Networks
- EU – European Union
- HSFG - Healthcare Services Focus Group (CEN)
- NCPs – National Contact Points
- SAGS – Strategic Advisory Group on Services (CEN)
- WHO - World Health Organization

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# 1. EXECUTIVE SUMMARY

This report gives an insight into consumer attitudes and experiences of planned and unplanned cross-border healthcare, based on the findings of an ANEC survey of 1,656 EU consumers. It explores issues related to: access to healthcare; provision of information; quality of care; patient satisfaction; payment; reimbursement; and complaints, identifying common problems and offering recommendations for improvement.

Within the European Union (EU) two key pieces of legislation<sup>1</sup> give citizens the right to access planned and unplanned medical treatment in other parts of Europe, and seek reimbursement under certain conditions. These laws offer consumers the opportunity to benefit from the greatest medical expertise and best available treatment in the EU, regardless of where they live, travel, study or work.

The ageing population of the EU, and growing prevalence of chronic diseases,<sup>2</sup> is putting increasing strain on national healthcare systems, and increasing demand for affordable, timely and quality healthcare. In this context, the ability to choose from a wider range of service providers, in other Member States, offers clear potential benefits for patients.

However, despite a clear legal framework having been in place for almost five years, our findings suggest that **planned cross-border healthcare is still not working effectively in practice**. Our study shows that the number of people receiving medical treatment abroad is low. While 37% of respondents had received unplanned medical treatment in another EU country, only 4% had travelled abroad specifically to receive planned medical treatment.

Our study suggests that a key barrier to seeking planned treatment abroad is a **lack of awareness about rights**. When asked five questions about their cross-border healthcare rights, only 5% of survey respondents answered all questions correctly. Less than half (47%) knew that they could apply to be reimbursed for certain planned treatments by their national healthcare insurer. These low levels of awareness appear to be pushing patients towards paying for treatment privately. The majority of planned healthcare was funded privately, with only 34.1% seeking reimbursement of costs from their national healthcare insurer.

On a positive note, the majority of patients who had received medical treatment abroad, either planned or unplanned, reported high levels of satisfaction with the

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1 Cross-Border Healthcare Directive 2011/24/EU on the application of patients' rights in cross-border healthcare and EU Regulation (EC) No 883/20041 on the coordination of social security systems

2 European Commission, press release 20th July 2017

quality of their care, such as the competency of medical staff. Although three in ten respondents reported problems of some kind, these were more likely to be related to the process of accessing treatment, getting reimbursement, or resolving disputes, rather than the quality of care received. Analysis of these problems identifies challenges at both ends of the patient journey, which must be addressed before EU patients can take full advantage of the benefits of cross-border healthcare.

At the beginning of the journey, patients lack clear, consistent and comparable information with which to make informed choices about care. For both planned and unplanned healthcare, there is confusion around how to access cross-border healthcare, how to choose the best healthcare provider, which treatments and providers are covered, and rules for reimbursement. Awareness of National Contact Points (NCPs), which were set up in each Member State to provide information and advice about cross-border healthcare, is extremely low, with only a quarter (25%) of respondents aware of their existence.

At the other end of the patient journey, there are clear obstacles to consumers achieving satisfactory redress. Multiple avenues for cross-border healthcare complaints create confusion about who to complain to, about what. Our study shows that propensity to complain is extremely low, with disgruntled patients more likely to share negative experiences with family and friends than to make an official complaint, particularly for planned healthcare. The most common reasons for not complaining were: not knowing who to complain to; or thinking that it would be too complicated or difficult. Of those that did complain, satisfaction with the outcome was low.

This study highlights an urgent need to **raise awareness of rights, improve patient access to information** to empower them to make informed decisions, and **create tangible mechanisms of redress**. It is only by achieving these three goals that levels of consumer confidence and trust will be raised. In parallel, there is a clear need for guidance to underpin legislation, which focuses on the delivery of healthcare services and details good practice at all stages of the patient journey - from provision of information to complaints - to improve the quality and consistency of the consumer experience.

## 2. ABOUT THIS STUDY

### 2.1 Background

At the annual meeting of the ANEC Services Working Group, in June 2016, the topic of cross-border healthcare was discussed at length. Healthcare services are a key part of the ANEC Services Work Programme and there are a number of healthcare service standards in development at national, European and international level.

However, members of the Services Working Group agreed that healthcare is a particularly problematic area for standards development. ANEC consumer representatives have reported difficulties with gaining consensus on health standards due to the variations in medical qualifications and practices throughout Europe. They agreed that a possible solution was to focus on the healthcare needs of consumers from a services perspective, rather than clinical procedures and specific qualifications, which will remain the same regardless of where the healthcare provider is located.

ANEC consumer representatives felt that it would be useful to have more data regarding cross-border healthcare services from the consumer perspective. Therefore, ANEC commissioned this technical study in April 2017 to achieve a better understanding of the consumer experience and to inform the future work of the ANEC Services WG and its Health, Care & Support Project Team in this area.

### 2.2 Study aims and objectives

The main aim of the study was 'to investigate the consumer experience of using healthcare services located in other European countries, with a view to informing current and future standards work in this area.' The main tasks were to:

- Identify existing rules and standards that offer protection to consumers.
- Collect data about the EU consumer experience.
- Identify common problems faced.
- Define a list of common consumer needs in healthcare.

### 2.3 Study scope

This study looks at consumer attitudes and experiences of:

- **Planned healthcare** – travelling abroad specifically for the purpose of accessing medical diagnosis and treatment.
- **Unplanned healthcare** (emergency medical care) – accessing urgent medical treatment if taken ill while temporarily visiting another European country.

It does not cover treatments that are not considered medically necessary, such as beauty treatment and spas, although it is recognised that these fall into a broader definition of healthcare and wellness.

## 2.4 Research methodology

To achieve ANEC's objectives, the following primary research was carried out:

- **Consumer survey** – online survey to collect consumer opinion about cross-border healthcare in the EU.
- **Healthcare provider survey** – brief survey sent to the National Contact Point (NCP) organisations for cross-border healthcare services in each EU country.

The following secondary research was also conducted:

- **Existing legal framework** - to collect background information about EU rules and regulations in this area.
- **Literature review** – to identify relevant studies and reports.
- **Voluntary standards** – to identify any standards that may be useful and relevant to cross-border healthcare.
- **Complaints** – to collect any existing complaints data regarding cross-border healthcare services.

## 2.5 Important information about this survey

### 2.5.1 Survey development

Preliminary research for this study indicated that a small proportion of EU consumers receive planned healthcare abroad. To increase the number of questions that would be applicable to all respondents, and boost the sample size, it was decided to:

- Broaden scope to include unplanned healthcare.
- Include a range of questions about attitudes towards, and knowledge of, cross-border healthcare.
- Give respondents the option to record details of up to three experiences of medical treatment abroad.

### 2.5.2 Survey promotion

The survey was hosted online, and the survey link was promoted by 29 consumer and healthcare organisations in 15 EU countries (see **Annex 1**) for a six-week period during August and September 2017. Different organisations promoted the survey in different ways – for example, Which? in the UK emailed the survey link directly to a large panel of Which? members, whereas other organisations were only able to promote the survey on social media or display information on their website - which led to significant variations in country sample sizes (see **2.5.3.1**).



## 2.5.3 Survey sample and analysis

### 2.5.3.1 Filters

The survey asked respondents if they had 'ever' received planned or unplanned medical treatment in another EU country. However, when analysing questions related to personal experience (e.g. quality of care, reimbursement and complaints), a filter was applied to the data to separate respondents who had received treatment within the last five years. This was partly to help with recall, and partly because Member States had until October 2013 to implement the Cross-Border Healthcare Directive into their national legislation.

### 2.5.3.2 Country differences

In total, there were **1,656 respondents** to the survey but, as shown in **Annex 2**, a large proportion of respondents were from the UK (60%) and the Czech Republic (18%). It is likely that this was caused by different survey promotion methodologies (as described in **2.5.2**).

An analysis of responses identified some differences between countries, particularly in levels of awareness, but it is likely that these are due to sampling differences. For example, the UK sample contained a large number of older males, whereas other countries had a more even split of respondents of all ages. Where the differences between countries are significant, these are highlighted in the relevant place in the text. However, the aim of this study was not to provide a representative sample of EU citizens, or compare attitudes or experiences by country. So, this report categorises respondents as 'EU citizens' and the topline results focus on these overall figures.

**Please note: the sample demographics should be kept in mind when promoting the study and sharing results.**

### 2.5.3.3 Quantitative vs. qualitative evidence

As expected, the number of respondents with direct experience of using planned cross-border healthcare services was relatively low. Overall, we collected data about 78 'experiences' of planned treatment, with 47 occurring within the last five years. As a result, when analysing consumer experience data within this subset, the sample sizes are too small to allow robust quantitative conclusions to be drawn. Attention is drawn to low sample sizes, where relevant, throughout the report. However, the survey generated a lot of valuable qualitative evidence in the form of open comments, which gives valuable anecdotal evidence about the consumer experience. These are used throughout the report to corroborate quantitative findings.

## 3. HEALTHCARE IN THE EU

### 3.1 Overview

This section of the report summarises the existing legislation and standards relevant to cross-border healthcare services, the key issues that may affect the delivery of these services, and the EU consumers who wish to use them.

### 3.2 Legislation

#### 3.2.1 Roles and responsibilities

National governments in EU countries are responsible for organising and managing their own healthcare services. The role of the European Commission is to coordinate healthcare across borders, tackle shared challenges and achieve shared objectives. At a European level, DG SANTE (Health and Food Safety) is the department responsible for the Health Policy, Health Strategy and monitoring the implementation of related laws.<sup>3</sup>

#### 3.2.2 Cross-border healthcare

EU citizens' rights to obtain medical treatment in other EU countries are set out in **Directive 2011/24/EU on patients' rights in cross-border healthcare**. The Directive benefits consumers by:

- Offering additional possibilities for patients to obtain healthcare abroad.
- Providing a minimum set of patients' rights – such as the right to appeal authorisation and reimbursement decisions; the right to a transparent complaints procedure and to seek redress; the right to privacy; the right to access a copy of one's own medical records for all treatments; and non-discrimination on the basis of nationality regarding access and prices.
- Requiring Member States to provide clear information to patients on their rights and options.
- Providing a legal basis for European collaboration in the fields of health technology assessment, eHealth, rare diseases, and safety and quality standards.

