

CEL 30 (2010)

20 August 2010

Dear Colleague

## **CROSS-BORDER HEALTHCARE AND PATIENT MOBILITY: ADVICE ON HANDLING REQUESTS FROM PATIENTS FOR TREATMENT IN COUNTRIES OF THE EUROPEAN ECONOMIC AREA**

1. This letter introduces the above-named guidance, and the Regulations that it underpins. It is primarily aimed at NHS health commissioners who have responsibility for considering requests from patients who wish to exercise their rights to travel to other countries in the European Economic Area (EEA) for treatment under Article 56 of the Treaty of the Functioning of the European Union. Article 56 does not apply internally - the UK as a whole is the EU Member State and member of the EEA.

### **Background**

2. You will recall that at the end of April 2010 I sought comments on the draft guidance and the draft National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010, which came into force on 7 July 2010 and can be accessed from the following link:

[http://www.opsi.gov.uk/legislation/scotland/ssi2010/ssi\\_20100283\\_en\\_1](http://www.opsi.gov.uk/legislation/scotland/ssi2010/ssi_20100283_en_1)

3. I am grateful to everyone who responded to the engagement exercise. As far as possible, we have tried to encompass your views and comments in the guidance, bearing in mind that this and the Regulations are an interim measure and that we do not want to second guess the content of the proposed cross-border healthcare directive which will, in time, bring greater certainty to the rules surrounding patient mobility.

### **Issues**

4. A number of respondents were concerned about reimbursement and that the level of repayments should be uniform across Scotland. NHS Boards may use the tariffs established by the Scottish National Tariff Project, or local costings if available, in calculating reimbursement for Scottish patients who have chosen to receive treatment in another part of the EEA under the Article 56 arrangements, or in charging patients from other EEA countries who wish to receive treatment in Scotland under Article 56. The tariffs can be accessed at: <http://www.isdscotland.org/isd/3551.html>.

The calculated cost of reimbursement can be actual or average.

### **Addresses**

For action or information as necessary

NHS Board Chief  
Executives  
Finance Directors  
Medical / Clinical Directors  
Nursing Directors  
Overseas Visitors  
Managers  
Primary Care  
Administrators  
Medical Practitioners  
General Dental  
Practitioners

### **Enquiries to:**

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The guiding principle is that the method of calculation must be objective and transparent.

5. The majority of people in Scotland wish to receive quality medical treatment and services as close to home as possible. A recent trawl of NHS Boards indicated that since 2006, when the European case-law was established, only 3 patients have exercised their rights to travel to another EEA country to receive treatment under the Article 56 arrangements and only 2 patients have come to Scotland for treatment under Article 56.

6. Nevertheless, as Scots (and other EU citizens) become more knowledgeable about the Article 56 route, not least because of the proposals for a cross-border healthcare directive, we must ensure that we have the procedures in place so that they can use Article 56 to receive treatment in another part of the EEA if they wish, and that this does not have an adverse impact on the way that we plan or deliver NHS treatment and services in Scotland.

**7. I would, therefore, remind you of the need to record the number of patients (and other necessary information as set out in Section 6.3 of the guidance) who use the Article 56 route to receive treatment in another EEA country or who come to Scotland for this purpose. The Cabinet Secretary for Health and Wellbeing confirmed that we had started to do so when she appeared before the Health and Sport Committee to move the motion that the Committee agreed to the introduction of the Reimbursement of the Cost of EEA Treatment Regulations on 23 June 2010.**

8. We plan to place information with regard to using the European Health Insurance Card; E112 scheme and Article 56 route on the NHS Inform website. NHS Boards should consider how they can make information about accessing healthcare in the EEA more readily available to the public.

#### **Further Information**

9. This is not new. Interim guidance was issued to NHS Scotland in 2007 following the *Watts* determination (included as an Annex to the guidance). It is, however, evident that NHS Boards still need to develop procedures for handling Article 56 enquiries, including prior authorisation and reimbursement arrangements.

10. As a number of respondents have acknowledged, the guidance cannot, and does not attempt to, address all the scenarios that may arise. Rather, it sets out the main criteria that should be considered and underpins the National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010. Together the Regulations and Guidance provide a framework for handling Article 56 cases, which will need to be considered on an individual basis as appropriate handling arrangements are developed over time.

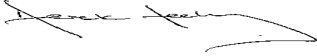
**11. I will write to you again in 6 months time to assess the progress that NHS Boards have made in putting the necessary arrangements in place, as set out in the guidance, to deal with Article 56 applications in compliance with the European case-law. We are also in the process of establishing a European Healthcare Working Group and I will write to you about that in due course.**

12. Enquiries should be directed to John Brunton, European Healthcare Policy Manager in the Scottish Government's Patient Support and Participation Division:

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Yours sincerely



DEREK FEELEY



**THE NATIONAL HEALTH SERVICE (REIMBURSEMENT OF THE COST OF  
EEA TREATMENT) (SCOTLAND) REGULATIONS 2010**

# **CROSS BORDER HEALTHCARE & PATIENT MOBILITY**

Advice on Handling Requests from Patients for  
Treatment in Countries of the European Economic Area

## **GUIDANCE FOR NHS SCOTLAND**

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# Cross Border Healthcare & Patient Mobility

## 1. Introduction

1.1 The purpose of this guidance is to help local health commissioners in NHS Boards to handle requests from the public to go to other European Economic Area<sup>1</sup> countries, under the freedom to provide services provisions of Article 49\* of the EU Treaty, for treatment to which they are entitled to under the NHS. (\* this Article is now numbered Article 56 under the Treaty on the Functioning of the European Union - "TFEU" - and referred to as such hereafter).

1.2 The guidance accompanies the National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010. The Regulations set out the obligations of NHS Boards in Scotland in relation to claims for reimbursement of treatment costs. In some cases applications from patients will be necessary to obtain prior authorisation from the NHS Board for the receipt of health care in another EEA State. It also provides guidance about the exercise of those functions by NHS Boards. There is also some information for NHS providers who may receive requests from overseas patients for treatment in Scotland.

1.3 This updated guidance should be read in conjunction with the interim guidance that was prepared for the NHS in 2007<sup>2</sup>, following the 2006 *Watts*<sup>3</sup> judgment given by the European Court of Justice (ECJ).

