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Cross-border Healthcare in the European Member States

An exploratory study on the adaption of the Directive 2011/24/EU

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1. INTRODUCTION

As a fundamental principle, free movement across the European Union (EU) has been established through a variation of legal frameworks, like the Schengen Agreement for a common region without border controls (European Union, 2009) or the Lisbon Treaty (TFEU, 2007, Art.45) granting free movement for persons, services, capital and especially workers in the EU. Supporting this principle, a directive on healthcare across borders has been introduced into European legislation in 2011, with the objective to provide a legal framework for reliable and high quality healthcare in Europe. (European Commission 2011, p. 46) With regard to the implementation in 2013, the Health Commissioner Tonio Bor stated: "For patients, this Directive means empowerment: greater choice of healthcare, more information, easier recognition of prescriptions across-borders" (European Commission, 2013a, p.1) The Directive 2011/24/EU is designed as a specific policy instrument of the European Union, that aims to enhance the possibilities for variation in the Member States in the adoption of the legislation. However, it includes many specific details that need to be realized by the states, like the establishment of National Contact Points (NCP) to provide information on request and also in electronic form on websites. Since healthcare policies are mainly in the responsibility of the Member States and the competencies of the EU are limited to monitoring and coordination, the disparities between the healthcare systems in the EU are a major challenge for cross-border healthcare. (Greer, 2014, 21) To evaluate the progress in the adoption of the Directive and the demand on cross-border care, only little information has been collected in the last years. As found in different studies, the data collection practice is heterogeneous and the great variation of institutional frameworks makes it difficult to evaluate and compare data across the Union. However, some evidence could be found, that especially the lack of awareness on the patients' rights and the administrative requirements are the main challenges to cross-border care so far. (Footman et al., 2014) (Zucca et al., 2015) Therefore, the information of the population on their rights and possibilities in medical treatment abroad is a major component of the Directive. With the establishment of National Contact Points in every Member State, the population shall be given the possibility to access specific information and to make an informed choice. From a patient perspective, however, the heterogeneous landscape of national frameworks can be challenging. Therefore, it is of importance to explore, what differences and similarities can be found in the adoption of the Directive to the national circumstances. Following an explorative study by Zucca et al. conducted in fall 2014, this paper is an approach to analyse the websites provided by the NCPs along selected indicators. This shall therefore reflect the current conditions in the adoption process and might also reveal opportunities for mutual learning among the Contact Points.

1.1. RELEVANCE OF THE TOPIC

According to Johannes Bircher, health is "characterized by a physical, mental and social potential, which satisfies the demands of a live, commensurate with age, culture, and personal responsibility" (Bircher, 2005, 335). Therefore, health can be seen as an essential component of personal development and a long-term investment. It is a key element in people's lives as a resource for social and economic participation. According to the World Health Organization it can be defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2006, p.1) In the European Union, the health status of the population has increased in the last decades, still maintaining disparities within and across the Member States. However, in the context of the financial debt crisis and the ongoing reforms, the expenditure on healthcare has decreased or slowed down all over the Union. Nevertheless, universal health coverage is still available in most Member States, except in countries with a high ratio of uninsured population like Greece, Bulgaria and Cyprus. (OECD, 2014, p.9) The Charta of Fundamental Rights of the EU proclaims in Article 35, that everyone has "the right to benefit from medical treatment under the conditions established by national laws and practices" (European Union, 2000, Art.35) and that European legislation shall establish "a high level of human health protection" (European Union, 2000, Art.35). This assigns the persistent principle of health protection across and within the Member States to the EU governance. However, the competencies of the European Union concerning health policies are limited and the responsibilities of shaping healthcare systems still is in the hands of the Member States. This creates a typical paradox, inherent to many other areas of EU legislation and distribution of power (see section 2). As defined in the healthcare Directive, "healthcare means health services provided by health professionals to patients to assess maintain or restore their state of health, including the prescription, dispensation and provision of medical products and medical devices" (European Comission 2011, p.55 Article 3a) Based on a long history of social security systems in the EU, a variety of different healthcare systems is to be found that show individual approaches in provision and financing of healthcare. (Zucca et al., 2015, p.12) Therefore, the Directive was intended to provide a legal framework adoptable to all Member States. Moreover, it aims to grant access to qualitative healthcare across the Union. Two years after the official implementation into national legislation, the question arises, if the Directive is working for the empowerment of patients' rights and what differences and similarities in adopting cross-border healthcare rights to the national contexts can be found.

2. THEORETICAL FRAMEWORK

To give an overview to the broader policy context of the Directive, the EU health policy paradox is briefly discussed in the following. Moreover, a general outline of legal instruments in the EU is given, to align the Directive as one instrument among others and give insight to the possibilities and limitations. The movement of patients across borders for healthcare in the EU has already taken place before the implementation of the Directive for different reasons. To illustrate the background of the legislation, an overview shall be given along some examples and with previous legislation. Finally the content of the directive will be summarized with special regards to the requirements for NCPs.

2.1. EUROPEAN HEALTH POLICIES PARADOX

With the progressive integration process of the European Union (EU) and increasing economical interaction, questions of healthcare security have slowly appeared in the common debates. With the Single European Act (SEA) of 1987, the Member States stated the goal of health protection in the community framework and gave competencies to the Council of the European Union to work on guidelines for health security in the work-place. (Schölkopf & Pressel, 2014, p.242) The EU single market with free movement of trade also generates challenges for the national healthcare systems. Together with deeper integration of the EU in the Maastricht Treaty of 1992, the member states agreed that "a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities." (Maastricht Treaty, 1992, Art.152I) However, the treaty also determined the limits of the competencies of the EU by obligating them to fully respect the responsibility of the Member States for the organization of health care. This agreement initially excluded a harmonization of European healthcare organization and policies. As Greer et al. state, "the issue with EU powers on health has been striking a balance between potential interest in working on health and the high degree of national sensitivity and specificity about health matters." (Greer, 2014, p.20) The European health policy is currently framed in Article 168 of the Treaty of the Functioning of the European Union (TFEU). It determines the common objective of high quality health care, which shall be protected and considered in European politics and legislation. Moreover, the Article states, that EU action shall complement the Member States' policies and encourage cooperation and high quality. This is further defined in paragraph seven where it says: "the Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care." (TFEU, 2007, Art.168VII) Altogether, this legal framework gives some, but limited competencies to the European Union, whereas Member States are mainly in charge of healthcare policies. According to Greer et al., the

legislation is explicitly directed towards public health in the EU, focusing on the population as a whole. It limits the competencies of the EU to non-binding instruments and further monitoring and evaluations to identify current challenges and best practices. (Greer, 2014, 21) Therefore, it is notable that the EU has implemented different legislations to frame healthcare in accordance with the principle of free movement.