To help implement the Directive, the European Commission created a **Cross-Border Healthcare Expert Group** with representatives from all EU-28 countries. In 2017, it also launched a system of **European Reference Networks (ERNs)** - specialised centres of expertise where health experts from across Europe can share knowledge, resources and best practice.<sup>4</sup>

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<sup>3</sup> [www.ec.europa.eu/health](http://www.ec.europa.eu/health)

<sup>4</sup> [https://ec.europa.eu/health/ern\\_en](https://ec.europa.eu/health/ern_en)

## 3.3 Standards

### 3.3.1 Background

CEN publishes standards at a European level. In late 2014, CEN/BT/WG 214 Strategic Advisory Group on Services (SAGS) and the Advisory Board for Healthcare Standards (ABHS) created a joint ad-hoc group on healthcare services. The group was asked to identify where European standards could add most value to healthcare services and incorporate this into a draft strategy.

In 2016 CEN BT created the CEN Healthcare Services Focus Group (HSFG), of which ANEC is a member, to facilitate interaction between key stakeholders in the area of healthcare. The group does not develop standards deliverables but makes recommendations on what criteria new European standards in the area should follow for supporting the quality, efficiency and safety of complex health care systems throughout Europe. The HSFG has been tasked to further elaborate on the healthcare strategy drafted by the CEN SAGS ad-hoc group on healthcare services.

At a broader level, through Mandate 517, the Commission proposed the development of a range of horizontal services standards on topics such as procurement and pre-contract information provision, contracts and performance assessment, which could theoretically be applied to a wide range of services, including healthcare. ANEC is supporting the CEN Strategic Advisory Group on Services (SAGS) on this work. However, it remains to be seen if these may be too general to be of practical use to consumers wanting to take advantage of cross-border healthcare services.

### 3.3.2 Healthcare standards

European standardisation in the healthcare sector has traditionally been focused on medical devices and e-Health. In recent years, there have been an increasing number of healthcare standards at national and European level, covering a wider range of issues. For example, there are new standards for specific treatments and procedures, such as aesthetic surgery and osteopathy, which offer specialist guidance in these areas. There are also horizontal standards for specific topics, such as privacy and complaints-handling, that may be applied to many services, including healthcare. See **Annex 4** for a summary of European (CEN) and international (ISO) standards that cover healthcare.

There are no standards with direct relevance to the delivery of cross-border healthcare services – from patient information, through to treatment and aftercare. However, EN 15224: Quality Management System in Healthcare has the potential to address consumer issues in this area. Although it includes 11 basic quality aspects, which could be relevant to consumers (including a requirement for patient-centred care), it appears to focus on clinical processes, rather than service quality, and would require a broader remit to be of true value to consumers.

## 3.4 Health trends and data

### 3.4.1 State of Health in the EU

The European Commission works with the OECD on a research initiative entitled: 'The State of Health in the EU', which assesses the health of EU consumers every two years. The work has various outputs including a 'Health at a Glance' overview report, and 28 country profiles.<sup>5</sup> However, these reports focus on the health of citizens, rather than giving information about the state of healthcare service providers that could be helpful to those considering cross-border treatment.

### 3.4.2 Increased pressure on national healthcare systems

A number of factors are placing increased pressure on national healthcare systems. The European Commission cites 'demographic change, growing prevalence of chronic diseases, re-emergence of infectious diseases and the rising cost of healthcare' as posing 'major challenges for healthcare provision in Europe'.<sup>6</sup>

Population ageing is a long-term trend across European Member States and life expectancy is increasing, rising from 74.2 years in 1990 to 80.9 years in 2014, according to the 2016 'Health at a Glance' report.<sup>7</sup> The share of EU consumers aged 80 years or above is projected to more than double between 2016 and 2080, from 5.4 % to 12.7 %.<sup>8</sup> 'As the population ages, the number of patients with chronic diseases is growing', says the European Patients Forum (EPF).<sup>9</sup>

Changing lifestyles, such as an increase in obesity, can increase the risk of chronic diseases such as cardiovascular disease, type-2 diabetes, hypertension, coronary heart diseases and certain cancers, which can impact healthcare services. According to the World Health Organization (WHO), 'obesity is one of the greatest public health challenges of the 21st century' and the prevalence of obesity 'has tripled in many countries of the WHO European Region since the 1980s, and the numbers of those affected continue to rise at an alarming rate'.<sup>10</sup>

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5 OECD/ European Commission 'Health at a Glance: Europe 2016' November 2016

6 European Commission, press release 20th July 2017

7 Ibid 5

8 Eurostat - [http://ec.europa.eu/eurostat/statistics-explained/index.php/Population\\_structure\\_and\\_ageing](http://ec.europa.eu/eurostat/statistics-explained/index.php/Population_structure_and_ageing)

9 European Patients Forum (EPF), 'Defining and Measuring Access to Healthcare: the patients' perspective', March 2016

10 <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity>

### **3.4.3 Drivers for cross-border healthcare**

As national systems come under pressure, waiting times for treatment can increase. Having to wait a long time for treatment is a potential driver for patients to look at cross-border options for planned healthcare. Some national health insurers, such as the NHS in the UK, publish performance data related to waiting time targets, which could help to inform consumers, but it is difficult to find consistent and comparable data regarding waiting times for various treatments in different EU countries.

The demand for unplanned medical treatment in other EU countries has increased due to: increased mobility of EU citizens; growth in intra-EU tourism; and the boom of budget airlines.<sup>11</sup>

### **3.4.4 Growth of 'health tourism'**

It is difficult to quantify how many people are using cross-border healthcare services. There are substantial differences in statistics from various sources, due to lack of consistency in data collection and variation of terms. For example, some organisations refer to 'medical tourism, others to 'health tourism' and others to 'cross-border healthcare', which have different definitions.

A 2017 report from the European Parliament<sup>12</sup> shows an increase in health tourism, stating that it generates revenues of approximately €34 billion, which represents around 5% of all tourism revenues in the EU-28, with the majority of 'health tourists' travelling from other Members States. However, it defines 'health tourism' as 'medical, wellness and spa'. Only the first part - 'people travelling expressly to access medical treatment' - would be covered under the criteria of the Cross-Border Healthcare Directive, and relevant to our study.

## **3.5 People-centred care**

There is increasing global demand for healthcare providers to focus on people-centred care (sometimes referred to as 'patient-centred care'), which means tailoring healthcare systems to the needs of the individual and empowering people to play a more active role in their healthcare and share in decision-making.

In 2016, WHO published its framework on Integrated People-Centred Health Services (IPCHS),<sup>13</sup> claiming that 'today's health services are not fit for 21st century challenges'. The Framework calls for a fundamental shift in the way that

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11 Eurostat – intra EU tourism flows, May 2017

12 European Parliament, 'Research for TRAN Committee - Health tourism in the EU: a general investigation', July 2017

13 WHO, Framework for Integrated Health Services, April 2016

health services are funded, managed and delivered, and recommends five strategies that need to be implemented:

- Engaging and empowering people and communities;
- Strengthening governance and accountability;
- Reorienting the model of care;
- Coordinating services within and across sectors;
- Creating an enabling environment.

It claims that people-centred care:

- Improves trust, experience and outcomes;
- Improves efficiency of health systems;
- Reduces unnecessary use.
- Ensures that people get the right care at the right time and in the right place.

## **3.6 Quality and safety of healthcare**

### **3.6.1 *Inconsistency of healthcare provision***

Quality and safety of healthcare is of paramount importance, and patients need to feel confident that cross-border healthcare services will be consistent. In a 2017 study,<sup>14</sup> the European Commission states that 'health care professions are highly regulated at national level' but claims that, despite EU legislation to facilitate the provision of cross-border health services, there are inconsistencies. It claims that healthcare professionals still face a variety of potential obstacles caused by: 'dissimilarities of rules between Member States, various (cross-sectorial) administrative requirements, language barriers, and even challenges in the process of recognition of qualifications.'

### **3.6.2 *Information about providers***

To make informed decisions about cross-border healthcare, patients need access to data that allows them to assess and compare the quality of care from different providers. While National Contact Points (NCPs) can supply contact details of suitable healthcare providers, there is a lack of data for prospective patients who wish to learn more.

A 2014 Eurobarometer survey<sup>15</sup> asked respondents what kind of information they would find useful in assessing the quality of a hospital. Almost four in ten mentioned the general reputation of the hospital (38%), while 31% mentioned

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14 European Commission. 'Study on cross-border health services: potential obstacles for healthcare providers', May 2017

15 Eurobarometer, 'Patient Safety and Quality of Care', 2014

the opinion of other patients. Around one in five said that specialisations (22%), the waiting time to get seen and treated (21%), the available equipment (20%), or the diplomas of the doctors and nurses (19%) would be useful in assessing quality.

The Eurobarometer study found that, currently, patients rely heavily on friends/family and internet/social media for information about quality of care in EU hospitals, which raises concerns as these may not give an independent or qualified assessment.

There does not appear to be any official EU-wide source of information on quality or safety of healthcare. The Health Care Quality Indicators (HCQI) project measures and compares the quality of health service provision across OECD countries, but does not give information about specific providers so has limited practical use for individual consumers wanting information that will help them decide which provider to use for treatment.

### **3.6.3 Skills and qualifications**

European Directive 2005/36/EC on Mutual Recognition of Professional Qualifications regulates the sectoral professions (e.g. doctors, nurses, midwives, dentists and pharmacists), allowing them to work cross-border and have professional qualifications automatically recognised. The European Professional Card (EPC) does not replace 2005/36/EC, but makes it quicker and easier for a professional worker to prove that they are qualified in a particular profession in their home country. In relation to healthcare it only covers nurses, pharmacists and physiotherapists, although it may be extended to cover other professions, such as doctors, in future.

## **3.7 eHealth**

There is increasing use of digital technology in healthcare, which can benefit patients in terms of sharing information to help combat disease. However, it also brings potential risks to patients in terms of privacy and security of personal data.

In July 2017, the European Commission launched a public consultation<sup>16</sup> to ask for feedback on 1) access to, and 2) use of, health data. Respondents mentioned privacy and security as their main concerns. In October 2017, experts met at the 'Health in the Digital Society' conference in Tallinn<sup>17</sup> to discuss future work in this area. The forthcoming General Data Protection Regulation (GDPR) is likely to have a significant impact on the way that the healthcare industry handles patient data.<sup>18</sup>

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16 [https://ec.europa.eu/info/consultations/public-consultation-transformation-health-and-care-digital-single-market\\_en](https://ec.europa.eu/info/consultations/public-consultation-transformation-health-and-care-digital-single-market_en)

17 <http://www.ehealthtallinn2017.ee/ehome/index.php?eventid=252892&>

18 [http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:OJ.L\\_.2016.119.01.0001.01.ENG&toc=OJ:L:2016:119:TOC](http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:OJ.L_.2016.119.01.0001.01.ENG&toc=OJ:L:2016:119:TOC)

## 4. CONSUMER ATTITUDES

### 4.1 Low levels of awareness

This study suggests that EU citizens lack knowledge and awareness of their rights to receive cross-border treatment, which is a major barrier to the effective functioning of EU legislation. When asked a set of five 'true or false' statements about their rights, a large proportion of respondents answered these incorrectly, or simply did not know the answer. Only 5% of respondents got all questions right.