1.4 In this guidance treatment / healthcare means all health services provided by health professionals to patients to assess, maintain or restore their state of health. It does not apply to services whose primary purpose is to support people in need of assistance in carrying out routine, everyday tasks. More specifically it does not apply to long-term care services.

## 2. The E112 and Article 56 routes for receiving services in another EEA state

2.1 There are currently two potential routes for patients to receive planned care in another Member State at the expense of the NHS:

(a) The long-established route under Articles 20 and 27(3) of Regulation (EC) 883/2004 (which co-ordinates the social security systems of Member States) whereby the Secretary of State issues to a patient a form E112 ("**the E112 Route**") and,

(b) Article 56 of the TFEU and the freedom to provide services ("**the Article 56 Route**").

2.2 This guidance is concerned primarily with the Article 56 route and existing European Court case law (not proposals for a Cross-border Directive referred to later). However, it will assist NHS Boards to be aware of the differences between the two routes.

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<sup>1</sup> The Member States of the European Union plus Iceland, Liechtenstein and Norway

<sup>2</sup> "Patient mobility – Advice to local healthcare commissioners on handling requests for hospital care in other European countries following the ECJ's Judgement in the Watts case.

<sup>3</sup> Case C- 372/04 *The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust and the Secretary of State for Health*[2006] ECR I-4325 ("The Watts Judgement")

2.3 The key difference between the two routes is that the E112 route relates only to state-provided treatment and costs are dealt with directly between Member States, which have discretion to authorise planned treatment in another Member State. However, where treatment cannot be provided by the NHS within a time that is medically acceptable, based upon clinical assessment, authorisation must be given. An NHS Board will decide whether to authorise treatment, based upon:

- A clinical assessment of the patient's specific needs;
- Agreement that the health commissioner will fund the cost of treatment;
- Confirmation that the treatment is not experimental or a drug trial;
- That the treatment is available under the other country's state health scheme, and
- That the patient is entitled to treatment under the NHS.

2.4 Based on the NHS Board's decision, the Department of Health, who administer the E112 Scheme, will normally approve the issue of an E112 form.

2.5 Under the Article 56 route, patients can seek any health care service (including private care) in another Member State that is the same as, or equivalent to, a service that would have been provided to the patient under the patient's home healthcare system. The patient has a right to claim reimbursement up to the amount that the same, or equivalent, treatment would cost had the patient obtained that treatment from their home healthcare system - or the actual amount where this is lower. The patient can receive treatment in the state-provided sector or they can access services in the private sector. **A major difference from the E112 route, which does not cover private sector treatment.**

2.6 The principle of reimbursement assumes that patients will pay the overseas provider at the time of their treatment and then claim reimbursement from their NHS Board. It is possible to limit the amount that may be reimbursed to the cost of the same or equivalent NHS treatment. The patient will also bear the financial risk of any additional costs arising.

2.7 Except where legislation requires prior authorisation, a patient may obtain care in another EEA State without authorisation by their NHS Board. **Whereas under the E112 route, all care must be authorised in advance.**

### 3. The history of cross-border health care

3.1 Until quite recently (i.e. a decade ago), there was little discussion of the issue of patient mobility at a European level. The UK and some other Member States with similar health systems argued, until the *Watts* case, that EU Treaty law did not apply to NHS-style systems. It was also thought that sufficient arrangements existed for those people who wanted to travel for treatment - through the E112 arrangements for planned care under Regulation (EC) 883/2004 or through the emergency care arrangements under the E111 (now the European Health Insurance Card - EHIC).

3.2 This situation has changed and the extent of mobility within Europe has increased markedly over the last decade. This includes an increasing number of citizens who work in or retire to a different country and wish to use the health care system of the country where they are living. There are also more patients who are choosing to cross a border specifically to receive healthcare.

3.3 This new generation of Europeans, accustomed to crossing borders with ease and able to purchase goods and services from any part of the European Union, are proving less willing to accept constraints on where their healthcare may be obtained. This is often due to perceived advantages relating to quality or favourable cost, the availability of different treatments or where patients have close cultural, family or linguistic links in another country.

3.4 A consequence of this trend has been a number of individuals challenging the status quo, and numerous ECJ judgments over the years have clarified that even though Member States are responsible for organising and delivering health services within their territory, the free circulation of goods, freedom to obtain services and movement of persons within the wider European Community can also apply to healthcare services.

3.5 Currently, the numbers of people travelling overseas for state-sponsored treatment are low - e.g. to date, about 1000 people travel each year from the UK as a whole under the E112 route. Although case law from the European Court has demonstrated that individuals can, and do, exercise rights under Article 56 of the TFEU, a recent trawl of NHS Boards has confirmed that only 3 patients from Scotland have used the Article 56 route since the Watts determination in 2006 and only 2 patients have received treatment under Article 56 in Scotland. Nevertheless, it is essential that patient mobility is managed in a sustainable manner and that mechanisms are put in place to allow patients to exercise their rights under Article 56 if they wish to do so.

### ***Cross-border Healthcare Directive***

3.6 In July 2008, the European Commission published a draft Directive on the application of patients' rights in cross-border healthcare. This draft legislation seeks to codify existing ECJ case law on patients' rights in accessing cross-border healthcare and to clarify its application.

3.7 The draft Directive aims to set out a legal framework for patients seeking access to healthcare in another EEA Member State. The broad outline of the Commission's proposal is that in cases of patients accessing cross-border care, the 'home' state has responsibility for deciding what healthcare it will fund and for setting up a system of cost reimbursement to patients. The patient will then be entitled to a reimbursement of their costs, up to the amount the home state would have paid to treat that person at home. Where a patient is treated in another Member State, that country's legislation and standards apply - this includes the arrangements for negligence or redress, should anything go wrong. The draft Directive does not alter the right of Member States to define the benefits that they choose to provide.

3.8 The detail of the draft Directive is subject to ongoing negotiations between Member States and with the European Parliament, but it is likely to be agreed and adopted in the not too distant future. However, the case law that the Directive seeks to codify and clarify applies now. Therefore, NHS Boards and particularly health commissioners should already be mindful of the need to have procedures in place to respond promptly and appropriately to requests on patient mobility issues.

### ***The National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010***

3.9 Scottish Ministers have accordingly made the National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010 ("the 2010 Regulations") which came into force on 7 July 2010.