2.2. EU DIRECTIVES AND OTHER POLICY INSTRUMENTS

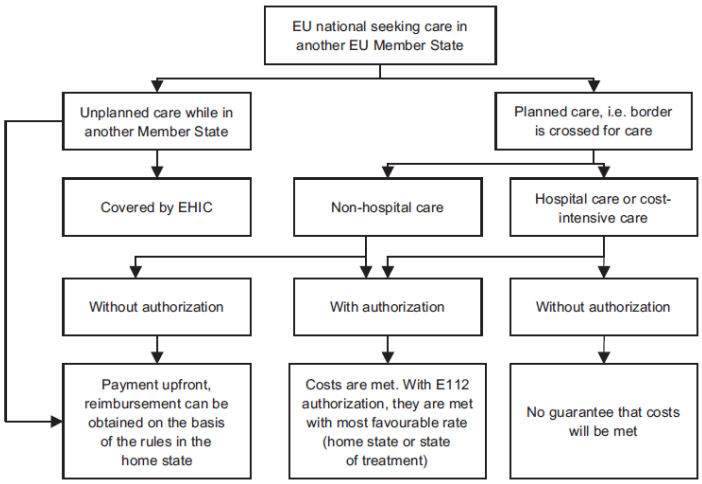
The instruments used by the EU to frame common agreements can be ranked from strong instruments, which are binding in their details, to softer instruments giving a certain direction to support international dialogue. Depending on the policy area and state of negotiations, the European Member States might rather agree on a less binding document, than on detailed legislation. As Buonanno and Nugent point out "soft policy has increased in importance in the EU, in large part as a result of the increasing use of 'new modes of governance' (NMG) approaches" (Buonanno & Nugent, 2013, p.132). Emerged in the 1980s, those alternative ways of international decision making in the EU are based on the principles of semi-voluntarism, inclusion and subsidiarity. By keeping the outcome and conditions flexible, the participants are more likely to maintain an active discussion and find common approaches by avoiding laborious procedures of traditional legislative decision making. (Héritier, 2002 pp.1-4) The Member States might agree on recommendations or opinions that, according to the Lisbon Treaty, "shall have no binding force" (TFEU, 2007, Art.288), but give an indication for domestic policies. Nevertheless, those instruments might not generate a suitable or necessary outcome. Softer policy instruments are designed to facilitate the transfer of policies to the Member States, when forced solutions do not seem promising. However, they also "have limited operational effectiveness when member states are not fully in accord regarding the end goals of policy" (Buonanno & Nugent, 2013, p.133). With the cross-border healthcare Directive, the European Community agreed on a rather binding framework with limited leeway for the Member States, although the overall health policies particularly remain at national level. According to the Lisbon Treaty, "a directive shall be binding, as to the result to be achieved, upon each Member State to which it is addressed, but leave to the national authorities the choice of form and methods." (TFEU, 2007, Art.288) In contrast to other legal instruments of the EU, a Directive is binding towards the political outcome, still having capacities for each Member State to include own variations in this process. To avoid different models of national application, the Member States also have the option to agree on a European regulation, that "shall be binding in its entirety and directly applicable in all Member States" (TFEU, 2007, Art.288). Compared to other modes of legal agreement, a regulation is the most legally binding in any terms and has instant validity. Regarding the limited power in health policies of the EU (see section 2.1), an agreement on a

regulation at this level is rather difficult. As Lelievledt and Princen point out, "social policy is, politically speaking, a sensitive area, in which member state governments have been reluctant to cede power to the EU." (Lelievledt & Princen, 2011, p.81) In contrast to a regulation as finished legislation, directives need separate national arrangements to produce a certain outcome. Therefore, a directive leaves the states with possibilities to adopt the legislation to their domestic circumstances and is more likely to be agreed on in European health policies. In other areas, regulations might be rather necessary to inforce common standards or fixed legal frameworks. However, "the formal distinction between Regulations and Directives has become blurred as Directives are often so detailed and specific that they leave little room for variation between the member states" (Lelievledt and Princen 2011, p.83). As to be seen in the Directive 2011/24/EU, the possibilities for national adoption is still given in many areas, where as other details (like the establishment of National Contact Points) are rather explicit and strict. In the analysis of similarities and differences in the adoption it will be seen, how far the Member states complied with the legal framework and where individual solutions are put into practice.

2.3. THE MOVEMENT OF PATIENTS IN DIFFERENT CONTEXTS AND FRAMEWORKS

Healthcare has increasingly become a matter of free choices, with informed partners in decision making. Therefore, decision on mobility across borders is often influenced by the composition of the healthcare system in the home country and individual experiences. (Wismar et al., 2011, p.1) It can be distinguished between different groups of patients, which receive medical treatment abroad. (Footman et al., 2014, p.2) At first, there are people planning to get medical treatment across the borders on their own initiative, or are sent abroad by their own healthcare systems. Reasons for this might be the quality of health care, which is not satisfying in the home country, the affordability of treatments that need to be paid for outside the coverage of the insurances, or individual preferences, like migrant workers, who return home for treatment. (Footman et al., 2014, p.4) The planned treatment in other Member States has long been an area of legal uncertainties and individual arrangement, but is now covered by the Directive 2011/24/EU. Countries sending their population abroad for treatment can be part of long-term political programs or short term political initiatives to cover treatment for rare diseases or to offset shortages in the national systems. Due to their smaller population size, the Maltese overseas scheme has become a regular mechanism to send patients with complicated or rare diseases abroad to guarantee quality healthcare for the population. (Glinos, 2011, p.238) A different example can be found in England, where the National Health Services faced an increase in waiting times for treatments in 2003. With a twelve month initiative called "London Patient Choice Project" (Dawson, 2004, p.1) the government intended to offer treatments abroad to

patients exceeding six months on the waiting list for elective surgery. The program was accepted by approximately 15,000 patients and also paved the way for alternative approaches in the national healthcare services. (Dawson 2003, p.1) In border regions, patients may choose medical services with closer proximity, located across a national border, rather than traveling over long distances in their home country. Several examples show a growing network of single projects and cooperation with shared infrastructure and services to enhance efficiency and enlarge the supply of special services. (Footman et. al., 2014, p.3) To give an example, the cooperation of hospitals across the Austrian-German border originated from shortages in the surgical ward in Simbach (Germany) and intensified to further exchange and a shared angiography unit. (Glinos &Wismar, 2013, p.12-13) Those patients who unexpectedly fall ill during their stay abroad, or suffer from chronic diseases and handicaps, are entitled to use their European Health Insurance Card (EHIC) to receive treatment in the Member States. There have been complains about the acceptance of this insurance card in some countries[1], in times of shortages or in major tourist regions, but the EU Decision 189 on the EHIC provides a clear legal basis in this case. It entitles to "reimbursement of healthcare costs during a temporary stay in a Member State other than the competent State or, for recipients of a retirement or other pension and family members who do not reside in the same Member State as the worker, in a Member State other than the State of residence" (European Commission, 2003, p.2).



PICTURE 1: WISMAR ET AL. 2011, P.77 MOVEMENT OF PATIENS ACROSS BORDERS

In picture 1, an overview of different circumstances of cross-border healthcare is given, also considering prior authorization and intensity of care (see section 2.4). Only in case of intensive planned healthcare in a different Member State without prior authorization, reimbursement of the costs cannot be guaranteed. All other cases are legally regulated as discussed in the following section.

[1] The EU has opened an infringement procedure about recurring complains about medical services provider in Spain refusing to accept the EHIC referring to other travel insurances. (European Commission 2013)

2.4. CROSS-BORDER HEALTHCAREDIRECTIVE

With the Cross-border healthcare Directive, the EU has created a legal framework for the EU population to choose a healthcare provider across the borders of their country of residency. The directive passed in 2011 and had to be transferred into national law till 25 October 2013. (Zucca et al., 2015, p.11) To reach this agreement, different legislative steps and negotiations have been taken. According to the European Observatory, the lacks of common legislation and legal uncertainties in the last decades have limited the movement of patients across borders and were attributed to "the insufficient functioning of the internal market in health services" (Wismar et al., 2011, p.2). Therefore, a framework for a common directive had to be designed, that was compatible with all types of heath care systems, clarified the entitlement to treatment and "obliged Member States to define, implement and monitor quality and patient safety standards to assist cross-border patents making an informed choice" (Wismar et al., 2011, p.3).

2.4.1. TOWARDS A COMMON DIRECTIVE

The legal basis of the directive on cross border healthcare originates from a first agreement of the 1970th with a Regulation on the application of social security schemes to employed persons and their families moving within the community. This Regulation No 1408/71 was designed to coordinate social security legislation and complement free movement of employees in the EU. It was updated in 2004 by regulation No 883/2004, that aimed to simplify the free movement of citizens in the Union. (European Commission 2008) Treatment abroad was limited to prior authorization from insurances or official administrations, but was permitted in cases of emergency treatments in the Member States. With several individual cases decided by the European Court of Justice (ECJ) on the matter of cross border care[2], the range of this regulation has been progressively expanded and created legal uncertainties that made a revision and reconstruction of the legal framework necessary. (Legido-Quigley et al., 2011, p.364) On the one hand, the Court recognized that a system of prior authorization opposes the principle of free movement, with healthcare as economic activity. On the other hand, the ECJ pointed out, that healthcare is to some extend different to other services and creates difficulties to sustainable administration within different healthcare systems. (Footman et al., 2014, p.5-6) In an attempt of modernization and coordination, the Member States agreed at the Barcelona European Council 2002 on introducing a European Health Insurance Card (EHIC), to replace paper forms and generate access to occasional health treatment. This new instrument was designed to promote the mobility of employees in line with the Lisbon agenda. Moreover, it should simplify