#### 4.1.1 Awareness of cross-border healthcare rights

Overall, 82% of respondents know that they are entitled to access medical treatment - whether planned or unplanned - in another EU country. However, awareness of rights relating to planned medical treatment is much lower than for unplanned treatment. For example, only 47% of respondents know that they can apply to their national healthcare insurer to be reimbursed for certain planned treatments received abroad. Awareness of this fact varied between countries, with residents of Slovenia and France having higher awareness than those in the UK. These variations could be due to sampling differences, such as age (see **2.5.3.2**), or to the way that different EU countries and organisations promote cross-border rights.

Awareness of rights does not seem to have increased over time. A 2015 Eurobarometer report into cross-border healthcare found that 'when asked about their rights when being treated in another EU country, fewer than two out of ten Europeans feel they are informed.' It concluded that, 'Europeans are clearly unfamiliar with these regulations' and 'have only partial knowledge of their rights regarding cross-border healthcare'.<sup>19</sup>

#### 4.1.2 Awareness of NCPs

National Contact Points (NCPs) in each Member State are the gateway to cross-border healthcare, giving information about options and reimbursement, but our study shows that only one respondent in four (25%) is aware that NCPs exist. This varies by country, with residents of Greece and Slovenia having higher awareness of NCPs than UK respondents. A 2015 Eurobarometer report<sup>20</sup> found that only one respondent in ten had heard of NCPs, so our study suggests that awareness of NCPs has increased over the last few years.

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<sup>19</sup> Eurobarometer, 'Patients' rights in cross-border healthcare in the European Union, May 2015

<sup>20</sup> Ibid 18



## 4.2 Attitudes to cross-border care

When asked a series of attitudinal statements, survey respondents were generally positive about the potential benefits of cross-border healthcare. Three-quarters (75%) agreed with the statement: 'All EU citizens should be offered the same level of healthcare, regardless of the country they live in, or where they receive treatment'. In the comments, respondents reacted positively to EU consumers being given the widest choice of providers so that they could find the best treatment for them.

A female respondent from Slovenia said: *'When using healthcare services within the EU, it is really great to have a choice of providers, so I can dedicate myself to finding the solution that is most suitable for me'*. Another female respondent from Belgium said, *'It is always most important to find the right treatment; therefore, it does not matter to travel. In my family, for the same disease my brother in Germany gets better treatment, while the doctors in Belgium have other views. So, it is important to find out where to get the best cure.'*

Other respondents agreed that there are differences in the quality of care between different EU countries. 21% thought that they would get faster treatment and 22% felt that they would receive a better standard of healthcare in another EU country. However, despite the mostly positive outlook, almost four in ten (37%) agreed with the statement: 'Going to another EU country for planned healthcare brings additional risks for patients.'

## 4.3 Likelihood to use cross-border healthcare in future

We asked those who had not received planned treatment abroad, how likely they would be to do so in future. Half (53%) said they would not consider this option, while (20%) said that they definitely would and 27% said that they might, depending on the circumstances. The top six reasons that would make respondents 'extremely' or 'very' likely to consider cross-border treatment are:

1. To receive treatment not available in my home country (57%)
2. To receive treatment from a renowned specialist (40%)
3. To receive better quality treatment (37%)
4. To receive treatment more quickly (31%)
5. To receive treatment from a provider that is closer to my home (19%)
6. To receive cheaper treatment (18%)

Several commented that their willingness to travel would depend on the gravity of the problem and the costs involved. One respondent said it would depend on *'the seriousness of the health problem and the better treatment of it in another country'*. Another said it would depend on *'the severity of my illness and my finances'*.

## 4.4 Barriers to using cross-border healthcare

### 4.4.1 Patient view

For those respondents who said they would never consider seeking planned treatment abroad, the main reason was concerns about redress if things went wrong. The second most common reason was a lack of knowledge about patient cross-border healthcare rights. Four in ten (37%) said that they simply did not have a need to go abroad as they were satisfied with healthcare in their own country. Lack of confidence in the quality of healthcare services abroad was also a barrier.

<b>Q. Why would you not consider travelling to another EU country to receive medical treatment? (multiple choice) (sample: 465)</b>	
I would be worried about what happened if things went wrong	57%
I wasn't aware that I could choose my service provider from another EU country	48%
I am satisfied with medical treatment in my own country	37%
I wouldn't be able to afford it	33%
I would be worried that standards would be lower than in my home country	29%
I would not feel confident using a healthcare provider in another EU country	18%

### 4.4.2 NCP view

As part of this study, we asked NCPs what they considered to be the main barriers to patients in their country seeking planned treatment abroad under the Cross-Border Healthcare Directive. They highlighted problems with language barriers, lack of awareness, advance payments, the fact that travel costs are not reimbursed, as well as geographical and cultural barriers. Their responses are summarised below:

Estonia	Higher price levels than in Estonia, language barriers, travel costs which must be covered by the patient and lack of information.
Finland	Long distances and remote geographical location, well-functioning and high-quality healthcare system in Finland, language barriers.
France	Language and knowledge of prices.

Ireland	<p>Cultural habits - Irish people are not used to travelling abroad for healthcare.</p> <p>Remote geographical location acts as a physical barrier – involves air or sea travel as opposed to getting into a car or a train.</p> <p>Uncertainty of where to access the healthcare. Lack of information or rather lists of facilities in other countries and the services they provide including a lack of knowledge on the importance of accreditation of such facilities.</p>
Germany	Advance payment, language, information on legal rights.
Romania	Treatment costs and the language.
Sweden	Foreign languages and different kind of healthcare systems.

# 5. PLANNED HEALTHCARE

## 5.1 Overview

### 5.1.1 *What is planned healthcare?*

Planned healthcare is when patients travel abroad specifically to access medical diagnosis or treatment. Patients might arrange and pay for treatment themselves, but legislation gives them a right to information and advice, plus reimbursement under certain conditions.

### 5.1.2 *EU legislation*

EU citizens have a right to benefit from healthcare services in other Member States, under certain circumstances. Patients may be able to get some or all of their medical costs covered. There are two main legal instruments that facilitate planned cross-border medical treatment:

- Cross-Border Healthcare Directive 2011/24/EU on the application of patients' rights in cross-border healthcare
- EU Regulation (EC) No 883/2004<sup>21</sup> on the coordination of social security systems (S2 route)

Patients may take either route, depending on their circumstances, but the rules for accessing treatment and getting reimbursement are different. If in doubt about which route to take, patients should contact their statutory healthcare provider or NCP to discuss which is better suited to their needs. For more information about the various routes, see **Annex 3**.

### 5.1.3 *National Contact Points (NCPs)*

Under the Cross-Border Healthcare Directive, each Member State is required to set up at least one NCP to:

- assist patients and advise them on their rights;
- provide information about the national healthcare system to patients from other Member States;
- deal with prior authorisation requests (if required) and reimbursement;

## 5.2 Number of patients receiving planned healthcare

### 5.2.1 *Difficulties with data collection*

It is difficult to quantify the total number of people travelling abroad for planned medical treatment, for two main reasons:

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<sup>21</sup> <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=LEGISSUM:c10521>

- **Multiple routes of access**

EU citizens may access, and pay for, planned medical treatment in other EU countries via a number of different routes. Patients hoping for reimbursement from their national healthcare insurer (either the S2 or Cross-Border Healthcare Directive route) must go via their NCP. Alternatively, they can organise treatment privately, either funding the treatment themselves or seeking reimbursement from their private medical insurer. There is no reliable data about the number of EU citizens who have chosen to fund treatment privately.

- **Lack of consistent and comparable NCP data**

Our study suggests that NCPs record data differently making it virtually impossible to compare information.<sup>22</sup> One problem identified was that some NCPs find it difficult to separate requests made under the Directive, to requests made under Regulation 883/2004, as the two are so closely linked. A European Commission study in 2015 also highlighted similar issues that made it difficult for NCPs to provide data when asked.<sup>23</sup>

### **5.2.2 Low numbers seeking planned treatment**

Our survey found that only 4% of respondents had received planned treatment in another EU country, although this varied significantly by country. For example, only 2% of UK respondents had received planned healthcare abroad, compared to 27% of Slovenian respondents.

A 2015 Eurobarometer study<sup>24</sup> found that only 2% of EU consumers had received planned treatment abroad, but it must be noted that official data tends to look only at those seeking reimbursement under the Directive, whereas our survey looked at all experiences of planned treatment, regardless of funding.

NCP data on how many requests for reimbursement have been received can give an indication of how many people have had cross-border treatment under the Directive. However, this varies enormously by country. When we contacted NCPs, the French NCP told us that it reimbursed 78,552 French citizens for cross-border healthcare in 2016, whereas the Estonian NCP had only reimbursed 80. A 2015 European Commission report<sup>25</sup> of a survey to NCPs shows that, in general, NCPs

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22 ANEC survey to NCPs 2017

23 European Commission, 'Member State Data on cross-border healthcare following Directive 2011/24/EU', 2015

24 Eurobarometer, 'Patients' rights in cross-border healthcare in the European Union, May 2015

25 European Commission, Member State Data on cross-border healthcare following Directive 2011/24/EU, 2015

receive low numbers of requests for reimbursement, with the exception of Belgium and Denmark, which both received over 30,000 requests.

It must be noted that requests for reimbursement may not be comparable because in some cases data is collected per individual, application, treatment or solution. The Finnish NCP told us that it dealt with 20,512 cases in 2016, but states that it compiles statistics on 'solutions' which can mean an operation or treatment given, so one individual may have several operations and solutions per visit.'

### **5.3 Reasons for seeking medical treatment abroad**

A patient's decision to seek planned medical treatment in another EU country will be influenced by a number of factors. Firstly, there has to be a medical need for treatment and a perceived benefit to seek healthcare abroad. Knowledge and awareness of rights are the key facilitator, closely followed by trust and confidence in the quality of care in other countries.

The reason that so few people travel abroad for healthcare could be that, in many cases, the benefits do not outweigh the inconvenience and/or effort required to make the necessary arrangements. If a patient's home country provides adequate facilities, there may be no need to travel abroad for treatment. However, in some cases, the benefits might outweigh this. For example, if there are substantial cost savings or if waiting lists are long and consequences of waiting are severe, as might be the case with cancer treatment.