These Regulations amend the NHS (Scotland) Act 1978 by inserting new sections 75B, 75C and 75D to clarify the obligations of NHS Boards with regard to the authorisation and reimbursement aspects of patient mobility and cross-border healthcare. The 2010 Regulations are available at:

[http://www.opsi.gov.uk/legislation/scotland/ssi2010/ssi\\_20100283\\_en\\_1](http://www.opsi.gov.uk/legislation/scotland/ssi2010/ssi_20100283_en_1)

3.10 Bearing in mind that a perceived failure to act in accordance with European law may result in infraction proceedings (as well as Judicial Review in domestic courts), the 2010 Regulations and this guidance seeks to provide greater clarity about how the NHS can apply the European case law.

## **4. New sections 75B, 75C and 75D of the NHS (Scotland) Act 1978**

4.1 In complying with European law it is important that the correct legal basis exists in domestic legislation to support the NHS in Scotland for its decisions on issues such as prior authorisation and reimbursement of patients' costs.

4.2 New sections 75B, 75C and 75D of the National Health Service (Scotland) Act 1978 (as inserted into that Act by the 2010 Regulations):

- Provide for the reimbursement by NHS Boards of the costs of health services provided in another EEA State by a provider lawfully providing services in that State;
- Lay down the conditions that must be met before an NHS Board is required to reimburse the patient;
- Limit the amount of the reimbursement to what it would have cost if the service had been provided under the NHS;
- Provide for the deduction of applicable NHS charges;
- Provide a mechanism for prior authorisation by the Health Board when patients wish to receive specified services in another EEA country, and set out the circumstance in which prior authorisation must be given to a patient.

4.3 These measures will not remove all scope for challenge - patients will retain the right to challenge health commissioners' decisions by way of judicial review in the domestic courts and/or to submit a complaint to the European Commission. The legislation and this guidance are likely to be further updated in light of a final Cross-border Healthcare Directive.

## **5. Handling Article 56 requests**

### **General principles**

5.1 In general, UK residents who are entitled to NHS services can seek treatment in another EEA State under the provisions of Article 56 of the TFEU and can claim reimbursement of the cost of that treatment (This arrangement does not apply internally in the UK, which is the member of the EEA and Member State). Where this happens, the law of the country of treatment will apply. It is the patient's responsibility to be clear on who in the Member State of treatment is accountable for assuring their safety throughout the course of their treatment.

5.2 In some cases, in order to be eligible for reimbursement, prior authorisation may be required before a patient accesses treatment in another EEA State. The process of prior authorisation, where this is applied, is the mechanism by which individual patients can get clarity about a range of matters relating to patient care.

This includes confirmation that the treatment is one the NHS offers (i.e. the patient would be entitled to reimbursement and the level of such reimbursement), what elements of the care pathway are being funded; continuing care arrangements back in the UK; what the patient must do if there is a problem with the treatment they receive, etc.

5.3 There are a range of other issues that patients will need to be aware of when seeking treatment abroad - e.g. there may not be the same standards of care; there may not be the same styles of treatment or of aftercare; and there may be language barriers to negotiate.

5.4 The granting of prior authorisation by the NHS for treatment overseas is an acknowledgement of the patient's right to access treatment in another country - **it is not a process for referring patients to providers in other countries**. Patients need to be aware that prior authorisation does not imply clinical approval of a patient's planned healthcare in another Member State, nor does it imply acceptance of any responsibility for that treatment. No duty of care attaches to the authorisation by the home Member State.

### ***Travel Insurance***

5.5 These general principles help highlight the need for commissioners to remind anyone seeking medical treatment in another country to ensure that they have comprehensive medical insurance for their trip.

5.6 We know, from evidence of patient mobility in other areas that a large number of people choose not to bother with medical or travel insurance at all - preferring to "take the chance" or rely on the EHIC. Those that do often believe that insurance for medical treatment is something that is covered as part of normal travel insurance policies - but this is very often not the case. Regular travel insurance does not routinely cover people going abroad specifically for medical treatment, just as many policies will automatically exclude cover for any pre-existing condition and may not include repatriation costs.

5.7 However, with the increased interest in patient mobility in recent years there are signs that the travel insurance market is diversifying. A number of specialist, "niche" insurance providers have entered the patient mobility market willing to work out packages of cover for individual patients, enabling them to travel for medical treatment safe in the knowledge that they and any travelling companions are covered. It is in the patient's interest to ensure they have the appropriate cover for their trip and health commissioners should play their part in reminding people of this when the opportunity arises.

5.8 **The cost of travel insurance is not reimbursable by the NHS.**

## **6. Reimbursement**

6.1 The principle of reimbursement under the Article 56 route assumes that patients will pay the overseas provider directly for the treatment they receive. They will then seek reimbursement from their NHS Board.

6.2 In cases which do not require prior authorisation, an applicant is only entitled to reimbursement for treatment where the treatment:

- (a) Was necessary to treat or diagnose a medical condition of the patient;

- (b) Is the same as or equivalent to a service that the Health Board in whose area the applicant lives would make or have made available to the patient under the NHS (Scotland) Act 1978 in the circumstances of the patient's case; and
- (c) Is not a "specified service" (for which prior authorisation is required).

6.3 NHS Boards should establish and publish their procedures for handling claims for reimbursement under Article 56. It is envisaged that, as a minimum, NHS Boards will need to obtain the following information with regard to the patient:

- The patient's name and contact details;
- The patient's date of birth and gender;
- Information or a declaration to show that the applicant did not incur the costs of treatment in the course of business;
- The treatment or service the patient has received;
- The name and address of the provider that provided the treatment or service and the location at which the treatment or service was provided, if different;
- Details of any prior authorisation that has been granted in relation to the treatment or service;
- If no prior authorisation had been granted, evidence that the service was clinically necessary to treat or diagnose the patient;
- Details of the cost of treatment and proof of payment by the applicant.

6.4 The person who applies for reimbursement of costs incurred does not have to be the patient - it may be another person such as a close relative or friend who has paid for the medical treatment - although the claimant must provide evidence of their relationship to the patient to the NHS Board's satisfaction. **There is no duty to reimburse a person who has incurred the costs under an arrangement in the course of business for any financial benefit.**

## 7. Prior authorisation

### Introduction

7.1 The European Court has held on several occasions that a system of prior authorisation for the receipt of health services in another Member State is a restriction on the fundamental freedom of EU citizens to move across the Community and receive services, **but that this can be justified in certain circumstances.** Specifically, the ECJ has reached the view that prior authorisation for hospital care (which it has not defined) is justified - the court has also said it has not to date seen the evidence to justify this for "non-hospital care".

