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HOPE Position Paper

on the evaluation of the directive 2011/24/EU on the application of patients' rights in cross-border healthcare

The evaluation of the Directive 2011/24/EU and its interaction with other legislation, in particular, Regulation (EC) No 883/2004 on the coordination of social security systems, provides an opportunity to propose elements for adapting existing mechanisms.

Regulatory gap of this framework under health crisis circumstances

During the coronavirus pandemic, patients were treated in neighbouring European countries because medical care could no longer be fully guaranteed in their home countries. As these patients entered the EU Member State with the intention of receiving treatment abroad, these treatments are to be classified as planned inpatient treatments. These are subject to prior approval. At the same time, due to the life-threatening situation, it was not feasible or acceptable to go through the usual approval process.

Comparable cases existed prior to 2020, when, on an emergency basis due to a major incident on one national territory, patients were transported across the border to a hospital in another Member State. Special cases are emergency situations occurring in direct cross-border regions, when an emergency (e.g., myocardial infarction, stroke) occurs on a national territory and the nearest adequate hospital is located on another national territory and the transfer is cross-border.

Position

In health crises and major events, it can be assumed, based on relevant case law, that the domestic health insurance funds are beholden to provide approvals retroactively and to make the payments. Nevertheless, the matter has not been definitively cleared up by the legislators, which continues to lead to legal uncertainty in the admission, treatment, and billing of patients in these special European cross-border emergency situations.

HOPE suggests that hospitals should be able to bill crisis-related, cross-border treatments as emergencies via the European Health Insurance Card procedure, if these cross-border treatments are officially released by the competent authority. Instead of the patient declaration, the hospital encloses, with the invoice, the official release as well as a document with the patient's choice of the assisting health insurance fund and - if the patient is no longer able - the hospital's choice of the assisting health insurance fund.

This additional provision does not exclude the possibility for Member States to adopt other simplified procedures in times of crisis, such as the assumption of costs by Member State's governments. It also does not exclude to make use of the existing mechanisms, if practicable under crisis circumstances (prior approval form). The special situation in direct border regions is to be evaluated depending on the regional situation by the responsible regional and local parties. In some cases, emergency rescue agreements do exist.

However, these do not exist broadly and leave open questions in practical implementation, e.g. billing issues related to the medical treatment that follows the rescuing action (transport). In very rare cases, dedicated cross-border treatment agreements exist. Negotiating these agreements (rescue and treatment agreements) in border regions can be complex and lengthy due to systemic, linguistic, financial, jurisdictional differences between negotiating parties. Even after negotiation, resources are needed for the long-term successful implementation, support, and management of the agreements. Hospitals are indispensable as partners in cross-border treatment agreements. Nevertheless, hospital staffs, which are already fully occupied in their original medical, nursing, and administrative activities, are not able to manage in addition to these activities cross-border projects. Therefore, if the European Union and the Member States want to promote successful agreements in cross-border health care, EU funding must be made available in an unbureaucratic manner for the cooperating parties (translation, project management)

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