Our survey shows that the most common reasons for respondents to seek planned cross-border healthcare were:

1. To receive treatment more quickly (28%)
2. To receive cheaper treatment (22%)
3. To get better quality treatment (20%)
4. To get treatment not available in their home country (14%)
5. To get treatment from a renowned specialist (14%)

### **5.4 Choosing where to have treatment**

#### **5.4.1 Sources of information**

To get information about healthcare options EU citizens can contact the NCP in their country, or the country to which they want to travel. However, our study shows that only 4.3% of respondents who received planned medical treatment abroad contacted an NCP for information prior to booking. A 2015 European Commission report<sup>26</sup> also shows that, in general, NCPs receive low numbers of

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<sup>26</sup> European Commission, Member State Data on cross-border healthcare following Directive 2011/24/EU, 2015

requests for information, with most Member States receiving only a few hundred requests in 2015.

This evidence suggests that the majority of people did their own research into which countries and hospitals offered the treatment that they wanted. There does not appear to be any central source of information where prospective patients can compare what is on offer, although some healthcare providers have information on their own websites, in a choice of languages.

#### **5.4.2 Reasons for selection**

Our study shows that the most common reason for choosing a particular country was availability of treatment, ease of travel from home country and a country where treatment was cheaper than at home. People were also influenced by recommendations from friends and family and, to a lesser extent, by online reviews. The most common reasons for choosing a particular country, or healthcare provider, were:

- Availability of treatment I wanted (25.5%)
- Recommendations from family and friends (21.3%)
- Ease of travel from home country (19.1%)
- To save money as it was cheaper there (17%)
- A country where I had friends or family (8.5%)
- Online reviews (8.5%)
- Same language as home country (4.3%)
- A country I wanted to visit (4.3%)

The Cross-Border Healthcare Directive does not cover travel or accommodation costs, which usually have to be borne by the patient themselves. Therefore, distance and travel costs are factors in selecting which country to have treatment in. This is demonstrated by the number of respondents who chose neighbouring countries for their treatment. For example, many UK respondents chose to have treatment in France, while many Slovenian respondents chose to have treatment in Croatia.

#### **Case study: 'Tedious' S2 process**

Raymond, aged 67 from the UK, has a holiday home in France and chose to have necessary cancer treatment there as waiting time was much shorter than in the UK. He was very satisfied with his treatment and his healthcare insurance provider in the UK reimbursed the full cost of his treatment.

However, he says that he had *'difficulty using S2 form to get registered in France'* and claims that it was *'a tedious process'* because *'UK GPs and consultants did not know what was needed or tell me who to contact'*.

**Advice: Contact your NCP beforehand to discuss fully what is needed and what must be done.**

## 5.5 Accessing treatment

### 5.5.1 Prior authorisation

Member States can require patients to seek prior authorisation for some treatments - for example inpatient care and care requiring highly specialised or cost-intensive medical equipment or infrastructure - but not all do. For example, in Sweden and Ireland, seeking prior authorisation for cross-border treatment is voluntary. However, the Irish NCP told us that prior approval is recommended because: *'It is designed to protect the patient. In completing the application, the patient will have collated information on the anticipated cost abroad, the anticipated procedure and associated reimbursement rate and will have time away for the consultant's room in order to have a cooling off period before any decision to proceed with the treatment abroad.'*

Different Member States also have different rules for treatment that needs prior authorisation and the system can be complex. This makes the situation confusing for patients, and complicates data collection. For example, in response to our NCP questionnaire, the German NCP told us that it cannot calculate how many requests for prior authorisation it received because *'the prior authorization will only be granted by the statutory health insurance or the private insurer, where the patient is insured. But we have 113 statutory health insurances and more than 48 private insurance companies.'*

Only 4.3% of our survey respondents seeking planned treatment got in touch with their NCP to seek prior authorisation. A 2015 European Commission report<sup>27</sup> shows that the majority of NCPs received fewer than 100 requests for prior authorisation during year 2015, but only half of these requests were authorised.

Our study suggests that these low numbers could be due to low awareness of NCPs. 91.5% of respondents seeking planned healthcare abroad during the last five years did not contact their NCP. The majority of those said it was because they were not aware that NCPs existed. 17% simply decided not to.

## 5.6 Information about treatment

Healthcare providers should give patients clear information before, during and after their treatment. This should include details of the costs, the procedure to be carried out, how long the patient should expect to be in hospital, the potential risks, follow up appointments and recommendations for aftercare.

Overall levels of satisfaction with information was extremely high. Of those who had received planned treatment abroad during the last five years, 85.1% were satisfied with the information they were given before the treatment, 83% were

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<sup>27</sup> European Commission, Member State Data on cross-border healthcare following Directive 2011/24/EU, 2015



satisfied with the information given during treatment and 82.9% were satisfied with information given to them afterwards.

## **5.7 Healthcare delivery**

### **5.7.1 Cross-border treatments used**

Our study shows that people are most likely to have received the following planned treatments abroad, in order of popularity:

1. Dental Services (e.g. teeth whitening, crowns)
2. Obstetrician Services (e.g. pregnancy, scans, birth)
3. Cancer treatment
4. Orthopaedic surgery (e.g. knee, hip, shoulder replacement).
5. Aesthetic/cosmetic surgery (excluding dental)
6. Ophthalmic/eye services (e.g. cataract removal, laser surgery)
7. Rehabilitation services not addiction related (e.g. recovery from illness or injury).

The Irish NCP told us that, *'In general patients are seeking treatments for which there are significant waiting lists in Ireland i.e. hip and knee replacements, cataract surgery, ENT for children and orthodontics.'* NCPs in Estonia and Romania told us that they receive many applications to travel abroad for the testing and treatment of serious illnesses, such as cancer, neurological diseases, bone and joint diseases, and cardiac and vascular diseases.

### **5.7.2 Type of healthcare provider used**

Almost two thirds (61.7%) of those who had received planned treatment in another EU country had used a private healthcare provider and 36.2% had visited a public healthcare provider.

### **5.7.3 Patient satisfaction**

Patient satisfaction is dependent on the quality of care received, including the competency of staff, the medical facilities and the outcome of the procedure. The majority of respondents who had received planned medical treatment abroad were very satisfied with the level of care that they received.

- Satisfied with competency of medical staff (87.2%)
- Satisfied with outcome of the procedure (74.5%)
- Satisfied with quality of medical facilities (89.4%)

### **Case study: Poor quality dental treatment**

Alenka, 43, from Slovenia, went to Croatia for private dental treatment to receive treatment more quickly and cheaply. She claims that *'health services are only accessible to the wealthiest, no matter where you are.'*

She was very dissatisfied with the information provided to her, and the outcome of the procedure. She says: *'I was very unhappy with the service itself, a very superficial work that brought me new complications.'*

**Advice: 'Check the provider thoroughly to make sure you get a quality service for your money'.**

## **5.8 Paying for treatment**

### **5.8.1 Self-funded**

Four in ten survey respondents (40.4%) who received planned treatment abroad during the last five years paid for it privately rather than getting costs reimbursed via the Directive. The rules are complicated, so it is impossible to judge, based on survey responses, whether the treatment that respondents received would have been eligible for reimbursement under the Directive.

However, taking our evidence into account, that patients have low awareness of cross-border healthcare rights and NCPs, it is likely that some of these privately funded cases would have been eligible for reimbursement.

### **5.8.2 Private medical insurance**

Only 6.4% of survey respondents had their treatment funded by their private medical insurance. Some respondents claimed that they sought reimbursement from their private medical insurance, but were refused. A couple were disappointed that treatment that would have been covered by their insurance company, if delivered in their home country, would not be covered if they had it in another EU state, despite the treatment costing less.

Raymond, aged 73, from Northern Ireland told us: *'I don't understand why my medical insurance doesn't allow me to have private treatment in another EU country when treatment can be superior and cheaper.'*

### **5.8.3 Reimbursement from national healthcare insurer**

A third (34.1%) of our survey respondents, who received planned treatment abroad during the last five years, received full or partial reimbursement from their national health insurer. Of those who did have requests granted, several reported that they found reimbursement to be a difficult, complicated and confusing process.

A 2015 European Commission report<sup>28</sup> found that the average time for NCPs to process requests for reimbursement varied from four days in Denmark to 10 months in Bulgaria. Some NCPs set a maximum time limit, but this was also found to vary hugely, from 20 working days in Ireland and the United Kingdom (England and Wales) to three months in Bulgaria, Estonia, Slovakia, Spain and Sweden. Three months is a long time for patients to wait for reimbursement, especially if up-front costs are high. The report found that nine Member States do not have a set maximum time limit.

### **Case study: Long wait for reimbursement**

Cindy, aged 32, travelled from Luxembourg to France to see a haematologist/specialist in rare diseases. She chose to travel abroad as the treatment she needed was not available in her own country.

Although she was satisfied with her care, she was unhappy with the reimbursement process. She didn't contact the CNS (her national health insurer) beforehand as she wasn't aware that it existed at the time. She financed the treatment herself and requested reimbursement retrospectively. She says: *'The process for refunds is long and uncertain, and the legal framework is not well known to billing services. Uncertainty reigns as to the applicable law (need of a S2 or not, application of another directive). The administrative formalities are still too heavy.'*

**Advice: To avoid a long waiting time, check all the facts with your NCP beforehand.**

The European Commission report<sup>29</sup> shows that around a quarter of requests for reimbursement were declined. When we contacted NCPs, they told us that the most common reasons for declining requests is that the treatment received does not fall into the 'healthcare services basket' in their own country, or that the patient failed to provide the necessary documents.

#### **5.8.4 Additional costs**

Anyone planning healthcare abroad through their NCP should bear in mind that additional costs, such as travel and accommodation are not covered. The NCP may require medical documents to be translated into the home language before reimbursement can be made, which the patient may have to pay for themselves.

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28 European Commission, Member State Data on cross-border healthcare following Directive 2011/24/EU, 2015

29 European Commission, Member State Data on cross-border healthcare following Directive 2011/24/EU, 2015

### **Case study: Unexpected costs**

Ana, 37, travelled from Slovenia to Austria for a medical procedure at a private clinic. She chose Austria because it was easy to travel to and she wanted *'to have individual treatment, without having the feeling that I was on the conveyor belt'*. Ana was dissatisfied with the outcome of her treatment and had a dispute with the provider about payment. *'The clinic said that the medicines were included in the price, and in the end, they pointed out an additional account for the medication I had before and after the procedure.'*

*'It is important to ask about all possible additional costs, including those related to potential complications. Often the price is only for the basic procedure, but additional services, for example anaesthesia, medication, consultation, ultrasound, blood tests ... add up. In truth, the price was almost double what I'd expected.'* She didn't complain to anyone as she thought her complaint wouldn't be successful, but she warns people to think about other costs, such as transport, accommodation, *'which may be higher than they seem at the outset'*.