**Paragraph 113 of Watts judgement:** "...Community law, in particular Article 49 EC, does not therefore preclude the right of a patient to receive hospital treatment in another Member State at the expense of the system with which he is registered from being subject to prior authorisation".

7.2 The *Watts* judgement and earlier case law from the European Court was also clear that arrangements for matters such as prior authorisation and limits to reimbursement of costs must, to be justified, be based on transparent, objective and non-discriminatory criteria which are known in advance and not used arbitrarily. Prior authorisation must be based on a procedural system which is easily accessible and capable of ensuring that a patient's request for treatment in another EEA country is dealt with objectively and impartially within a reasonable time - and that any refusal of authorisation must be capable of being challenged.

7.3 In the vast majority of cases, hospital treatment required by patients in Scotland is available on the NHS, but that in itself is not a sufficient reason to refuse requests from patients for treatment elsewhere in the EEA. However, patients seeking hospital care in another EEA State should contact their local NHS commissioner in advance of travelling to discuss whether prior authorisation is required and what levels of cost reimbursement will apply. This should happen before the patient accesses treatment in another EEA State (although retrospective applications may also be considered). This will enable the patient to confirm that they are entitled to the treatment requested, as well as the level of reimbursement that will apply. It will also allow health commissioners to ensure that patients are aware of all of the possible treatment options within the NHS. Nevertheless, although a health commissioner may offer such alternatives, they cannot insist that a patient must accept them.

### **“Specified services”**

7.4 In the absence of any clear European Court of Justice definition on the limitations of “hospital” as opposed to “non-hospital” care, there is a need to develop a sensible view about how these artificial distinctions might work in practice.

For example, the Scottish Government considers that it would be anomalous to insist that a patient seeks prior authorisation for relatively straightforward treatments that require an overnight stay in hospital, whilst not requiring the same level of prior scrutiny for more costly and specialised services (e.g. PET scans, specialist radiography services etc) simply because service delivery advancements have determined that these may, in some cases, be delivered in a primary care setting or in the community.

7.5 Therefore, in the Regulations and for the purposes of this guidance, hospital care for which authorisation will be required by the patient, prior to treatment being undertaken is termed as **“specified services”**. This includes:

- (a) A service that involves a stay in hospital accommodation for at least one night;
- (b) Medical treatment that involves general anaesthesia, epidural anaesthesia or intravenously administered sedation;
- (c) Dental treatment that involves general anaesthesia or intravenously administered sedation; or
- (d) A service whose provision involves the use of specialised or cost-intensive medical infrastructure or medical equipment.

### ***Arrangements in respect of non-hospital care/services not defined as “specified services”***

7.6 Patients seeking treatments that comprise services which are the same as equivalent to services made available by their Health Board and which do **not** fall within the scope of “specified services” do not need prior authorisation from their local NHS commissioner before travelling. However, they are strongly advised to discuss their plans with the health commissioner in advance, to ensure that they are entitled to the required treatment under the NHS. Otherwise, patients may discover after treatment that they have obtained a service that they are not entitled to from their NHS Board in Scotland and will not receive reimbursement.

7.7 In relation to dental treatment, patients should be strongly encouraged to provide the health commissioner with full details of the individual components of the proposed treatment before they travel since a number of dental treatments, such as implants, are not available under general dental services and the health commissioner (the NHS Board) may limit the amount payable by way of reimbursement to the amount that would have been payable (via the Statement of Dental Remuneration) in respect of general dental services (i.e. “equivalent services”). Additionally, if the dental treatment the patient receives abroad would have required the prior approval of the Scottish Dental Practice Board if provided under general dental services, on the patient’s return to Scotland, the Health Board may require the patient to submit evidence as to the clinical necessity of the dental services received and may decline to reimburse the eligible person in respect of the costs of any services which were not clinically necessary.

## **8. The application process**

### **Stage 1 - Determining eligibility for NHS services**

8.1 NHS eligibility is based on whether or not a patient can demonstrate that he or she meets the test of ‘ordinary residence’ in the UK (although there are rights conferred by Regulation 883/2004 on non-UK residents who meet the relevant requirements). Those that cannot are subject to the NHS (Charges to Overseas Visitors (Scotland) Regulations 1989, as amended; are considered overseas visitors when in Scotland; and are liable for NHS hospital treatment charges unless an exemption category, listed within the regulations, applies.

#### ***What to do if a patient is residing overseas***

8.2 Under Regulation 883/2004, the UK already reimburses other Member States for the healthcare costs of British pensioners living and registered there. Similar arrangements apply to people working abroad. In normal circumstances, pensioners in this situation are already receiving health care within the system of the other Member State as if they were a citizen of that country and therefore requests for treatment under Article 56 in these circumstances should, in the first instance, be addressed to the relevant authority in their Member State of residence.

8.3 Some people may still meet the ordinary residence test for NHS hospital treatment if they spend time out of the UK. In such cases, commissioners should cross-refer to The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989<sup>4</sup>, as amended. Where people retain entitlement to NHS services, they may be eligible for reimbursement under Article 56, if the NHS would normally fund the treatment and the patient has a clinical need.

### **Stage 2 - The role of gate-keeping; determining clinical need and NHS entitlements**

8.4 Gate-keeping by healthcare professionals for access to secondary care is an important element of the NHS’ overall structure in determining access and entitlements to treatment. It helps direct patients to the appropriate service for diagnosis or treatment.

8.5 Gate-keeping arrangements may be applied to all patients who wish to access treatment under Article 56, including those who may already be in another Member State. This is in order to ensure that the patient has a clinical need for treatment.

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<sup>4</sup> S.I. 1989 No. 364 (S.40), The Stationary Office

It also helps to ensure that those patients are only able to access services which they would be entitled to receive under the NHS. Without it, there is a possibility that patients may opt for treatment in another Member State that is not available through the NHS, and for which they will not receive reimbursement.

8.6 Health commissioners should ensure that they have systems in place for determining and confirming entitlements for patients seeking treatment in another Member State. In particular, they will need to ensure arrangements for patients who are already outside the country to be able to contact them to confirm their entitlements. For non-hospital care, this might be done through specific telephone numbers for patients to contact the health commissioner or through email or other electronic media.