[2] Among others: Case C-158/96 [Raymond Kohll v Union des Caisses de Maladie], 28 April 1998 on free services, prior authorization, reimbursement and dental treatment; Case C-372/04, [Yvonne Watts v Bedford Primary Care Trust], 16 May 2006 on national health services and reimbursement of cost for treatment abroad due to waiting time. (Wismar et al., 2011, p.4)

the process for all stakeholders like healthcare providers, insurances, national administrations and patients. However, this improved system only applied to unplanned, but necessary treatment during a temporary stay in a Member State. (Bertinato et al., 2005, p.8) For other medical services and planned treatments, the legal framework was still heterogeneous and unsettled. To achieve some common ground, the Commission proposed including health services in a horizontal directive on services in the internal market in 2004, which was criticized for the lack of consideration of general interest. However, this attempt was not successful and health services were particularly excluded. (Footman et al., 2014, p.6) After this first proposal, the process towards a directive was restarted with a public consultation among Member States to capture individual circumstances. Additional research was conducted and combined in an assessment procedure to evaluate different proposals. As a result, a common legal framework in EU legislation was considered to bear the greatest potential and transferred into a proposal adopted in July 2008. (Palm et al., 2011, 30-32) After further deliberations and adjustments, the Cross-border healthcare Directive was passed as "Directive 2011/24/EU of the European Parliament and of the Council of March 2011 on the application of patients' rights in cross-border healthcare" (European Commission, 2011, p.45). As reflected in the title of the Directive, the focus has shifted from healthcare services to empowerment of the rights of patients in the EU. It was designed to create a standardized framework, settling legal uncertainties originated by the ECJ decisions and defining responsibilities.

2.4.2. INSIDE THE DIRECTIVE

The Directive on the application of patients' rights concerning cross border healthcare is based on the Articles 168 and 114[3] TFEU and pursues the following goals (European Commission 2011, p. 46):

1. Establish a set of rules for the access to safe and high-quality cross-border healthcare
2. Building a framework for patient mobility
3. Promote cooperation between Member States in terms of healthcare and information flows

At the same time, the sovereignty of the Member States for "the definition of social security benefits relating to health and for the organization and delivery of healthcare and medical care and social security benefits" (European Commission, 2011, p.46) shall be respected. This reflects the conditions of the policy paradox in health policies in the EU as well as the framework of a directive (see section 2.1. and 2.2.). Furthermore, the healthcare in all the Member States shall be provided in accordance with the principles of universality, good quality, equity and solidarity,

[3] Article on legislative adaptions in the Member States towards "the establishment and the functioning of the internal market" (European Union, 2008, p.94) of the EU.

reflecting the legislation of the EU and the Member State. (European Commission, 2011, p. 56 Art.4.1) The Directive distinguishes between the rights and obligations of 'Member States of treatment', defined as "on whose territory healthcare is actually provided" (European Commission, 2011, p. 55 Art.3d) and 'Member States of affiliation' "that is competent to grant the insured person a prior authorization to receive appropriate treatment outside the Member State of residence" (European Commission, 2011, p.55 Art.3c). The reimbursement of the costs of cross-border care is incumbent on the Member State of affiliation, if the applicant is insured in that country and would have been entitled to the same services or benefits on the territory. Thereby, the costs have to be covered to the extent assumed in the state of affiliation with a transparent calculation, but also might be reimbursed altogether. Despite some exceptions, cross-border care should not require prior authorization by the state of affiliation and should only be limited by overriding reasons of general interest. (European Commission, 2011, p.57-58 Art.7) The necessity of prior authorization on cross-border healthcare is limited to cases requiring planning, like overnight hospital accommodation, highly specialized and cost intensive treatment and for rare diseases. It might also be necessary for reasons of quality concerns and risks for individuals or the population. (European Commission, 2011, p.59 Art.8) In contrast to the 883/2004 Regulation, the patient seeking healthcare abroad has to pay the costs upfront to get reimbursed later in any case. The Member States have to provide information on request concerning the different rights of patients, the terms and conditions as well as on the quality and safety on the treatment. Therefore, National Contact Points are required to be established in every Member State. To build a network of informational intersections in the Member States, the Directive furthermore assigns the National Contact Points to "consult with patient organizations, healthcare providers and healthcare insurers" (European Commission 2011, p.57 Article 6.1). Moreover, those agencies are designated to close cooperation and exchange of information among themselves and with the Commission. On request of patients, they are responsible for providing information on healthcare providers and patients' rights and entitlements, especially in cases of complains and harm. In addition, the contact points shall provide information on terms and conditions on reimbursement and related procedures, as well as available information on quality and safety of targeted providers and treatments. All this information needs to be easily and publicly accessible and appropriate, in different formats of communication (electronic means) and especially for people with disabilities. (European Commission, 2011, p.57 Art.6) With the adaption of the Directive after implementation in 2013, there are now National Contact Points officially available in every Member State, which are going to be targeted in this paper.

3. LITERATURE REVIEW

Although the cross-border healthcare is a topic of European interest, the data base on this topic is rather small. As Footman et al. point out, there are major differences in data collection practices in the Member States and most healthcare systems do not differentiate patients by migration status. Moreover, the access to healthcare in other member states is difficult to evaluate due to the variation of organizational frameworks and legal uncertainties in the in the countries. (Footman et al., 2014, p.11-12)

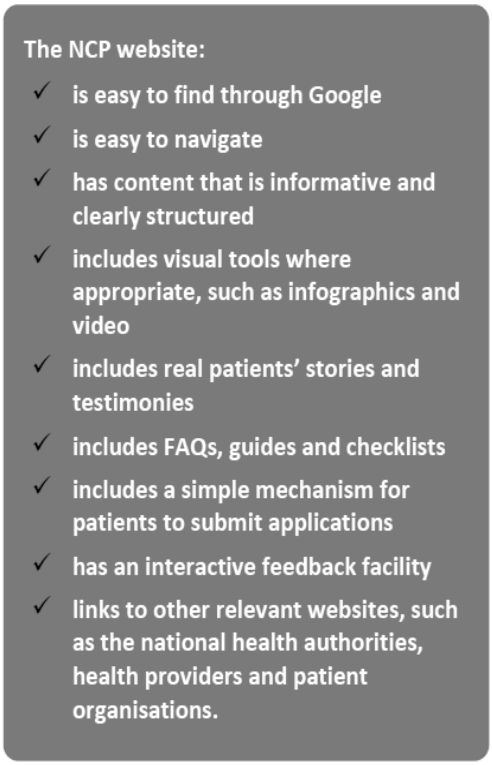
Regarding the patient mobility in Germany, there is some data available from several surveys on cross-border care with different focus areas by the Techniker Krankenkasse (TK), a German public insurance company. A general study was conducted in 2010, the year before the implementation of the directive, which was already the third follow up survey on cross-border health care. This study was held among a random sample of insurants of the TK on matters of satisfaction with cross-border care, quality and information with a response rate of around 30 %. (Wagner et al., 2011, p.6-7) The results reflect a growing demand and satisfaction for treatment in other EU Member States, but also a relatively high share (62%) of people, without any knowledge towards the entitlement to those treatments, if planned or emergency. (Wagner et al. 2011, p.23) Whereas the satisfaction with the treatment and the circumstances was pretty high, 40% of the sample was rather dissatisfied or very dissatisfied with the amount of expenses borne. (Wagner et al., 2011, p.16) In the follow up survey in 2012, the research design only focused on those insurants with experiences in planned cross-border health care. In this sample, 79% of the interviewees had already reached retirement age with 60 years or above and half of the treatments registered in the study had been given in health resorts. Similar to the 2010 survey, the overall satisfaction with the treatments has been very high with around 1% dissatisfaction (Wagner et al., 2013, p.9-17)

In a special Eurobarometer (2014), the European Commission requested a report on the status of patients' rights in cross-border healthcare after the implementation of the directive 2013. It has been a follow up to a 2007 survey on the cross border health services and awareness of the population. The study found that only a very small number (5%) of the population had received medical treatment in other member states in 2013 and for a majority, these services have not been intentionally planned. (TNS Opinion & Social, 2014, p.5-7) This reflects a general trend recognized in literature about the small scope of this legislation so far. As Footman et al. point out, "the absolute volumes of patient mobility within the European Union remain relatively small and the vast majority of healthcare is obtained from providers within the same country as the patient, as people are usually unwilling to travel significant distances for care" (Footman et al. 2014, p.1). This can also be shown in the results of the Eurobarometer, in which 46% state to

be unwilling to receive medical treatment abroad, whereas 33% would also go to another Member State for treatment. (TNS Opinion & Social 2014, p.13)