**Advice: Ask the service provider beforehand for the total costs with a breakdown, and ask which are included in the price and which might be extra.**

## **5.9 Problems experienced**

As shown in **section 5.7.3**, the majority of those who had received treatment abroad were satisfied with their treatment. However, 27.7% of respondents who had received planned treatment in another EU country during the last five years claimed that they had experienced problems of some kind.

The most common problem was language and communication difficulties. One female respondent from the UK said there is *'too much potential for vital medical information to get lost in translation'*. Language barriers could potentially cause problems if patients are asked to sign paperwork or contracts in a different language, as they could be entering into legally binding terms without full knowledge and understanding.

A male respondent from the UK said, *'language difficulties in some countries can, without proper understanding, lead to risks and possibly incorrect procedures.'* Other common problems were disputes about payment and issues with the quality of medical treatment.

## **Case study: Translation of legal documents**

Panagiotis, 74, travelled from Greece to Sweden for cancer treatment. He was very satisfied with his care, but had concerns about the translation of legal documents related to his treatment. He says: *'The healthcare system of each country is strongly connected with the local language, which undoubtedly causes problems to the patient.'*

The staff were all fluent in English, as was Panagiotis, so they were able to communicate in a common language. However, he felt uncomfortable when he had to sign *'a document in Swedish, which was summarised to me in oral English. This document to the best of my recollection had a legal dimension and would be important if things went wrong. This made me feel uncomfortable when I was in a vulnerable position.'*

He says: *'I believe that the system needs more standardisation across languages, so that EU citizens can choose their native and/or preferred language for the documents at least. If there is a linguistic barrier between doctor and patient, a medical interpreter should be available to solve the problem.'*

## **5.10 Complaints**

### **5.10.1 Reluctance to complain**

The majority of respondents who used cross-border healthcare services were satisfied. However, no one who experienced problems made an official complaint, although around half (46.2%) shared their negative experience with family and friends. The two main reasons for not complaining were:

- It seemed too complicated/difficult.
- I didn't think my complaint would be successful.

One respondent stated that *'it was only a minor difficulty so didn't seem worth complaining about'*. A male respondent from Greece received rehabilitation treatment in Slovenia after an illness and was unhappy with *'expensive services'* but says that he did not complain as he later discovered that *'the cost of the service was in the agreement, so there was no issue of protest.'*

### **5.10.2 Multiple avenues of complaint**

Our study highlights that there are multiple avenues for complaint, so it is possible that reluctance to complain is caused by confusion about where to direct complaints. This can depend on:

- the nature of the problem;
- which country is funding treatment;
- which country treatment was delivered in;
- whether the healthcare provider was state-funded or private.

If the complaint is about the handling of a cross-border healthcare authorisation or request for reimbursement, it should usually be directed to the organisation that dealt with the case – whether that is the NCP or the national healthcare insurer. In many cases these are one and the same but, in some cases, it is a separate organisation. For example, the Finnish NCP told us that it *'does not deal with consumer complaints, the patient must complain directly to the health care provider or to supervision authority'*.

For those organisations that do deal with complaints, details are not publicly available. NCPs that we contacted were willing to give us a summary of the types of complaints received, but did not supply any statistical data on complaints. The German NCP told us that it received the following consumer complaints in 2016: *'Prior authorization was refused; prior authorization took too much time; refund was too small; missing information about the existence of the NCPs; missing information in own languages on the websites of the NCPs.'* The Swedish NCP told us: *'Patients appeal our decisions on a regular basis, which is mainly due to dissent regarding the level of reimbursement. It is not easy to investigate the highest price of healthcare that would have been available in Sweden.'*

If a complaint is about the quality of care or medical expertise it should be directed to the healthcare service provider in the first instance. If the complaint is not dealt with satisfactorily, it appears that the consumer would have to go to the healthcare authority or relevant ombudsman in the healthcare provider's country, not their country of residence.

Consumers can also contact the European Consumer Centre (ECC) in their own country for help and advice regarding complaints about healthcare providers in another Member State. However, data on the quantity and nature of these complaints is not publicly available and ECC-Net did not respond to our requests for further information.

This huge number of potential avenues for complaint means that there is a lack of consistent and comparable empirical data, making it difficult to understand the quantity and nature of complaints received at an EU level.

### **5.11 Reasons for not going ahead with planned treatment**

When asked, 4% of respondents said that they had considered getting medical treatment in another EU country, but had not gone ahead with it. The main reason stated by respondents was that they didn't know how to organise it, followed by fears that it would be 'too complicated' and 'too expensive'.

Many cited 'other' reasons, which were mostly around lack of confidence, or a change in circumstances. One male respondent from the UK thought about arranging medical treatment abroad but says he did not go ahead due to *'lack of confidence in the outcome'*. A female respondent from France said that she decided against treatment abroad as she *'was too apprehensive'*.

For others, their circumstances had changed. One female respondent from Germany said that she had to change her plans as '*I was too ill to travel*'. Another female respondent from the UK was planning to go abroad but changed her mind as she was '*offered the necessary treatment at home at the last minute*'.

For some, they discovered that they needed treatment whilst they were abroad but decided to wait until returning home. A female respondent from Northern Ireland said: '*The treatment wasn't urgently required. I preferred to have it back in UK with support of family and friends around.*'

A female respondent from the Czech Republic said: '*I decided to have the treatment in the USA*'. One male respondent from Greece said he decided not to go ahead as he was uncertain about '*the costs, what exactly is covered, how much time will be needed, travel costs, how it is organized?*'. Others said that they were still thinking about it.

## 6. UNPLANNED HEALTHCARE

### 6.1 Overview

#### 6.1.1 *What is unplanned healthcare?*

Unplanned healthcare covers emergency or urgent care that cannot be foreseen. If an EU citizen unexpectedly falls ill during a temporary stay abroad - whether on holiday, a business trip or studying abroad - they are entitled to any medical treatment that cannot wait until they get home. They have the same rights to health care as people insured in that country.<sup>30</sup>

#### 6.1.2 *EU social security rules*

Each EU country has its own social security system, where citizens make contributions to the system and receive certain benefits. Social security usually includes unemployment benefits, healthcare provision, maternity care and pensions. Each country is free to decide who is insured, what benefits they are given and under what conditions.

EU Regulation (EC) No 883/2004<sup>31</sup> on the coordination of social security systems protects EU citizens' social security rights when moving around within Europe (EU-28 plus Iceland, Liechtenstein, Norway and Switzerland). In terms of healthcare, it provides common rules allowing EU citizens who are temporarily in another EU Member State (whether working or on holiday) to access medical treatment on the same terms, and at the same cost, as people insured in that country.

#### 6.1.3 *European Health Insurance Card (EHIC)*

EHIC cards provide 'proof' that a person is eligible to receive social security healthcare in their own country. They are issued free of charge by the health insurance services in the country of the insured person. Each person needs their own card, which must be renewed regularly.

The EHIC card can be used to access medical care in the event of an emergency, to receive treatment for pre-existing medical conditions and to obtain maternity care. The costs are then paid, or reimbursed, by the social security system in their country of origin. In some countries, patients might have to pay the doctor or the hospital directly for treatment, even though they may not normally do that in their home country.

The EHIC card cannot be used for planned medical treatment – where someone has travelled abroad with the express purpose of receiving medical treatment - or

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30 [http://europa.eu/youreurope/citizens/health/unplanned-healthcare/index\\_en.htm](http://europa.eu/youreurope/citizens/health/unplanned-healthcare/index_en.htm)

31 <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=LEGISSUM:c10521>



for private treatment. It covers EU citizens who are 'temporarily' visiting another EU country. For example, if they are on a temporary work contract and intend to return to their home country after that time.

## 6.2 Unplanned treatment received

### 6.2.1 Number of experiences

Our study shows that a total 37% of respondents had received unplanned medical care in another EU country. This equated to a total of 765 experiences, 407 of which had taken place during the last five years.

### 6.2.2 Healthcare services visited

Unplanned treatment may involve the use of one or more types of service, or healthcare professionals. For example, someone involved in a road traffic accident may be taken to Accident and Emergency (A&E) where they might see a doctor, have diagnostic tests, undergo an operation and be given prescription medication. Of those who had received unplanned medical treatment during the last five years the following services were used:

<b>Q. Which healthcare services did you visit regarding your most recent unplanned treatment? (multiple choice) (sample: 407)</b>	
Hospital accident and emergency	50.9%
Doctor consultation (to diagnose illness or get treatment)	43.2%
Pharmacist	27.3%
Hospital diagnostic and screening services (x-ray, CT scan, MRI scan, blood tests, etc)	25.3%
Dentist	6.6%

*Note: All experiences of unplanned treatment within the last five years.*

### 6.2.3 Private or public?

The EHIC card is only accepted by doctors or hospitals affiliated to the statutory health care system, and does not usually cover private health care. Although in rare circumstances this may be allowed with prior approval if, for example, there was no alternative public provider to carry out the necessary treatment.

Therefore, a patient's choice of provider is crucial, as it can mean the difference between paying for their own healthcare or not. Two thirds (65.8%) of respondents requiring unplanned treatment in another EU country during the last five years were treated by public health providers. A quarter (25.6%) were treated by private healthcare providers. Almost one in ten (8.6%) did not know whether the healthcare provider was public or private.

To be able to make informed decisions about their healthcare provider patients need to understand.

- Whether the provider is public or private.
- The implications of choosing public or private.

In some cases, a patient may choose to go privately, if they understand the options and have private funds or travel insurance in place to cover the cost. However, in the case of urgent treatment, the patient may not always be able to choose which healthcare provider they go to, be in a fit state to weigh up the options or state a preference for private or public care.

Some respondents complained that the 'first responder' to the incident – e.g. the hotel or person to call the emergency services – automatically sent them to a private provider when they would have preferred to go to a state provider. Or in some cases, that they would have preferred to go to a private provider but were sent to a state one.

#### **Case study: No choice but private**

Robert, 77, from the UK was holidaying in Tenerife, Spain when he had an infection that led to sepsis. The hotel called a private doctor, telling him that this was the only option as there were no state hospitals in the area.

He was very pleased with the '*excellent treatment*' he received and told us that '*English was spoken widely*'. However, as private hospitals are not covered by the EHIC card, Robert had to pay for the treatment himself and try to claim back on his travel insurance. His travel insurer refused to pay saying that it only covers treatment in state hospitals.