8.7 For hospital care, the health commissioner may insist that the patient returns to the UK for confirmation of their entitlement before treatment is authorised and given, in line with the requirement in the accompanying Regulations that prior authorisation is sought before treatment is provided.

### **Stage 3 - Applying to the health commissioner for “prior authorisation”**

8.8 A patient wishing to go to another EEA Member State to access treatments designated as “**specified services**” under the Article 56 route would need to apply to the local NHS commissioner for prior authorisation to do so. In addition, a patient may apply for prior authorisation for services that are not the same or equivalent to those offered by the Health Board. It is envisaged that as a minimum the NHS Board will need to obtain the following information:

- The treatment or service the patient requires;
- Whether or not an NHS or overseas health professional (and what type of professional) has confirmed their need for this treatment, and the name and address of that professional;
- What kind of treatment they propose to access overseas;
- Where and at what facility;
- How much the treatment is likely to cost as estimated by the overseas provider.

8.9 In turn, the NHS commissioner will need to provide patients with the appropriate clarity as to:

- Where patients should apply to for prior authorisation;
- How long the process will take;
- What factors will be taken into account in arriving at the decision whether to grant or refuse authorisation;
- What patients can do if they are unhappy with the outcome - i.e. what the appeals/review process is, and what timescales apply.

8.10 Health commissioners will need to ensure that patients have clarity about what entitlements to treatment they have under the NHS in their area, as well as what services are not funded. They will also need to be clear that patients will require evidence of clinical need, from either a UK or overseas health professional, before seeking approval.

8.11 NHS Boards should determine applications within 21 working days of receipt, unless further information is required. When this is the case, the patient should be advised of the reason(s) for the delay and their application should be determined within 40 working days of receipt.

## **Stage 4 - Reimbursing the patient**

8.12 A patient seeking treatment in another Member State under the Article 56 arrangements would need to pay directly for their healthcare in that Member State. If it is treatment that the patient would be entitled to receive on the NHS, or prior authorisation has been given for services that are not the same or equivalent to those made available by the Health Board, he or she may subsequently request reimbursement from the local NHS commissioner for some or all of the costs of this treatment. Patients will need to provide proof of treatment (and payment) to the health commissioner in order to obtain reimbursement.

8.13 Under section 75B of the NHS (Scotland) Act 1978, as set out in the 2010 regulations, the maximum level of reimbursement may be limited to the cost of the equivalent NHS service, or the actual cost of treatment where this is lower than the NHS cost. NHS Boards are expected to reimburse patients at tariff price, where a tariff is in place. Any additional cost is borne by the patient.

8.14 NHS Boards may use the tariffs established by the Scottish National Tariff Project, or local costings if available, in calculating reimbursement for Scottish patients who have chosen to receive treatment in another part of the EEA under the Article 56 arrangements, or in charging patients from other EEA countries who wish to receive treatment in Scotland under their Article 56 rights. The tariffs can be accessed at:

<http://www.isdscotland.org/isd/3551.html>

8.15 Where no tariff or locally calculated cost exists, an average cost, which can be shown to have been calculated objectively and in a transparent way, may be used. If health commissioners are unable to work out an objective cost, or appropriately decode EU receipts for healthcare, they may face the prospect of reimbursing the full costs of treatment - including the higher cost where that applies. For dental treatment, the Statement of Dental Remuneration should be the reference point for calculating the costs of equivalent treatment and the relevant patient charges that should be applied.

8.16 NHS Boards should also be aware that retrospective applications are allowable under the case law established by the European Court of Justice where it was not reasonable to expect the patient to have applied for prior authorisation before receiving the service in another EEA State (or where the patient does not await the outcome of such an application). This will apply in cases of undue delay (see section 11 below). If an NHS Board decides that "undue delay" applied to the individual circumstances of the patient in this situation, they should consider reimbursing the patient in the normal way.

## **Stage 5 - Notifying the patient**

8.17 NHS Boards should prepare a formal written decision for the patient. The formal decision must set out the information considered by the NHS Board in reaching its determination and the reasons for that decision. It must also state the steps that the patient must take in order to seek an internal review of the decision.

## 9. Grounds for refusing prior authorisation

9.1 NHS Boards will need to consider each application carefully. Each case must be considered objectively on its facts. This means that there can be no blanket refusal given to applicants and no application may be rejected out of hand. The need to examine the circumstances of each case is paramount.

9.2 An early dialogue between patient and the health commissioner is important in establishing the facts around the reasons for seeking treatment in another EEA State.

9.3 **It is for each NHS Board to establish its own procedures.**

9.4 While they are not in themselves reasons to refuse prior authorisation as set out in the National Health Service (Reimbursement of the Cost of EEA Treatment)(Scotland) Regulation 2010, NHS Boards will wish to take the following circumstances into account, discussing with the patient as necessary:

- the treatment in question is experimental;
- the NHS Board considers that there is a proven or well-evidenced clinical risk to the patient or to wider public health if the patient travels abroad to receive the treatment in question;
- the NHS Board considers that there are inadequate aftercare or follow-up arrangements in place for the treatment in question; and
- the NHS Board has evidence that the provider is unsuitable because it has evidence of its previous negligent or fraudulent actions (**this criterion is expected to be used only in very rare cases where accurate and substantiated information/evidence is available**). Where an NHS Board has doubts about the suitability of a provider, it may wish to discuss this with NHS Scotland Counter Fraud Services.

## 10. Arrangements for handling patient appeals

10.1 NHS Boards must ensure that patients are able to appeal against decisions to refuse applications for reimbursement or for prior authorisation.

10.2 NHS Boards should have mechanisms in place to provide on request information to patients on accessing and determining their entitlements, the conditions for reimbursement of costs and, if the patient considers that his or her rights have not been respected, that systems which allow for appeal and/or review of decisions are easily accessible and timely. For dental treatment, we would suggest a review process involving a second opinion from a qualified dentist (for example, a dental practice adviser or consultant in dental public health) employed by a neighbouring Health Board would be appropriate.

## 11. Undue delay

11.1 A patient must be granted prior authorisation where:

- (a) The service is necessary to treat or diagnose a medical condition of the patient;

- (b) The service is the same as or equivalent to a service that the NHS Board would make available to the patient in the circumstance of the patient's case; and
- (c) The NHS Board **cannot** provide to the patient a service that is the same as or equivalent to the service requested within a period of time that is acceptable on the basis of medical evidence as to the patient's clinical needs, taking into account the patient's state of health at the time the decision under this section is made and the probable course of the medical condition to which the service relates.