In March 2015 Zucca et al. published an evaluative study on the implementation of the cross-border healthcare directive on behalf on the European Commission, sampling 12 countries. As an attempt to monitor the implementation and adaption of the Directive in the Member States, the study focused on three main areas, which are reimbursement of costs, quality and safety of care and undue delay. However, due to the lack of sufficient monitoring, the study remains an attempt to collect some evidence in a multi-level analysis. (Zucca et al., 2015, p.21-30) The study found, that there still was a lack of information in the population concerning the possibilities to find healthcare in other EU Member States, despite that there were National Contact Points to give advice. They recommended adjusting disparities between insurance providers and Contact Points by increased cooperation and communication. Regarding reimbursement, they detected some minor administrative problems, but found in the interviews with a patient group, that those burdens (like prior authorization) were the main reason for standing back from crossing borders for health care. Moreover, the study revealed that the information provided for quality and safety by the Contact Points was in most cases not comprehensive and the patient was in charge of collecting the relevant information. Therefore, the research group recommended the establishment of quality and safety assessment tools for care providers to make them internationally comparable. The main weakness so far appears to be, that there was almost no awareness towards the rights in cross border care with the patients and the providers and only insufficient information was distributed. Moreover, administrative delays and burdens limit the access to cross-border care. Finally the authors recommend focusing on the barriers of implementation in Europe, to find common solutions alongside with targeted information and communication. (Zucca et al., 2015, p.60-62) One of the main segments in the study also focused on the establishment of the National Contact Points. As found by the research group, the NCPs carried out different awareness campaigns, still experiencing low public interest with less than 100 requests per month for the majority. (Zucca et.al,. 2015, p. 128-132) The survey explored further details on the administrative processes and found that in some cases, no national tariff schemes are available for patients to refer to and moreover, there is no standardized system of required documents. In regards to information on quality and safety, most of the contact points were ready to provide some information, but some were more exhaustive than others. Moreover, most of the contact points only were able to work with English as a foreign language, leaving other requests unanswered. Finally, the research group investigated the nature of cooperation with other institutions and found that some of the centres maintain frequent contacts with other National contact points, insurance organizations and governmental organizations, but still see potential to enhance the cooperation, especially concerning patient groups. (Zucca et al. 2015, p.134-140)

In an attempt to accompany the adoption of the Directive, the European Patients Forum (EPF) has organised several conferences to create a connection between patient representatives, National Contact Points and European representatives. In a 2015 Summary-Report, they draw first conclusions from the multi-stakeholder exchange and give detailed recommendations. According to the EPF, main opportunities in cross-border care can be found especially for patients with rare diseases and long waiting times. The opportunity to look for treatment across borders generates more options and urges the Member States to imply transparency. (European Patients Forum, 2015, p.4) Nevertheless, there are major challenges and barriers listed by the organisation. The access to care is mostly depended on the upfront payment by the patients, which excludes those Europeans, who cannot afford those payments, extending existing inequalities. Moreover, the lack of sufficient information and awareness is addressed, disadvantaging especially vulnerable groups of the population. (European Patients Forum, 2015, p.4-5) In a diverse landscape of National Contact points, the EPF also collected recommendations for those institutions. First of all, the report stresses the importance of a multi-stakeholder approach, inviting all the involved partners to a common dialogue. For the National Contact Points, it is recommended to act as a mediator between the different levels and provide as much transparency and easily adoptable solutions as possible, rather than just offering information. To enhance the range of visibility, accountability and patient-orientation, the report also provides a check-list for the websites of the National Contact Points (see picture 2). This includes aspects of User-friendliness (easy to find, to navigate, clearly structured content, visual tools, FAQ and checklists) as well as communication possibilities (application tools, feedback, user stories and testimonies). (European Patients Forum, 2015, p.7) Moreover, it is recommended to provide information in different languages, especially those of most common border exchanges and to offer translation services of documents and case managers to give individual guidance. However, the report also recognizes the general circumstances of the adoption and highlights the lack of European standards in terms of quality and safety as well as definitions for waiting times and undue delay. The EPF recommends an increase in the funding of the National Contact Points, as well as options of subsidies for financially disadvantaged groups. Finally, the EPF calls for intensified cooperation and harmonization on the European level. (European Patients Forum, 2015, p.14-15)



PICTURE 2: EUROPEAN PATIENTS FORUM 2015. P.7 CHECKLIST FOR WEBSITES

To summarize the presented findings it can be said, that the actual impact of cross-border healthcare as well as the awareness of the legal framework is rather small. Although, the satisfaction with the treatment is high, the current research suggests that the administrative process, the lack of detailed information and high upfront expenses are the main barriers to the population. Therefore, it is suggested to provide systematic and exhaustive information, enhance the cooperation, communication and transparency to reduce the uncertainties surrounding cross-border healthcare.

4. METHODOLOGY

To create insights into the application of the cross-border healthcare Directive in the different Member States of the EU, this paper is designed as an exploratory study, focusing on National Contact Points and their task of providing information on websites. Following the traditional approach of McMillan (2000), which transferred the content analysis to the area of web-content, this attempt will be structured in different steps. First, a research question and sub-questions have to be found to narrow down the topic of the analysis. Second, a representative sample has to be selected. In the third step, categories have to be defined for the coding and subsequently, coders have to be instructed and trained. Finally the data is collected, analysed and interpreted. (McMillan, 2000, p.81-82) Due to the fact, that this data collection is executed by a single coder, the step of training will be skipped for this analysis. Therefore, the study will be organized in four steps: Definition of the research question, sampling, selection of indicators and finally, data collection, analysis and discussion.

After the settlement of the legislation in 2011 and the implementation into national law in 2013, the newly established structures, procedures and individual solutions to cross-border care under the Directive have officially been running for almost two years. Although the targets of the legislation are rather specific, the Member States have to adopt the required elements to the national circumstances. The research question of this paper therefore is:

What are the differences and similarities in the adoption of the Cross-border healthcare Directive 2011/24/EU in the different Member States of the EU in 2015, two years after its implementation?

Although the published data material on this topic is not exhaustive, some studies have generated first insights into the main barriers and opportunities, which shall be taken into account. Apart from a legal framework for patients, the Directive has included the establishment of National Contact Points in the Member States to work as a gateway for patients and an informational crossroad for different stakeholders like healthcare providers, insurers, other Contact Points and the EU. To explore the current developments and challenges with the

implementation of the Directive, this paper will focus on the websites of the National Contact Points. According to the Directive, the information "shall be easily accessible and shall be made available by electronic means and in formats accessible to people with disabilities, as appropriate" (European Commission 2011, p.57 Art.6). Following an investigation of Zucca et al. from 2014, the websites will be analysed with focus on the framework of the Directive. In this manner, the following questions shall be answered in this paper:

- Did the 28 EU member states establish a functioning and accessible website in accordance with the Directive 24/2011/EU?
- What are the similarities in the provided information by the National Contact Points on the established websites?
- What are the differences in the provided information by the National Contact Points on the established websites?

Analyzing the similarities of the websites, it might reveal common grounds in terms of the content or functions that have been included all over the Union, or that are generally still missing. In contrast, when looking at the differences, the analysis could provide opportunities for further improvement and mutual learning. However, since the Directive is a legislative tool that makes individual adoptions possible, differences might also be conductive.

According to the EU, all 28 EU Member States have established those agencies and although they are is not obligated to do so, Norway and Iceland have also arranged a contact possibility. (European Commission, 2014) In the evaluative study of Zucca et al., an entity of 32 available National Contact Point websites has been considered in the analysis, more than published by the European Commission. Concerning the United Kingdom, there are four separate Contact Points available, for England, Scotland, Northern Ireland and Gibraltar. (Zucca et al. 2015, p.76-77) The research group assessed the websites from 6 October 2014 till 6 November 2014, based on a set of 48 Special Analytical Items organised in 12 categories (see picture 3). To keep the results comparable, the investigated websites will be taken from this study, complemented by those from Norway and Iceland. Altogether, there is a total sample of 34 websites to be investigated in this paper.