Robert says: '*My insurance provider doesn't state in any of its publicity material that it only covers state hospitals, this fact is hidden away in multi-paged Terms and Conditions.*' He lodged a complaint with his insurer but was dissatisfied with the outcome of the complaint and is now taking legal advice regarding the ongoing dispute.

**Advice: Always have travel insurance. Before buying, check the small print and make sure that your policy covers treatment in both state and private hospitals.**

### **Case study: Confusion over provider**

Klavdija, 39, from Slovenia, was holidaying in Croatia when her child became ill with an ear infection. She told us: *'We waited for more than two hours at the emergency medical aid clinic, despite only three people in the waiting room. Then they sent us next door to a private tourist clinic where a fee of 200 kuna (approx. €30) had to be paid for examination and medication'*.

She was unhappy that she had to pay, despite showing her EHIC card and felt that she should have been given a choice about going to a state-funded or private clinic. She also felt that she should have been given more information about the costs.

**Advice: 'Where possible find out your options for treatment, and how it is possible to pay, in advance. Always save your receipts!'**

## **6.3 Information about treatment**

In the case of unplanned treatment, it can be difficult for patients to make informed decisions about their healthcare provider, as there is not always time to weigh up all the options. However, once in the care of the healthcare provider, consumers should be given clear information about their treatment. This should include information about the costs, potential risks and any aftercare.

Overall, those respondents who had received unplanned treatment in another EU country during the last five years, were happy with the level of information given to them by healthcare providers. Three quarters of respondents (77.6%) were satisfied with the information they received before treatment, 84.7% were satisfied with the information given during their treatment and 74.2% with information received afterwards.

## **6.4 Quality of healthcare delivery**

### **6.4.1 Patient satisfaction**

Overall, those who had received unplanned care in another EU country during the last five years were satisfied with the quality of care they received. Overall satisfaction with the following aspects was:

- Competency of medical staff (89.5%)
- Outcome of procedure (87.7%)
- Quality of medical facilities (86.3%)

**Q. How satisfied were you with the following aspects? (sample: 407)**

	<b>Very satisfied</b>	<b>Satisfied</b>	<b>Neither</b>	<b>Dissatisfied</b>	<b>Very dissatisfied</b>
Competency of medical staff	66.6%	22.9%	4.2%	2.5%	2.2%
Outcome of procedure	60.4%	27.3%	6.6%	2.7%	1.7%
Quality of medical facilities	58.5%	27.8%	7.9%	1.7%	2.7%

*Note: All experiences of unplanned treatment within the last five years.*

**Case study: First class experience**

A female respondent from the UK, who broke her arm while on holiday in Austria, was very satisfied with the treatment and care she received at the public hospital. She says, *'The whole experience was first class. I arrived in hospital by helicopter and woke up two hours later, having had x rays, CT scan, diagnosis and treatment schedule all completed. A follow up out-patient clinic was arranged and then a further clinic a week later. The only charge from the hospital was for the arm splint that I was given.'*

In some cases, respondents complained about the medical facilities as the standards were clearly different to what people were used to in their home countries. These highlight variations in patient expectations, and levels of care, in different Member States.

**Case study: Poor facilities**

A male respondent from the UK, and his wife, both in their seventies, were admitted to hospital in Hungary after a serious car crash that resulted in: *'lower back injury to me and a broken sternum and broken rib for my wife.'* They showed their EHIC, passport and travel insurance docs and did not have to pay anything.

They were satisfied with the treatment itself, but dissatisfied with long waiting times and the poor facilities. He told us: *'My wife, who was kept in hospital for three days lacked a knife, fork, spoon, pyjamas and toilet paper, which all patients are supposed to bring with them into hospital!'* He says, *'we didn't complain to anyone as I thought the staff in the hospital did their best in the circumstances.'*

**Advice: 'When holidaying in Europe make sure you take your EHIC card with you!'**

## 6.5 Paying for treatment

### 6.5.1 Overview

Under EU rules, patients with an EHIC card can get healthcare - and claim reimbursement for the costs they incur - according to the rules and rates of the country where the treatment was received. So, if the treatment needed is free for local residents, the patient will not have to pay. If part or full payment is required, patients can ask for reimbursement from the national institution whilst still in the country and get reimbursement directly there, or ask for reimbursement from their own health insurer when they get home.

### 6.5.2 Documents asked for

Of those patients who had received unplanned treatment during the last five years, six in ten (59.2%) were asked to show their EHIC card, three in ten (31.4%) were asked for their passport and 13% were asked to show their travel insurance documents. Almost three in ten (28.9%) cannot remember being asked for any documents at all.

### 6.5.3 Payment required

Four in ten respondents that received unplanned medical treatment did not have to pay for their healthcare at the point of delivery. A UK man who went to a private hospital in Cyprus following a suspected stroke said: *'The costs were fully covered by insurance who settled all charges directly with the hospital.'*

However, six in ten respondents had to make a payment to the healthcare provider. 22.9% paid in full/ part upfront, but were later reimbursed for the money they had spent. 20.2% paid in full/part and did not get reimbursed. Many of those who replied 'other' had paid in full but were still awaiting reimbursement.

<b>Q. How did you pay for your unplanned treatment? (sample: 407)</b>	
I didn't have to pay anything	41.8%
Other, please specify...	15.2%
I paid in full, but was later reimbursed	15.0%
I paid in full and did not get reimbursed	12.8%
I paid a proportion of the cost, but later got that reimbursed	7.9%
I paid a proportion of the cost, but did not get that reimbursed	7.4%
<b>Total</b>	<b>100%</b>

*Note: All experiences of unplanned treatment within the last five years.*

#### 6.5.4 Travel insurance

Travellers without EHIC cards, or receiving healthcare which does not meet the eligibility criteria, must rely on travel insurance (if they have it) to reimburse their costs, which can be a lengthy and onerous process according to some of our survey respondents.

In an emergency, consumers might not always be able to question where they are taken, but some complained that a third party had sent them to a public hospital when they had travel insurance which would cover private treatment. Others said that they had been sent directly to a private provider. Some suspected that the provider was suggesting treatment that may be unnecessary, simply because the costs were covered by travel insurance.

##### **Case study: Travel insurance terms**

A female respondent from the UK was holidaying in Portugal when she had a severe pain in her leg - a serious problem that required immediate attention. She says, *'I tried to contact my travel insurer for advice but had to leave a voice message. They only called back after staff at my hotel had made me an appointment with a private doctor (around the corner). My insurer objected, saying I had to go to a state hospital (30 miles away) even though locals said I would have to wait at least 8 hours in A & E.'*

She decided to stay at the private hospital which could see her straight away and arrange urgent scans. She contacted her insurance provider to try and seek reimbursement *'but they said my policy stated that I should seek state healthcare 'where possible' and if I went to a private hospital I would be liable to pay an excess of £500'*.

#### 6.5.5 Additional costs

Although an EHIC card might cover the cost of treatment, in many cases consumers face additional costs. For example, the cost of accommodation if the patient is unable to travel home immediately or needs follow-up care. A UK respondent told us: *'I was hospitalised for five days in Stockholm. The only charge was for the ambulance to get me there (very modest charge) and medication after leaving the hospital.'*

Other respondents received free medical treatment but said that they had to pay for additional costs such as medication. A woman from the UK who broke her arm while travelling in Austria said *'I paid nothing at the time, but received a bill for the cost of the arm splint some weeks later when back home. All other treatment costs were free.'*

Another additional cost may be repatriation – the cost of returning home if the patient is unable to travel alone via scheduled airline service and needs a specialist air ambulance, medical equipment or a medical escort to travel with them.

Many survey respondents reiterated the importance of having travel insurance in place to cover additional costs, and advised checking what it covers in terms of medical emergencies. For example, does the policy cover treatment in private hospitals as well as state ones? Does it cover repatriation? Most standard travel insurance policies should cover this, under the medical emergency expenses section of the terms and conditions.

## 6.6 Problems experienced

Of those respondents who had received unplanned treatment abroad during the last five years 30% reported that they had experienced a problem. The most common problem was language and communication problems.

<b>Did you experience any of the following problems with your most recent unplanned treatment? (sample: 407)</b>	
Language/communication problems	13.5%
Long waiting times	6.9%
Inadequate/poor facilities	4.7%
Dispute about payment	3.7%
Difficulty travelling back to home country	3.7%
Poor quality of medical treatment	3.2%
Poor follow-up care while still abroad	2.7%

*Note: All experiences of unplanned treatment within the last five years.*

The second most common problem was long waiting times and the third most common was inadequate or poor facilities. The fourth most common problem experienced was dispute over payment, which could be with the national health insurer or travel insurance provider.

## 6.7 Complaints

If a consumer experiences problems with the quality of care of unplanned treatment, they may complain to the service provider directly, or the ECC in their country. If the matter concerns reimbursement the complaint should be directed to the institution responsible for paying. For example, the national healthcare insurer (if claiming via an EHIC card) or the travel insurer for costs claimed via a travel insurance policy. Of those who had experienced a problem with unplanned treatment, only a fraction of respondents made an official complaint. Those who did complain did so to:

- Their travel insurance provider (10.7%)
- Their GP when they got home (7.4%)

- The service provider (1.6%)
- The national healthcare insurer in my own country (0.8%)
- The ECC (0.8%)

However, 11.5% shared their negative experience with family and friends, and 2.5% posted negative feedback online. A UK male who experienced problems said, *'I complained to anyone prepared to listen - which was only fellow travellers.'*

Of those that complained to their travel insurance provider, satisfaction with the way it was dealt with, and the outcome, was low.

### **Case study: Dispute with travel insurer**

Dorothy, aged 71, from the UK was taken to hospital in Spain following a bicycle accident. She says, *'I broke my femur and finished up with total hip replacement.'* She was satisfied with the level of care, which was mainly covered by her EHIC card. However, she got into a dispute with her travel insurer as they *'kept refusing to pay out for a lot of things required, such as physiotherapy, medication and repatriation'* which Dorothy had to pay for out of her own pocket.

She complained to them directly but was very dissatisfied with the way it was handled and the outcome, so took them to the small claims court. She says: *'It wasn't until I had received judgement, in my favour, that they paid me the full amount within 24 hours. I was absolutely furious with them and determined to make them pay.'*

For those who did not make an official complaint at all, the four main reasons were:

- I didn't think my complaint would be successful (19%)
- I didn't know who to complain to (15.5%)
- It was too complicated/difficult (15.5%)
- I wasn't sure about my rights (6%)

Other reasons given for not complaining were that the matter was *'too trivial'*, or *'it was only a minor problem'*. One male respondent from the UK who had problems with language/communication said it wasn't *'appropriate'* to complain as *'it is down to me to speak the local language'*. Others said they were more concerned about the ongoing health problem than the complaint.