11.2 The European Court has stressed that judgments on "undue delay" must be based on a clinical assessment of what is a medically acceptable period for the individual clinical circumstances of the patient, and that this assessment needs to be kept under review while the patient is waiting for treatment. **Significantly, the European Court has said that offering treatment within a national waiting time target does not necessarily avoid "undue delay"**.

11.3 In assessing undue delay, section 75C (5) of the National Health Service (Scotland) Act 1978, requires the NHS Board to have regard to:

- (a) The patient's medical history;
- (b) The extent of any pain, disability, discomfort or other suffering that is attributable to the medical condition to which the service is to relate;
- (c) Whether any such pain, disability, discomfort or suffering makes it impossible or extremely difficult for the patient to carry out ordinary daily tasks; and
- (d) The extent to which the provision of the service would be likely to alleviate, or enable the alleviation of, the pain, disability, discomfort or suffering.

11.4 NHS Boards should also be aware that "undue delay" might be relevant to the decision of whether to refund treatment costs to patients who have gone abroad without first seeking prior authorisation, since retrospective applications are allowable under the case law established by the European Court. If a health commissioner decides that "undue delay" applied to the individual circumstances of the patient in this situation, they should consider reimbursing the patient in the normal way.

## 12. Topping-up

12.1 NHS Boards have a responsibility to uphold the core principle that NHS care is based on clinical need, not ability to pay. Patients should never be charged for their NHS care, except in limited circumstances set out in legislation such as for general dental services. Nor should NHS funding ever be used to subsidise private care.

12.2 Having treatment abroad should not be seen as a way for patients to obtain public funding for treatments that the NHS would not otherwise pay for.

12.3 Of course, patients have the right to purchase healthcare privately; but privately funded and NHS-funded care should be kept entirely separate, with clear lines of accountability.

## 13. Payment of Travelling Expenses

13.1 The effect of current case law is that the costs associated with travel should only be considered where a patient would have been legally entitled to assistance with such costs if the treatment had been provided in Scotland. **This would be via the schemes governed by the National Health Service (Travelling Expenses and Remission of Charges) (Scotland) (No.2) Regulations 2003, as amended.**

13.2 These Regulations provide for reimbursement of travel costs by the cheapest “reasonable” means of transport only - not accommodation, nor subsistence. Under the arrangements, patients incur the costs and then claim reimbursement. The “reasonableness” test is whether the patient reaches the place of treatment in a reasonable time and without detriment to their condition. Decisions should take into account the distance to be travelled, length of journey, frequency of the journey, availability and accessibility of public transport - as well as the patient's age and medical condition. It should be noted that in certain circumstances, the travel costs of a patient's companion may also be met.

13.3 NHS commissioners should consider requests for assistance with travel costs from patients who are legally entitled to such support at home and should seek proof of entitlements as part of that consideration. Reimbursement of such costs should be for the most efficient mode of transport to the destination of treatment.

## 14. Patient inflow

14.1 The inflow of patients from other EEA States (“EEA patients”) who wish to access treatment from NHS providers (including those contracted to the NHS in the independent sector) raises particular issues for providers. Whilst there is no specific requirement on the provider to accept any patient, there are a number of factors that need to be considered. The proposed Cross-border Healthcare Directive, as currently drafted, will not require providers to accept patients for planned healthcare if this would be to the detriment of their own patients with similar health needs. However, NHS Boards would need to demonstrate that they were not simply discriminating against other EEA nationals on grounds of nationality if rejecting a request for treatment. In principle, the strongest grounds for refusing a non-UK patient are the lack of service capacity.

14.2 If NHS providers accept an EEA patient for treatment, they must not assume automatically that such patients wish to be considered as private patients. This is because although the patient is independent of the NHS system and is not referred formally by their state system, they may themselves receive reimbursement from their state system for the appropriate costs under the provisions of Article 56 (i.e. turning around the reimbursement process outlined at paragraph 8.12 of this guidance). Similarly, primary care providers (including pharmacies) must not assume that an EEA prescription/patient can, or should, be treated as a private prescription/patient.

14.3 In the first instance, NHS providers who receive requests from EEA patients under the Article 56 route should assume that they wish to be treated in the same way as an NHS patient, unless they specifically state that they wish to be treated privately. Article 56 patients who wish to be treated on the same basis as NHS patients should only be charged the appropriate NHS tariff price or average cost for NHS equivalent treatment or, for dental treatment - the cost they would have paid for treatment under general dental services. Providers contracted to the NHS cannot increase the price to an EEA patient simply because they are not an NHS patient, as this would be discriminatory under EU law.

Providers may, however, make additional charges for services that are not a standard part of the normal treatment arrangements for NHS patients. Of course, patients using the NHS who specify from the outset that they wish to be treated as private patients may be charged as such.

14.4 NHS providers will need to ensure systems are in place for dealing with requests for treatment from EEA patients. This includes processes for seeking more information about the patients' condition and diagnoses where this is not initially available; systems for dealing with payment made direct by the EEA patient; clear information about the services provided; and the terms of the treatment.

## 15. Additional Information/Enquiries

15.1 The National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010 have been introduced to provide a stable foundation for reimbursement and prior authorisation decisions that are made by NHS Boards. They take account of the case law of the European Court, recognising that this is continuing to develop as new cases are brought before the Court. The changes made to legislation are interim measures - the proposed Cross-border Healthcare Directive will, in time, bring greater certainty to the rules surrounding patient mobility. NHS Boards should therefore keep abreast of developments in the European Court and carefully apply UK and EU law.

15.2 For enquiries arising from this guidance, please contact the European Healthcare Policy Manager in the Scottish Government Patient Support and Participation Division:

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## ANNEX A

### THE 2007 POST-WATTS GUIDANCE

#### *Patient Mobility*

#### ***Advice to Local Healthcare Commissioners on Handling Requests for Hospital Care in other European Countries following the ECJ's Judgment in the Watts case***

##### *1. Introduction*

1. The purpose of this guidance is to help local healthcare commissioners<sup>5</sup> (commissioners) throughout the UK to handle requests from the public to go to certain other European countries (see part 1.2 for details of which countries are covered) for treatment which in the UK is provided in hospitals.