PICTURE 3: ZUCCA ET AL. 2015, P.80 CATEGORIES

After selecting indicators for the comparison by consulting previous attempts and the requirements of the Directive, an analytical template will be created and used for the data collection. Thereby the websites will be assessed systematically, exploring the content from the

upper left corner of the website to the lower right corner, following the provided external links for one further step. In the analysis, the gathered information will be compared and evaluated to find an answer to the research question. To determine if the information provided by the NCPs is considered as similar in the different indicators and to structure the discussion, the cut point is chosen to be at ≥ 75%. If the distribution of a particular result in an indicator represents 75% or more of the sample, it is considered as an indicator where the websites show similarities.

4.1. SELECTION OF INDICATORS

In extension to the evaluative study by Zucca et. al. published in March 2015, some indicators shall be chosen, to compare the outcome with the investigation, almost one year henceforth. Therefore, especially those factors shall be considered, that showed potential for further improvement in the preceding evaluation, to record possible changes. An overview to the selected indicators in the different categories can be found in table 1. As assessed by the research group, most of the investigated websites were easy to find, they offered different channels of communication and also possibilities to switch to an English version of the content. In terms of **User-friendliness**, only 17 websites included a category of frequently asked questions (FAQ) to help users finding most crucial information and only nine NCPc made a media library or videos available. (Zucca et al., 2015, p.114) Therefore, those two indicators will be re-investigated, complimented by a few indicators derived from the Directive's requirement, to provide information "accessible to people with disabilities, as appropriate" (European Commission 2011, p.57 Article 6.5). To ensure, that the websites are fitting to everyone, it is necessary to offer possibilities to enlarge the texts and images with a special tool to make it accessible to visually impaired people. Moreover, all images need to have informative labels and text equivalents to support those people using screen reader software. Furthermore, other types of media and visual tools like videos shall be included. To assist the users searching for specific content on the websites, a search utility provides a tool to quick and easy access. This shall also be an indicator in the analysis. As recommended by the EPF, the websites will also be investigated on the availability of real patients' experiences like stories or testimonies. Finally, the patients would profit from specific pathways or check-lists, summarizing the most important steps to access cross-border care. Like recommended by the EPF, those will also be included as an indicator for user-friendliness.

As the evaluative study found, less than half of the investigated websites made the date of the latest update publicly available. (Zucca et al. 2015, p.123) For patients looking for current changes and standards, this information might be important to relate to. Therefore, also the **information on updates** shall be considered as an indicator, whether it is available and when the page was updated latest.

To gather information about cross-border treatment for patients in other Member States, it might be favorable, if the content of the websites is available in other **languages** than only the native language. According to Zucca et al., almost all the websites (29 of 32) are available in English, either as native language or as second alternative. (Zucca et al. 2015, p.114) Nevertheless, it might be interesting to investigate, if all the content of the website is available in English or only part of it and if other additional languages are available as well to expand the access and the comprehensibility to foreign population.

According to the Directive, the patients shall be provided with **further information** on their rights, national circumstances and procedures. One of the main tasks of the National Contact Points is to provide information on the standards of quality and safety of healthcare "including provisions on supervision and assessment of healthcare providers" (European Commission, 2011, p.56 Art.4.2a) As the researchers found, most of the Contact Points include general descriptions of the national healthcare systems and available services, but only half of them provide statistics on healthcare services or qualifications required by the national system. (Zucca et al., 2015, p.115-118) To make an informed choice as a patient, those information take a main part in choosing a suitable healthcare provider and improving the transparency for the population. Therefore, the availability of information on the quality of healthcare providers in the country shall also be included. Further information shall be provided on patients' rights and administrative procedures in cases of harm or complains, data protection, entitlement to medical records and for patients with rare diseases (European Commission, 2011, p.56 Art. 4 – p.57 Art. 6). According to the data of Zucca et al., some websites present information on those topics, but there are still differences along the Contact Points. (Zucca et al., 2015, p.117) Therefore, the websites shall be analysed with regard to information about those particular cases.

As discussed in different studies, the **financial/ bureaucratic aspects** of cross-border healthcare are the most crucial point to the patients to consider treatment in a different Member State. This affects information and guidance in terms of reimbursement procedures and regulations, as well as conditions for prior authorization. As discussed above, there are rather specific instructions given in the Directive 2011/24/EU concerning terms and conditions in these cases (see section 2.4.2.). According to the results of the study by Zucca et al., about 2/3 of the websites declared which treatments are open to reimbursement and under what conditions a prior authorization is necessary. However, only 1/3 provided information on the time period required to process the requests, the specific treatments where authorization is necessary or on the application forms. Moreover, only half of the websites included information on the type of tariffs, which would be applied, and even less informed about the required documentation or the time period for reimbursement. (Zucca et al., 2015, p.118-119) Therefore, the websites shall be reinvestigated towards information about conditions for prior authorization and which

treatments are included in this category. Further indicators will be provided about the time periods needed to process a request or a reimbursement and the required documents. Following the recommendation of the EPF "information should be given on the full costs of the care abroad in a comparable and understandable format. This should not only give basic tariffs but indicate what is reimbursed by the home healthcare system, and what extra costs would need to be covered" (European Patient Forum, 2015, p.10). Therefore, the estimated costs of a treatment and additional costs will be another indicator.

To help the patient making an informed choice in healthcare, it might be helpful to provide **informational sources** on the topic for the interested reader to consult. Furthermore, it might be helpful to collect additional relevant **contact information**. Therefore, the websites will be investigated on the possibility to find a list of relevant links to the legislation, as well as to other scientific publications on the topic. To find healthcare abroad, the user of the website might want to contact other National Contact Points, healthcare providers, insurers, national or European authorities and Patient organizations. Concerning information on other National Contact points, there were nine websites without this information in the evaluative study. (Zucca et al., 2015, p.119) Moreover, the Directive states, that National Contact Points should "consult with patient organizations, healthcare providers and insurers" (European Commission, 2011, p.57 Arti.6.1). Therefore, a section on contact information might be necessary and will be defined as another indicator.

Finally, the lack of awareness of the Directive and the new rights to cross-border care are often discussed as a major challenge. To enhance the range of visibility, the National Contact Points have different options in **raising awareness**. In the analysis of the websites it will be checked, if they provide a possibility to connect with social media and if there is information provided in form of brochures or leaflets to download or print for further distribution. All of the selected indicators are collected in an analytical template (see table 1) used to investigate the websites.

Category	Indicator	Result
User-friendliness	FAQ	☐Yes/☐No
	Visual tools (videos)	☐Yes/☐No
	Tools to enlarge the text	☐Yes/☐No
	Label and description on pictures	☐Yes/☐No
	Search utility	☐Yes/☐No
	Patient stories and testimonies	☐Yes/☐No
	Check-lists/Pathways	☐Yes/☐No
Update	Information available	☐Yes/☐No
	Latest Update	Date
Languages	English available	☐Yes/☐No
	All English content	☐Yes/☐No
	Other foreign languages available	☐Yes/☐No
Further Information	quality of healthcare providers (standards)	☐Yes/☐No
	quality of healthcare providers (statistics)	☐Yes/☐No
	cases of harm	☐Yes/☐No
	complaints	☐Yes/☐No
	data protection	☐Yes/☐No
	entitlement to medical records	☐Yes/☐No
	rare diseases	☐Yes/☐No
Financial/ bureaucratic aspects	conditions for prior authorization	☐Yes/☐No
	treatments that need prior authorization	☐Yes/☐No
	time period to process request	☐Yes/☐No
	time period to process reimbursement	☐Yes/☐No
	required documents for request	☐Yes/☐No
	required documents for reimbursement	☐Yes/☐No
	estimation of costs for treatment	☐Yes/☐No
	estimated additional costs	☐Yes/☐No
Informational sources	Directive 2011/24/EU	☐Yes/☐No
	Publications	☐Yes/☐No
Contact information	National Contact points	☐Yes/☐No
	Healthcare providers	☐Yes/☐No
	Insurers	☐Yes/☐No
	National authorities	☐Yes/☐No
	European authorities	☐Yes/☐No
	Patient organizations	☐Yes/☐No
Awareness raising	Connection to social media	☐Yes/☐No
	Ready-to-print information	☐Yes/☐No

TABLE 1 ANALYTICAL TEMPLATE

4.2. LIMITATIONS

Although this research has been done in a structured and systematic manner, there are still some unavoidable limitations to the results. The analysis is based on a limited set of indicators that have been selected corresponding to the results and recommendations of previous analysis

and required aspects included in the Directive 24/2011/EU. Therefore, it can only be seen as an attempt to contribute to the ongoing research in a limited area as it is partly based on previous attempts. Therefore, the scope of the research is limited. Moreover, the impact of random errors and the validity has to be considered.