## 7. CONCLUSION & RECOMMENDATIONS

### 7.1 Overview

Legislation that gives EU citizens the right to access cross-border healthcare offers many potential benefits, but is not working effectively for consumers, according to our study. While access to unplanned treatment appears to be working relatively well, there is much work to be done to improve access to planned healthcare, to make this a viable option for EU consumers.

At present, the majority of EU consumers are unable to take advantage of planned healthcare abroad, should the need arise, as they have insufficient information about their cross-border rights and treatment options with which to make informed decisions about care. Improvement is needed at all stages of the patient journey.

To facilitate access, proactive steps need to be taken to raise awareness of cross-border healthcare rights and simplify the process. Prospective patients need clear, accurate information about healthcare options that allows them to compare healthcare providers, and choose the treatment that best suits their needs. When it comes to treatment, consumers need to have confidence that healthcare services meet minimum standards of quality and are delivered consistently. At the end of the patient journey, consumers who have experienced problems need clearer information about where to direct complaints, and a simplified complaints process to enable them to achieve satisfactory redress.

Addressing these issues, at all stages of the patient journey, would help to raise consumer confidence and trust, and unlock the potential benefits of cross-border healthcare.

### 7.2 Raise consumer awareness

Our study highlights an urgent need to raise awareness of consumer rights and entitlements related to cross-border healthcare. A lot of the information that consumers need – regarding rights, procedures and reimbursement – is held by NCPs, but our study suggests that low awareness of NCPs is preventing consumers from accessing the information they need to make informed choices about cross-border healthcare. NCPs are the gateway to accessing cross-border healthcare, so it is vital that prospective patients know of their existence, role and function.

It is not clear who is responsible for raising awareness of cross-border healthcare. The Directive requires NCPs to provide information 'on request', but there is no requirement to take proactive measures to raise awareness. The European Commission has extensive information available on its website, and has used social media to promote consumer rights in this area. The European Patient Forum (EPF) says that it has 'undertaken extensive awareness-raising among patient

communities across the EU'. However, it seems that information is not reaching everyone that may potentially need it.

Steps to raise consumer awareness should be led by the European Commission, while encouraging and empowering NCPs to be more proactive in their approach. Organisations that represent patients and consumers also have a role to play in raising awareness as they are in a key position to improve the quality of the information delivered to patients.

The key point is that raising awareness needs to be 'proactive', with organisations reaching out to consumers to signpost them to further information, for example through media campaigns, rather than 'passive' where information simply exists on a website. If consumers do not realise that they have rights, they will not go looking for information about those rights.

#### **Recommendations:**

- The European Commission should have a clear strategy to raise awareness of cross-border healthcare options and consumer rights, and to promote the existence of NCPs – with clear guidelines about role and responsibilities.
- Consumer and patient organisations to seek opportunities to raise awareness of all issues relate to cross-border healthcare, bearing in mind that many consumers bypass the Directive route and pay privately.
- Promotion should be 'proactive' rather than 'passive'.

### **7.3 Consistent standards for NCPs**

Individual NCPs are doing a good job, but our research highlights that NCPs across the EU operate very differently. Under the Cross-Border Healthcare Directive, NCPs must perform a particular role but there is a lack of consistent guidance on how they operate, which means that the system is fragmented.

Some countries have more than one NCP. Some are aligned with the national healthcare insurer, whereas others are separate organisations. Each NCP has different criteria for prior authorisation. They all require different documentation and have varying time limits for reimbursement. In addition to this, all NCPs appear to collect data differently. These factors combined can confuse prospective patients and make it difficult to compile consistent and comparable data which could be used to improve services. There is a clear need for more consistency, which could perhaps be facilitated by the creation of a central 'NCP-Net' (similar to ECC-Net, which coordinates European Consumer Centres in Europe).

#### **Recommendations:**

- Improve interoperability and communication between NCPs, with a central coordinating body.
- Develop a clear code of practice for NCPs with standard operational requirements to ensure consistency of procedures and data collection.

## 7.4 Empower consumers to make informed decisions

### 7.4.1 *Benefits of cross-border healthcare*

Our study suggests that EU consumers have some common misperceptions about cross-border healthcare, which have had a negative impact on confidence levels and may prevent patients from seeking planned medical treatment in other EU countries in future. For example, 29% of survey respondents expressed concerns about lower standards of healthcare in other EU countries, and 18% said that they would not feel confident in using healthcare services.

Our study shows that those who have received planned treatment abroad, generally have high levels of satisfaction with their treatment. Clearer information about patient satisfaction in these areas, and the benefits of cross-border healthcare, could help to break down common barriers to cross-border healthcare, and enhance consumer confidence and trust.

#### **Recommendation:**

- When promoting cross-border rights, organisations should also share information about the benefits of cross-border healthcare, patient satisfaction and successful outcomes.

### 7.4.2 *Information about service providers*

Prospective patients need information from reliable and independent sources, not just about cross-border rights and procedures, but about the quality of care that they can expect to receive from various healthcare providers in other Member States.

NCPs are limited to providing basic contact details of hospitals that provide the required treatment, but prospective cross-border patients should also be given the opportunity to compare healthcare service providers, in terms of treatment options, patient satisfaction, outcomes, quality and safety. An independent, central source of information would be invaluable to help prospective patients compare options and make informed decisions.

An independent certification scheme for EU healthcare providers, easily recognisable to consumers, would also help to boost confidence. A certification scheme could be based on a new CEN Healthcare Services standard (see **7.7.1**), which could offer guidance on good practice based on certain 'consumer criteria'.

#### **Recommendations:**

- Explore options for an independent central source of information about healthcare providers in the EU, that allows patients to compare options.
- Consider an EU-wide independent certification scheme for healthcare providers that meet good practice – in terms of information and quality of care.

### **7.4.3 Information from service providers about treatment**

Once prospective patients have chosen a healthcare service provider, they need information from that provider to ensure that they understand the details of the treatment, potential risks, medication and aftercare. Healthcare providers should be encouraged to follow good practice on information provision to patients. A horizontal CEN standard on 'Provision of Information' could act as a checklist of things to consider when communicating with patients, whether verbally or via published materials. However, if this is not specific enough, a standard covering all aspects of 'Healthcare Service' could include a section on information provision (see **7.7.1**).

Our study highlights that a common problem experienced by those receiving planned and unplanned cross-border healthcare was language and communication problems. Where possible, important documents need to be in the patient's language, or access to a medical interpreter provided - by telephone or in person - to ensure that patients fully understand all aspects of their treatment, including the risks.

#### **Recommendations:**

- Promote the use of ISO Guide 14 on the provision of information.
- Support a future CEN horizontal standard on 'provision of information' – ensure that this is adequate for use by healthcare providers, or consider a separate standard for this purpose.
- Encourage any moves to improve translation/interpreter services for consumer using essential services such as healthcare.

### **7.5 Insurance policies that are 'fit for purpose'**

Our study reveals that only a small proportion of cross-border patients currently seek reimbursement of costs from their national healthcare insurer via EU legislation, with many seeking to claim reimbursement from travel insurance (unplanned healthcare) and medical insurance (planned healthcare).

Our study highlights problems with the insurance claims process and satisfaction with complaints to insurance providers is low. Policy terms can vary, and consumers should be encouraged to look out for key information when comparing policies.

To offer better protection to consumers receiving cross-border healthcare, travel insurance should include adequate cover for repatriation and the additional expenses associated with unplanned medical care. Medical insurance should cover treatment that offers the patient the best care that meets their needs, regardless of which EU state it is in and whether it is carried out in a state hospital or private hospital. All insurance providers should be transparent about the limitations of their policies, so that consumers can make informed decisions in advance of purchase or travel.

### **Recommendation:**

- ANEC to input to any future policy or standards work related to travel or medical insurance, with a view to ensuring that it meets the needs of patients using cross-border healthcare services.

## **7.6 Equitable access to cross-border healthcare**

The aim of the Directive is to make cross-border healthcare accessible to all, but our study uncovered many obstacles, which could restrict choice and prevent equitable access. There is a risk that cross-border healthcare is only accessible to the wealthiest patients.

The complexity of the system makes it difficult for patients to access state-funded medical treatment in other EU countries. This, combined with low awareness of entitlement to reimbursement, appears to be pushing people down the private route. Our study shows that more than half of those who have received planned cross-border healthcare, paid for their treatment privately or claimed via private medical insurance.

The terms of reimbursement by national health insurers also create a barrier to those with limited funds. Many patients have to fund additional costs out of their own pocket, which can be expensive. The process requires many patients to pay some or all of the treatment costs upfront, and then wait for long or uncertain periods for reimbursement. These processes simply increase social inequalities and make cross-border healthcare even less accessible to those without adequate financial resources.

### **Recommendations:**

- Raise awareness of patients' rights to reimbursement for cross-border healthcare to ensure that everyone who needs care can consider this option.
- Remove upfront payment for cross-border healthcare.
- More effectively promote the uptake of Directive 2011/24/EU in national health policies.
- Ensure consistency of NCP operations by stipulating minimum requirements e.g. for time taken to deal with requests for reimbursement.

## **7.7 Consistent quality of care**

### **7.7.1 A single standard for healthcare service**

For cross-border healthcare to work effectively, consumers need to have confidence that all healthcare service providers meet minimum requirements for service quality. Developing a single European standard, that details good practice throughout the patient journey and focuses on common service elements, rather than clinical guidelines and medical procedures, could help to protect consumers,

prevent negative incidents and enhance consumer trust. A healthcare services standard could provide metrics for measuring quality in terms of patient satisfaction, treatment and outcome, which could be used by providers to ensure continual improvement, and help prospective patients to compare options. A European standard could benefit patients at a national level, but also facilitate cross-border healthcare by improving consistency and interoperability.

A certification scheme based on this standard (similar to that described in **section 7.3**) could help to increase consumer confidence and trust in healthcare services, and raise awareness of standards.

ANEC should support horizontal standards that may be applicable to healthcare, such as information provision, but bear in mind that these may not be specific enough to address the specific issues and problems highlighted in this study.

#### **Recommendations:**

- Cross-border aspect should be taken into account in all future CEN healthcare standards.
- Consider the development of a new standard for healthcare services detailing good practice at all stages of the 'patient journey', which could benefit consumers using both national and cross-border healthcare services.
- ANEC to contribute to work on a horizontal standard for information provision, or to consider developing standards specifically for healthcare services if these are not specific enough.