2. It reminds commissioners of the arrangements that already exist for handling such requests and explains the implications of recent rulings by the European Court of Justice (ECJ) in the Watts and other related cases. It advises commissioners that they must have systems in place for handling requests to go abroad for treatment in hospitals, and gives some practical advice on how to handle these requests.

3. The area of cross-border healthcare, including patient mobility, is currently the focus of discussions on possible EU action on health services. There is a possibility that a Directive may be proposed in this area. Given this, commissioners should bear in mind that there may be a need to alter the sorts of systems discussed in this guidance at some point over the next three or four years in order to take account of these developments.

4. This preliminary guidance – and the Watts case – deals with requests to go abroad for treatment in hospital. There are related judgments from the European Court on treatment outside hospitals: Annex 2 provides some preliminary thoughts about what arrangements the NHS could make in relation to non-hospital services. Comments are welcome on this guidance: it would be helpful to have them by 31 March 2007.

**5. Though this guidance is detailed to help commissioners manage requests effectively, there are a small number of relatively simple principles which if followed will allow commissioners to meet the main EU requirements. These principles are:**

- **Commissioners can (and should) set up systems for considering requests from patients for authorisation to go abroad for treatment which in the UK is provided in hospitals [see the annex of this note for “non-hospital” care]; these systems are different from the current E112 referral arrangements;**

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<sup>5</sup> In England, Primary Care Trusts, practice-based Commissioners and GPs; in Wales Local Health Boards and Health Commission Wales ; in Scotland the NHS Board of the patient's residence; in Northern Ireland Health and Social Services Boards

- A commissioner is entitled to refuse to pay for healthcare services that are available in other Member States but that it does not offer to patients in the UK. **A commissioner is entitled to refuse to authorise a request for treatment that it does not fund, even if that treatment is funded elsewhere in the UK – see 4.1:**
- ***If a commissioner agrees that a patient should be offered treatment on the NHS, and if that treatment is not available without “undue delay” in the NHS, then the patient is legally entitled to go elsewhere in the EU for that service, and can request either E112 or Article 49 authorisation;***
- **Under the case law developed by the European Court in the Watts case (*Article 49*), commissioners are only required to refund up to the costs of treatment in the UK: if treatment costs elsewhere in the EU are higher than those in the UK, then the patient needs to pay the difference [the rules for the existing E112 referral route are different].**

### *1.1 The difference between requests to go abroad, commissioning services abroad and Choice (in England)*

6. This guidance is about handling requests from individual patients to go to other European countries for treatment. It does not affect other commissioning activities, such as:

- contractual arrangements that commissioners may have made with healthcare providers overseas (for example for treatment for rare conditions, or because of capacity constraints in the NHS). Suggested guidelines to facilitate this process have been produced in discussions between the EU Member States and the European Commission and are available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_115256](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_115256)
- arrangements in England for patient Choice at the point of referral, since all healthcare providers under the Choice system fall under regulatory requirements of the NHS.

### *1.2 Countries covered by this guidance*

7. This guidance only relates to the European countries listed at Annex 1. References in this guidance to “Europe” and “European” should be understood accordingly. EU requirements do not give patients any rights to be refunded for treatment received outside the countries on this list.

## *2. Existing arrangements and recent caselaw from the European Court of Justice*

8. There are long-standing arrangements, under European law, to handle requests from patients for hospital treatment in other parts of the EU. Under European legislation (Regulation 1408/71<sup>6</sup>), patients can apply for an E112 authorisation, which the Department of Health issues on advice from commissioners. Under this pre-existing system, patients are entitled to go elsewhere in Europe for treatment offered by their home health system, if they face “undue delay”, although they need to be issued with an E112 authorisation before leaving the UK. E112 authorisations can also be issued where there is no formal entitlement. This system has not been altered by the ECJ ruling in the Watts case.

9. In the Watts judgment<sup>7</sup>, the ECJ ruled that its case law relating to patients seeking hospital treatment in another European country applies to NHS patients. This case law takes as its starting

<sup>6</sup> Council Regulation (EC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community, see [http://europa.eu/eur-lex/en/consleg/main/1971/en\\_1971R1408\\_index.html](http://europa.eu/eur-lex/en/consleg/main/1971/en_1971R1408_index.html)

<sup>7</sup> Judgment of the European Court of Justice, 16 May 2006, Case C-372/04, The Queen (on the application of Mrs. Yvonne Watts) v Bedford Primary Care Trust and the Secretary of State for Health, see <http://www.curia.eu.int/>

point the principle that any action that restricts patients' rights to receive treatment within Europe curtails the Single Market. However, the Court has accepted that health systems can justify the use of systems of "prior authorisation" before patients go abroad for treatment in hospitals. The Court has also confirmed that authorisation cannot be refused (and healthcare costs must be refunded) when the home health system cannot offer the service without "undue delay". Commissioners must base their decision about what "undue delay" means on a clinical assessment of the individual circumstances of the patient; this assessment needs to be kept under review while the patient is waiting for treatment.

10. The ECJ criticised the NHS for not having clear criteria for managing its prior authorisation systems: the rest of this guidance gives advice about how commissioners can put effective processes in place.

11. In managing requests, it is therefore important that commissioners bear in mind that there are now two different routes for treatment in other European countries under EU legislation: the **E112 authorisation** route and the **Article 49** route [Article 49 is the Article of the Treaty which guarantees the rights of service users to access services (and the rights of service providers to provide services) in the Single Market]. Further details about which route is appropriate are given in paragraphs 20-22.

### *3. Action*

12. Commissioners must ensure that their arrangements for handling requests to go to other European countries for hospital treatment are managed in accordance with the requirements set out in the Watts case. The set of questions that they need to ask themselves is summarised in the chart at Annex 3.

13. The UK Health Departments believe that it is in the financial and the clinical interests of both patients and commissioners to sort out the arrangements that will apply to treatment abroad *before* the patient goes for treatment. Where commissioners have "prior authorisation" processes in place for handling requests, they can normally refuse to refund treatment costs to patients who go abroad for treatment without seeking prior approval, except where the patient faces undue delay (see paragraph 17).

### *4. Specific points relevant to handling requests for treatment in other European countries*

14. This guidance focuses on issues for commissioners to bear in mind when handling requests for treatment in other European countries. The following points are worth highlighting in the process.

#### 4.1 Does the commissioner offer the service?

15. European case law respects the responsibility of Member States to decide, and prioritise, the services that they offer their populations, so long as this is done in an objective and transparent manner. This means that a commissioner is entitled to refuse to authorise a request for treatment that it does not fund, even if that treatment is funded elsewhere in the UK.