The reliability of a research instrument is reflecting the impact of random error on the outcome. "An instrument is called reliable to the extent that it yields data that is free of error" (Schreiner, 2012, p.167). This is connected to the consistency of the data collection, for example generating the same results across different points of time or different persons investigating the content. Moreover, a sampling error can occur when choosing the wrong or a small sample that gives a biased estimation of the population. (Rössler, 2010, p.197-205) In this paper, the data collection has been carried out by a single coder in a small period of time from a single investigation in the week of 24.08.2015 till 30.08.2015. This enhances the inter-coder reliability, but only gives a picture about the situation in this timeframe. Since some of the indicators are chosen to re-assess the previous analysis, the results will be comparable across time to enhance reliability, but also investigate changes that might have occurred. Although the websites have been investigated systematically, the variation in structure, content and size enhance the possibility, that some of the information has been missed or miss-interpreted.

The validity of a research design, however, is reflecting if the data measurement gives a picture of the concepts that are investigated. "An instrument is considered valid to the extent that it captures what it sets out to capture" (Schreiner, 2012, p.167). Since the chosen sample covers all of the National Contact Points, the analysis is representative and the findings are generalizable. However, the data collection is dependent on the English version of the websites or translations and not based on the native language. This might have an influence on the general validity of the results. The dichotomous indicators have been selected to reflect, whether the information in question is provided in any manner. They have not been designed to assess the quality or quantity of the information provided on a single website. Therefore, this research design cannot judge aspects of the quality of the web content, but generates a higher validity in the construction. If information was provided as a link to another website, the link was followed, but only till this second website. However, the website was not further explored than to the given web-page. If the information in question was not indicated there, the information was rated as missing. Since the National Contact Points are requested to provide relevant information to the user, this information shall be displayed on the website of this Contact Point. The task of researching general information on the topic shall not be diverted to the user. However, it is possible that information is provided on those linked websites, which might be accessible with further research.

5. ANALYSIS

In the following, the gathered data material will be illustrated, following the rational of the methodology. Therefore, the information is highlighted and compared to provide a detailed overview to the findings. The complete results can be found in the Annex.

In the data collection, two of the websites did not provide information due to different reasons. The website of Iceland did not include information on cross-border care, although included in the official list of the EU (European Commission, 2014). Therefore, it has not been included in the analysis. Moreover, the website of Gibraltar was not accessible in the time period of the data collection and could not be included either. Consequently, only 32 websites of National Contact Points have been included in the analysis.

5.1. ANALYSIS OF THE SELECTED WEBSITES

The first section that has been assessed was the **user-friendliness** of the websites. The collected data material reviles an ambiguous picture of the considered indicators. In some aspects, the websites provided helpful tools to the user to navigate and find information, but in other cases, recommended elements did not occur at all.

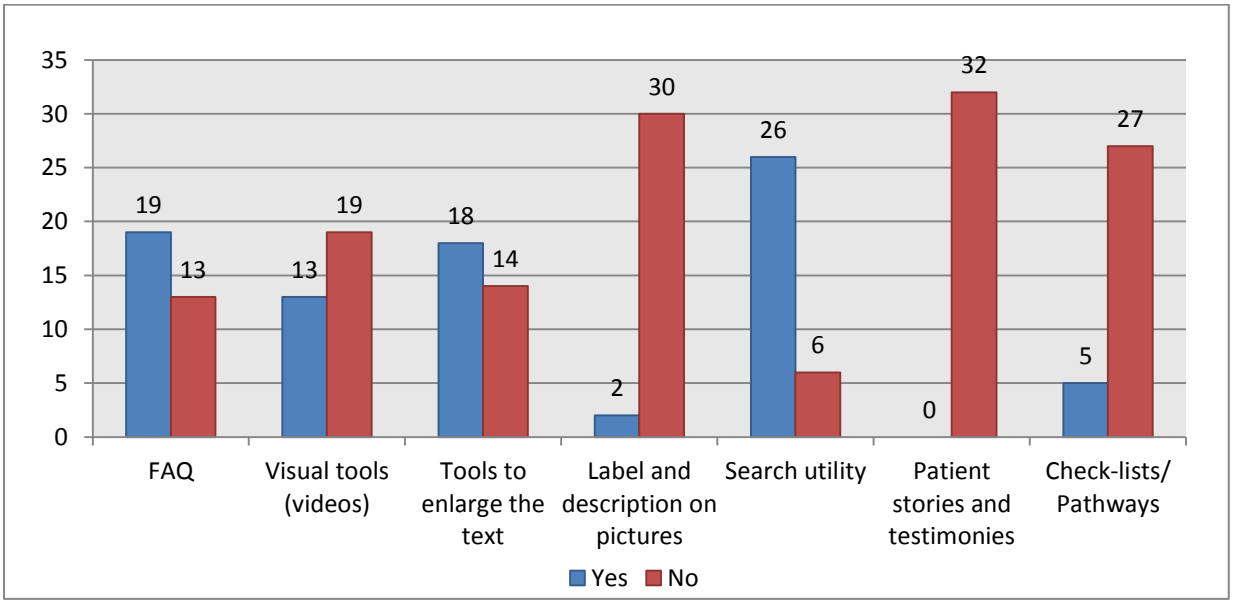


FIGURE 1 USER-FRIENDLINESS

As to be seen in figure 1, more than half of the National Contact Points included a FAQ section (59.4%), tools to enlarge the text (56.3%) and a search utility (81.3%). Thirteen websites provided videos in their content (40.6%), mostly a video provided by the EU. The other indicators in this category, however, could not be found on most of the included sites. Only two of them had labels and descriptions on the pictures used (6.3%), however some did not use any pictures at all. Following the recommendation of the EPF, only five of the National Contact Points

included check-lists or pathways in their information (15.6%) and real patients' stories or testimonies could not be found on any of the websites. Furthermore it could be noted, that some of the websites also provided tools to listen to selected text segments or to change the colour of the text or background to make it more user-friendly. Some of the websites also included videos with sign language on the rights as a patient to especially address deaf users.

The second section that has been assessed is the information on **updates** given by the websites. In 17 out of 32 cases, information on the latest update could be found. Three of those (9.4%) updated the website around September/October 2013, when the Directive was implemented officially and have not been adjusted since then. Other National Contact Points, however, updated the websites in the following years. In seven of the assessed cases (21.9%), changes have been made in the year 2014 and in addition, seven websites (21.9%) updated their content after the release of the evaluative study by Zucca et al. in March 2015.

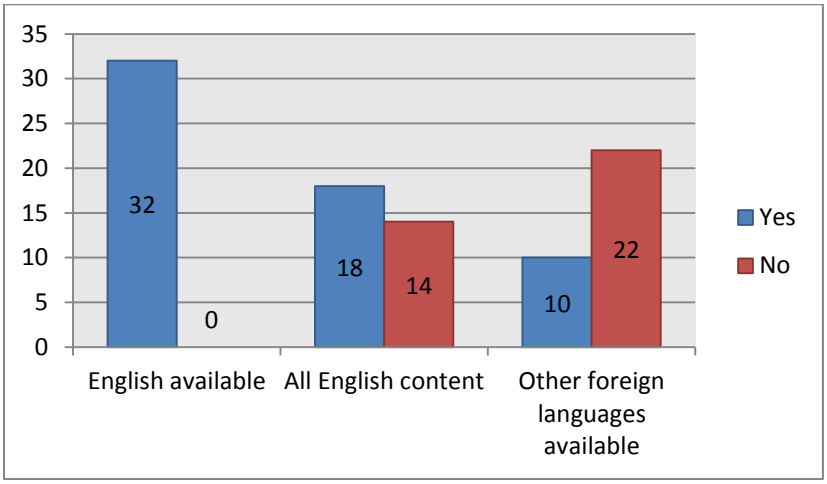


FIGURE 2 LANGUAGES

In the following section, the availability of foreign **languages** has been analysed, see figure 2. All of the assessed websites had information available in English language or had an alternative website for English speaking users. However, only 18 of them (56.3%) provided an all English content, which made it easier to navigate and find relevant information. In many cases, the information about the procedures and circumstances in the country was not given on the site directly, but as a link to other websites or PDF document, that was not available in English. Moreover, some of the websites in English provided only a selection of the information given on the original site. Finally, some of the National Contact Points (31.3%) also provided content in other foreign languages, mostly those with mutual borders.