#### **7.7.2 Consumer needs in healthcare:**

A list of consumer needs in healthcare should be developed to help inform future standards and policy work in this area. As a starting point, these could be defined as, but not limited to:

- Knowledge and understanding of patient rights.
- Provision of clear information to enable informed decision making.
- Access to accurate, independent information about healthcare providers to aid choice.
- Equitable access to the right services at the right time.
- Transparency of costs, risks and other implications.
- Competence of practitioners – with appropriate levels of knowledge, experience and skill.
- Adequate procedures for the effective transfer of knowledge.
- Privacy and security of personal information.
- Safety of equipment and service environment.
- Quality of service.
- Accessible and effective mechanisms for complaints-handling and redress.

**Recommendation:**

- ANEC to develop a list of common consumer needs in healthcare, aligned with the key consumer principles, and promote these throughout its future policy and standards work.

### **7.7.3 Improve privacy and security of patient data**

Digital technology is increasingly being used in healthcare services. According to a 2017 EU consultation on Digital Health, a key concern for patients is the privacy and security of medical records. Privacy and security are also key consumer principles that form the foundation of ANEC's work. Some standards already exist to deal with these issues. For example, ISO standards on privacy and healthcare informatics (see **Annex 4**). The General Data Protection Regulation (GDPR) could strengthen consumer protection in this area and help to raise confidence.

**Recommendations:**

- ANEC to keep a watching brief on standards and policy work related to eHealth, including implementation of the GDPR.
- Consider development of standards for management of electronic data and medical records in healthcare.
- Consider development of health-related cybersecurity standards.

### **7.7.4 Focus on person-centred care**

Our study shows that overall satisfaction with the quality of care is good. But it is clear that there are inconsistencies between Member States in terms of medical facilities, standards of care and how the Cross-Border Healthcare Directive is implemented. Quality and consistency of care is of paramount importance to patients, regardless of where they live or choose to have treatment. A focus on person-centered care, informed by organisations that represent consumers, could lead to improvements.

**Recommendations:**

- Continue ANEC involvement in new standard on Patient-Centred Care.
- Encourage concept of patient-centred care in ongoing policy and standards work related to health.

## **7.8 Tangible mechanisms for redress**

Our study shows that a key barrier to the use of cross-border healthcare services is uncertainty about what to do if things go wrong, and those who have experienced problems are extremely unlikely to complain. It is vital that all healthcare service providers have clear, documented processes for patient complaints to allow swift resolution of any problems and to help with continual improvement, which could be based on ISO 10002 on complaints handling.

When it comes to further complaints and dispute resolution, the system is complex and fragmented and it is extremely unclear where consumers should go in the event of a problem. Consumers who have been unable to resolve problems with the service provider face a confusing array of options, mostly at a national level, depending on the nature of the problem, how they paid for treatment and where it was delivered. There is no one central source, at a European level, collecting complaints, which has led to a lack of empirical evidence about the quantity and nature of complaints that could enable comparative analysis to help drive improvements.

EU consumers receiving medical treatment in other Member States need clear information about who to complain to, and under what circumstances. Ideally the choices need to be simplified, to minimise confusion, with more options for dispute resolution at a European level, rather than a fragmented and complex system of national healthcare institutions and ombudsmen. While complaints are dealt with by multiple organisations, there is a need for improved collaboration between those that collect complaints data, which is essential for industry and governments, as well as consumer and public interest organisations, to understand the current situation and focus improvements in the areas where it is needed the most.

#### **Recommendations:**

- Promote take up of existing ISO complaints-handling standards to facilitate complaints which are made directly to the service provider.
- Raise patient awareness of complaint handling/dispute resolution options.
- Create a central hub for complaints at a European level to simplify access for consumers and make it easier to analyse complaints data.
- Improve collaboration between different organisations dealing with cross-border healthcare complaints to aid analysis of complaints.



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## ANNEX 1: PARTNER ORGANISATIONS

Country	Organisations
<b>Austria</b>	<ul style="list-style-type: none"> <li>• Austria ECC</li> </ul>
<b>Belgium</b>	<ul style="list-style-type: none"> <li>• Belgium ECC</li> <li>• ANEC</li> </ul>
<b>Cyprus</b>	<ul style="list-style-type: none"> <li>• Cyprus ECC</li> <li>• Cyprus Consumers' Association</li> </ul>
<b>Czech Republic</b>	<ul style="list-style-type: none"> <li>• D-TEST</li> <li>• Czech Republic ECC</li> </ul>
<b>Finland</b>	<ul style="list-style-type: none"> <li>• Finnish NCP</li> <li>• Finland ECC</li> </ul>
<b>France</b>	<ul style="list-style-type: none"> <li>• Institut National de la Consommation (INC)</li> <li>• Association Leo Lagrange pour la Défense des Consommateurs (ALLDC)</li> <li>• AFNOR</li> </ul>
<b>Germany</b>	<ul style="list-style-type: none"> <li>• DIN-Consumer Council</li> <li>• Stiftung Warentest</li> </ul>
<b>Greece</b>	<ul style="list-style-type: none"> <li>• Greece ECC</li> <li>• NEW INKA</li> <li>• EKPIZO</li> <li>• KEPKA</li> </ul>
<b>Iceland</b>	<ul style="list-style-type: none"> <li>• Iceland ECC</li> </ul>
<b>Italy</b>	<ul style="list-style-type: none"> <li>• Italy ECC</li> </ul>
<b>Luxembourg</b>	<ul style="list-style-type: none"> <li>• Luxembourg ECC</li> </ul>
<b>Romania</b>	<ul style="list-style-type: none"> <li>• PNC</li> <li>• Romania ECC</li> </ul>
<b>Slovenia</b>	<ul style="list-style-type: none"> <li>• Zveza Potrošnikov Slovenije (ZPS)</li> </ul>
<b>Sweden</b>	<ul style="list-style-type: none"> <li>• Sveriges Konsumenter</li> <li>• Sweden ECC</li> <li>• Konsument Verket</li> </ul>
<b>United Kingdom</b>	<ul style="list-style-type: none"> <li>• Which?</li> <li>• Telehealth Quality Group</li> </ul>

## ANNEX 2: SURVEY DEMOGRAPHICS

### Q. Are you...?

Gender	Sample size	% of total
Male	978	59%
Female	663	40%
Prefer not to say	15	1%
<b>Total</b>	<b>1656</b>	<b>100%</b>

### Q. Which age range do you fall into?

Age	Sample size	% of total
<18	1	0%
18-24	12	1%
25-34	117	7%
35-44	141	9%
45-54	183	11%
55-64	347	21%
65-74	623	38%
75+	232	14%
<b>Total</b>	<b>1656</b>	<b>100%</b>

### Q. Do you consider yourself to have a disability?

Disability	Sample size	% of total
Yes	226	14%
No	1406	85%
Prefer not to say	24	1%
<b>Total</b>	<b>1656</b>	<b>100%</b>

<b>Country of residence</b>	<b>Sample size</b>	<b>% of total</b>
United Kingdom	1001	60%
Czech Republic	294	18%
Greece	142	9%
Slovenia	60	4%
France	35	2%
Germany	32	2%
Sweden	15	1%
Belgium	9	1%
Spain	8	0%
Ireland	7	0%
Italy	7	0%
Finland	6	0%
Estonia	5	0%
Austria	4	0%
Republic of Cyprus	4	0%
Netherlands	3	0%
Slovakia	3	0%
Turkey	3	0%
Bulgaria	2	0%
Malta	2	0%
Denmark	1	0%
Hungary	1	0%
Latvia	1	0%
Luxembourg	1	0%
Macedonia	1	0%
Norway	1	0%

Portugal	1	0%
Romania	1	0%
Switzerland	1	0%
<b>Total</b>	<b>1656</b>	<b>100%</b>

## ANNEX 3: CROSS-BORDER RULES

	<b>Cross-border healthcare directive (2011/24/EU)</b>	<b>S2 social security (EU Regulation 883/2004)</b>
<b>Prior authorisation</b>	Member States can require patients to seek prior authorisation for certain treatments.	Patients must get prior authorisation for treatment. If granted, they'll get an S2 application form.
<b>Where does it apply?</b>	All EU-28 countries, plus Iceland, Liechtenstein and Norway.	All EU-28 countries, plus Iceland, Liechtenstein, Norway and Switzerland
<b>What can be reimbursed?</b>	The same level of reimbursement as if the treatment would have been received in the patient's home country. However, the level of reimbursement can never exceed the actual costs of the healthcare received.	Treatment will be provided under the same conditions of care and payment as to nationals of that country.
<b>Type of healthcare covered</b>	State-funded or private treatment. However, some countries may restrict access to certain types of healthcare.	State providers only
<b>Additional costs (e.g. travel)</b>	Not covered	Not covered
<b>Payment</b>	In most cases patients will have to pay the costs upfront. They can then make a claim for reimbursement when they return home, up to the amount the treatment would have cost from their national healthcare institution at home.	In most cases, patients will not have to pay upfront as their national health insurer will deal directly with the hospital in the country of treatment. However, the patient may have to pay up front, then claim reimbursement, if this is usual practice in the treatment country.

## ANNEX 4: HEALTHCARE STANDARDS

European and international standards which may be relevant to EU consumers using cross-border healthcare services.

<b>International standards</b>	
ISO 17090-1: 2013	Health informatics- Public key infrastructure - Part 1: Overview of digital certificate services
ISO 21091: 2013	Health informatics - Directory services for healthcare providers, subjects of care and other entities
ISO 14441: 2013	Health informatics - Security and privacy requirements of EHR systems for use in conformity assessment
ISO 10002:2014	Quality management -Customer satisfaction - Guidelines for complaints handling in organizations
ISO/IEC 27001:2013	Information technology — Security techniques — Information security management systems - Requirements
ISO/IEC 27002:2013	Information technology — Security techniques — Code of practice for information security controls

<b>European standards</b>	
EN 15224:2012	Health care services. Quality management systems. Requirements based on EN ISO 9001:2008
EN 16372:2013	Aesthetic surgery and aesthetic non-surgical medical services
CEN/TR 15592: 2007	Health services. Quality management systems. Guide for the use of EN ISO 9004 in health services for performance improvement
EN 16224: 2012+A1:2014	Health care provision by chiropractors
EN 16844:2017	Aesthetic medicine services – Non - surgical medical treatment
EN 16686: 2015	Osteopathic healthcare provision
CWA 16642	Healthcare services – Quality criteria for health checks
In development by CEN TC 449	Quality of care for elderly people in ordinary and residential care facilities
In development by CEN TC 450	Minimum requirements of patient involvement in person - centred care

Further information about existing healthcare standards, and those in development, can be found at: [www.cen.eu](http://www.cen.eu) and [www.iso.org](http://www.iso.org).