16. There may be exceptional circumstances where commissioners will be prepared to agree a request for a service that is not otherwise funded: this must be determined on a case-by-case basis. In these circumstances, it is unlikely that “undue delay” will, in practice, be a consideration.

#### 4.2 Undue delay

17. The question of whether the patient faces “undue delay” is the other factor that determines whether a patient is *entitled* to go elsewhere in Europe for treatment. Where the patient does not face “undue delay”, there is no requirement to authorise treatment outside the UK. However, best practice is for commissioners to consider the best interests of the patients; commissioners should also bear in mind that an unjustified refusal where the patient does not face “undue delay” might constitute an infringement of EU law. Commissioners should consider requests on a case-by-case basis.

18. In arriving at a decision about what “undue delay” means, the ECJ has stressed that this must be based on a clinical assessment of what is a medically acceptable period for the individual clinical circumstances of the patient, and that this assessment needs to be kept under review while the patient is waiting for treatment. Commissioners need transparent systems for showing that assessments are kept under review separately from current waiting lists. Specifically, the ECJ has said that offering treatment within a national waiting time target does not necessarily avoid “undue delay”.

19. Commissioners should be aware that “undue delay” may be relevant to the decision of whether to refund treatment costs to patients who have gone abroad without first seeking prior authorisation. Normally, if commissioners have systems of prior authorisation in place, they can refuse to refund payment to patients who go abroad without first seeking authorisation. However, if the commissioner decides that “undue delay” applied to the individual circumstances of the patient in this situation, they should consider whether they should refund the patient. Given the recent substantial decrease in waiting times in the NHS, the number of situations where the patient is likely to face “undue delay” has reduced significantly in recent years.

#### 4.3 Which route [E112 authorisation or Article 49]?

20. Commissioners are reminded of the main practical differences between the two routes:

- E112 authorisations are issued centrally, although the decisions about whether to offer the service and about the patients’ clinical needs are based on the advice of the commissioner. The NHS is liable to pay the full cost of treatment (if free to the patient in the country of treatment) or the amount reimbursed by the state system (if treatment is not free to the patient), even if these costs are greater than in the UK. Where co-payments are charged, the NHS is also liable to pay any difference between costs reimbursed in the country of treatment and cost of treatment in the NHS (where higher). The Department of Health reserves the right to ask commissioners to pay the costs of treatment under the E112 system before the Department grants approval.
- Prior authorisation under Article 49 is handled locally, including the arrangements for refunding the patient, who will normally pay the hospital abroad directly for the treatment received. Commissioners are only liable to pay costs equivalent to those of treatment in UK, or the actual cost of treatment, whichever is the lower.

21. If the patient wishes to be treated in a hospital which is not part of a state system, then the EU regulations do not allow an E112 authorisation to be used: the Article 49 route must be used.

22. In other circumstances, either route can in principle be used. However, in circumstances where undue delay does not apply, the Department may seek justification from commissioners that the use of an E112 authorisation represents effective value for money for the NHS, if use of the E112 route results in greater expenditure by the NHS than would be the case if the Article 49 route (which restricts the costs to the NHS to the costs of treatment in the NHS) were used. Where undue delay applies, the patient may be able to insist on the referral route.

#### *4.4 The prior authorisation agreement [(Article 49 route)]*

23. On request, the commissioner should write to the patient, setting out the exact terms of the prior authorisation and related arrangements. This is for the benefit of both parties, and is the way in which the patient can be certain of the financial and clinical care arrangements that will apply.

24. It is also the opportunity to ensure that the patient is aware that the responsibility for ensuring the quality of the care that the patient receives is that of the health system in the country of treatment. It is important that patients understand that the NHS cannot vouch for the quality of providers that the UK neither oversees nor regulates. The letter also provides an opportunity to set out what care arrangements the patient can expect when they return to the UK. Specifically the letter will allow commissioners to set out that authorisation will not make the NHS liable for any clinical negligence and that any liability of the provider would have to be established in accordance with the legislation of the host state.

25. Practically, the prior authorisation letter should include at least the following:

- financial arrangements: who will pay what to whom and when (reimbursements will be retrospective); the NHS tariff for the treatment (where this is relevant); the total cost of the treatment abroad; payment mechanisms.
- any travel and subsistence costs: the NHS is only required to pay these where patients would have been eligible, on a means-tested basis (in most parts of the UK), to receive reimbursement for such costs if treatment had been provided in the UK;
- an explanation that the NHS is not responsible for the quality of the care that will be provided;
- an explanation that legal liability will be decided in accordance with the law of the host state, including (where appropriate) an explicit statement that the patient is not covered by the Clinical Negligence Scheme for Trusts (CNST) (Welsh Risk Pool in Wales), and needs to insure themselves against negligence (and other risks, such as the cost of repatriation);
- clinical arrangements: in particular arrangements for continued care when the patient returns to the UK

#### *5. What happens if patients disagree with decisions taken by commissioners?*

26. Commissioners need to ensure that patients can appeal against decisions made on requests for treatment in other European countries. Currently, the only means of challenging such a refusal is by way of judicial review. Commissioners may wish to put in place an internal system for review of their decisions (whether refusals to make recommendations to the Department under the existing E112 system or refusals to authorise under Article 49). This can be done, for example, through the standard processes that commissioners will have in place to deal with appeals against their decisions about domestic commissioning. However, patients would not be obliged to use such a system and must be told of their rights to seek judicial review of adverse decisions.

#### *6. Planning and Financial Stability: safeguards*

27. The European requirements about dealing with requests to be treated elsewhere in Europe are intended to respect the responsibilities that commissioners have for planning, organising and

managing healthcare services. If the volume of requests for treatment in Europe increases to an extent that may damage planning etc of healthcare services, it may be possible to reconsider the criteria for granting authorisation. Commissioners should alert the UK Health Departments if the number of authorisations granted increases significantly.

## Annex 1 – list of the countries where patients can ask to be treated under EU requirements

### EU Member States (other than UK)

Austria	Germany	Netherlands
Belgium	Greece	Poland
Bulgaria	Hungary	Portugal
Cyprus	Ireland	Romania
Czech Republic	Italy	Slovakia
Denmark	Latvia	Slovenia
Estonia	Lithuania	Spain
Finland	Luxembourg	Sweden
France	Malta	