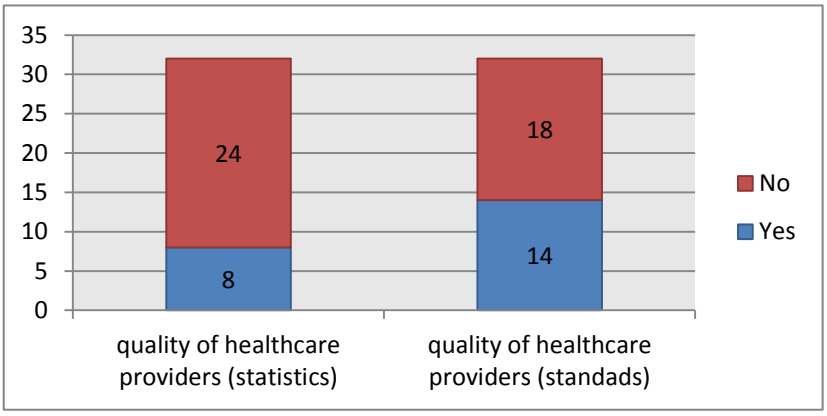


FIGURE 3 QUALITY OF HEALTHCARE PROVIDERS

In the fourth segment, the **information provided** on the websites has been assessed with some selected indicators. As to be seen in figure 3, there are some variations in the information on the quality of healthcare providers. Almost half of the National Contact Points (43.8%) included information on the national standards and legislations to promote high quality healthcare. Many of the pages provided a link to other websites or just request the user to get into personal contact for further information. Regarding the actual quality of the healthcare, only eight (25%) of the websites included possibilities to find statistics on the national healthcare providers. In the cases of the other indicators, there is also a variation in the distribution as to be seen in figure 4.

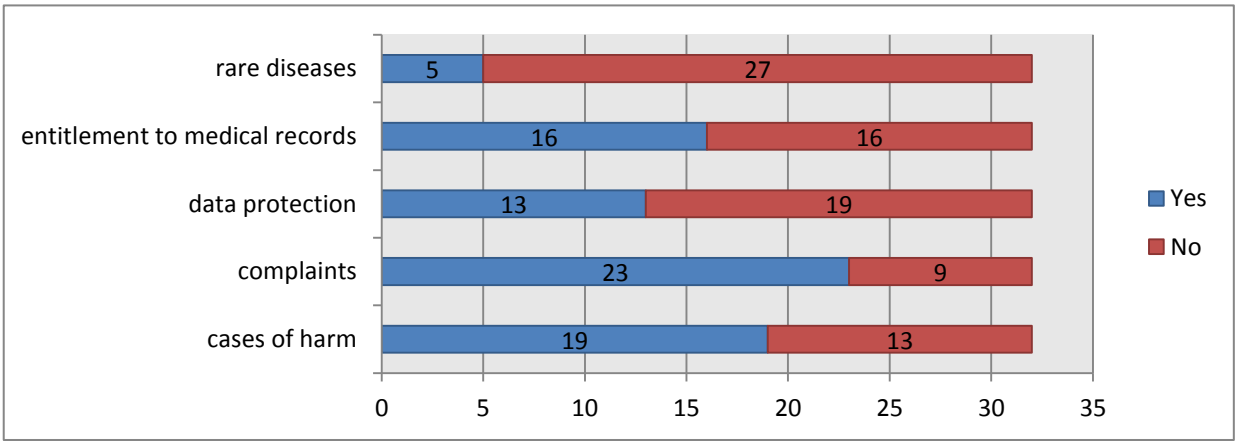


FIGURE 4 INFORMATION

A large share of the websites (71.9%) included sections about cases of complaints and whom to address. In cases of harm 19 pages (59.4%) had information on the procedures, although it was very brief in most of the cases. The data protection (40.6%) and the entitlement to medical records (50%) was addressed in about half of the websites, but only five of them (15.6%) provided information for rare disease patients. This mostly consisted of a link to a European funded portal of rare diseases.

In the next segment, **financial and bureaucratic aspects** of cross-border care have been investigated. Due to the necessity to upfront payment in most of the cases, it is crucial for the users to get an overview of the expenses incurring. Moreover, patients need to be informed about the procedures with prior authorization and reimbursement. In 3/4 of the cases, the NCPs

included information about the general conditions for prior authorization as listed in the Directive. However, on 19 websites (59.4%) there was no information to be found, on the actual treatments that fall under those categories in the country. The information concerning the legal procedure is also provided rather heterogeneous.

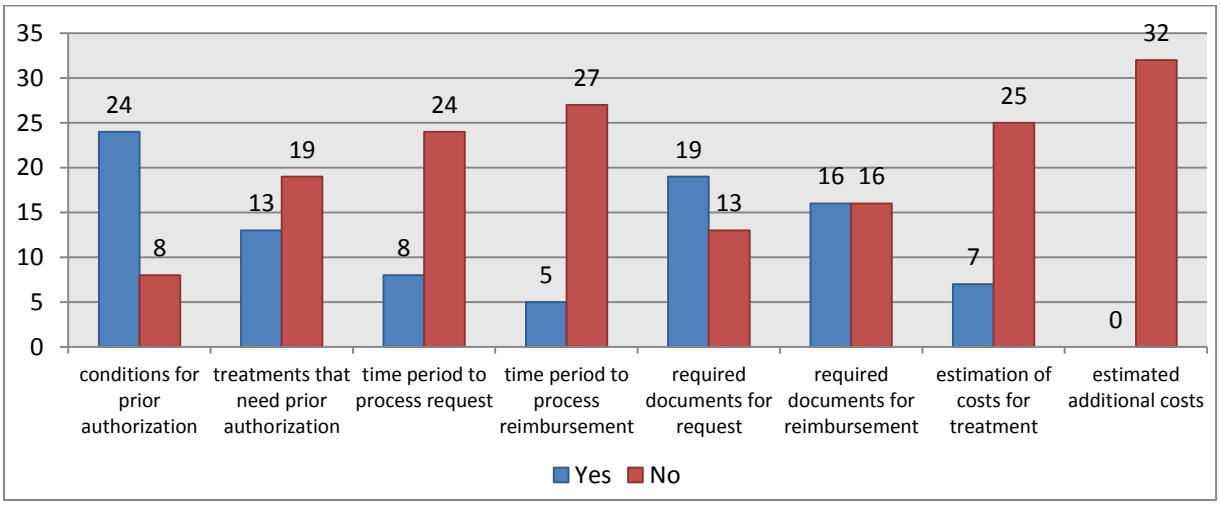


FIGURE 5 FINANCIAL ASPECTS

In 59.4% of the cases, the required documents for a request on prior authorization can be found or downloaded, but only eight of the websites (25%) had information on the time period which is needed to process the request. A similar situation can be found in terms of reimbursement of the costs. Half of the Contact Points provided information on the required documents, but only five of them included time periods for the processing. Finally, the websites have been assessed on estimations of treatment costs or additional costs for the EU citizen in this country. On seven of the analysed sites (21.9%), catalogues of incurring expenses could be found, whereas none of the websites included estimations of additional costs for a foreigner patient. To promote informed patients, that are able to make a well-acquainted choice on their healthcare, it might be helpful to include the **relevant legislation**, as well as other publications on the topic to the websites of the National Contact Points. In most of the cases (78.1%), the Directive 24/2011/EU could be found on the websites, whereas only eight of them (28.1%) provided a link or PDF with additional information. When users are looking for further information or individual consultation, **contact information** of key stakeholders might help to find responsible and competent contacts. In most of the cases, contact information on other National Contact Points (87.5%) or national authorities (90.6%)

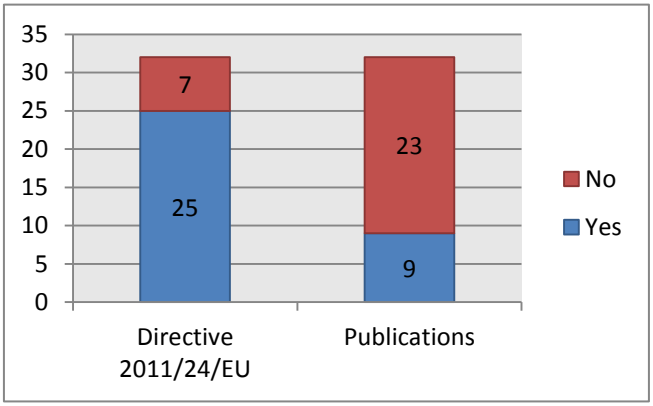


FIGURE 6 INFORMATIONAL SOURCES

has been provided (see figure 7). This might also be the case, because many of the websites are included in web portals of national health authorities. However, there has also been specific information on single healthcare providers in the country on 23 of the investigated sites (71.9%). Some of the pages included information about insurers (31.3%) or European authorities (46.9%), though only in seven cases (21.9%), contact information on patient organizations could be found.

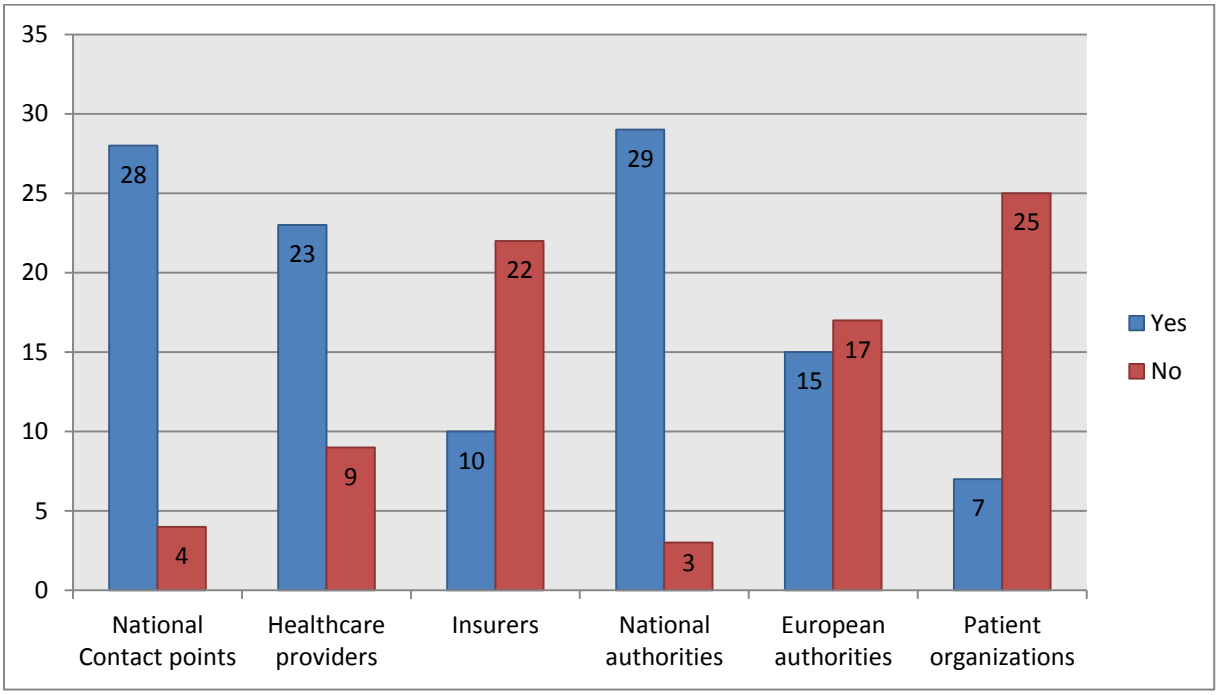


FIGURE 7 CONTACT INFORMATION

Finally, two possibilities of public interaction and **awareness-raising** have been selected as a category. Some of the assessed websites offer possibilities to connect with different kinds of social media, whereas 20 of them (62.5%) did not include this option. Regarding the availability of printable leaflets or other forms of ready-to-print information, 19 of the websites (59.4%) provided some sort of printable PDF with a summary of general information (see figure 8). In most of the cases, they offered a link to the leaflet provided by the EU.

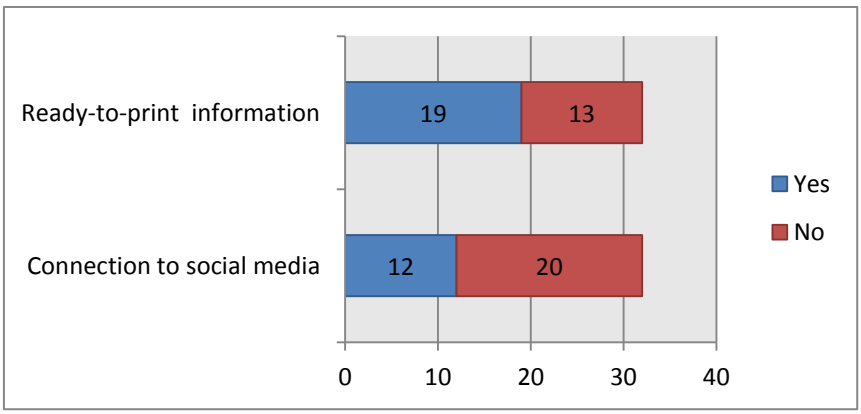


FIGURE 8 AWARENESS RAISING

5.2. DISCUSSION OF THE RESEARCH QUESTION

After assembling and comparing the collected data material, the results will be reflected in the context of the previous studies and literature. Moreover, the generated distributions will be structured following the outline in the methodology to establish similarities and differences on the websites and what changes can be found in comparison with the previous evaluative study. Thereby, the research questions shall be kept in the focus of the discussion to finally evaluate the adaption of the Directive 24/2011/EU in the Member States in 2015.

Did the 28 EU member states establish a functioning and accessible website in accordance with the Directive 24/2011/EU?

The Directive requires the Member States to establish National Contact Points to provide information on patients' rights, that "shall be easily accessible and shall be made available by electronic means" (European Commission 2011, p.57 Article 6). Two years after its implementation, the European Commission provides a contact list of 28 NCPs of EU Member States complemented by contact information on Norway and Iceland. (European Commission, 2014) Following this list, all of the websites are accessible. However, some of the links provided only directed the user to a general website of the Member State and the specific content on cross-border care had to be found. The website included for Iceland only provided general information on the healthcare system and some additional for tourists. However, no specific information on the Directive could be found and therefore, this website was not included in the analysis. Following the construct of the evaluative study of Zucca et al., the four websites of the United Kingdom have been investigated separately, revealing that the online platform of Gibraltar was not accessible in the time period of the data collection. Thus, only 32 of the 34 websites could be included in the analysis, although all of the 28 Member states provided a functioning and accessible website in accordance with the Directive. In the following, the similarities and differences in these sites are presented and discussed to answer the research question.

What are the similarities in the provided information by the National Contact Points on the established websites?

Referring back to the findings of Zucca et al., all of the websites were easily accessible, although the navigation is more complicated when embedded in other websites. Almost all of them (28 NCPs) provided different channels of communication like telephone or email contact and a majority (21 NCPs) had also published an office address. (Zucca et al., 2015, p.112-114) This makes it easy for the population to approach the National Contact Point with their chosen means

of communication and to acquire further information. In terms of user-friendliness (see figures 9 and 10), most of the websites (81.3%) included a search utility to simplify the navigation, which is especially useful because of the great variety of website designs and content. In contrast, it was common for most of the websites, that there were no labels on pictures or graphics (93.8%) to include users with screen reader software. In many cases, the providers did not make use of pictures at all to support the information given. Moreover, none of the NCPs provided real patients' stories or testimonies like recommended by the EPF and only five websites established actual check-lists or pathways for the users' orientation. Concerning the provided language, the evaluative study found, that 22 of the assessed pages offered English as a second alternative language. (Zucca et al., 2015, p.114) In this re-assessment it could be found that for all the investigated websites, an English section or alternative was provided, although it did not always feature the elements of the original versions. For users from other Member States, this is an opportunity to understand the main information if desired, although some details might be missed. In terms of financial or bureaucratic aspects, 75% or 24 of the websites had information on the conditions of prior authorization, an increase of 9.5% compared to the results of the previous study. (Zucca et al., 2015,

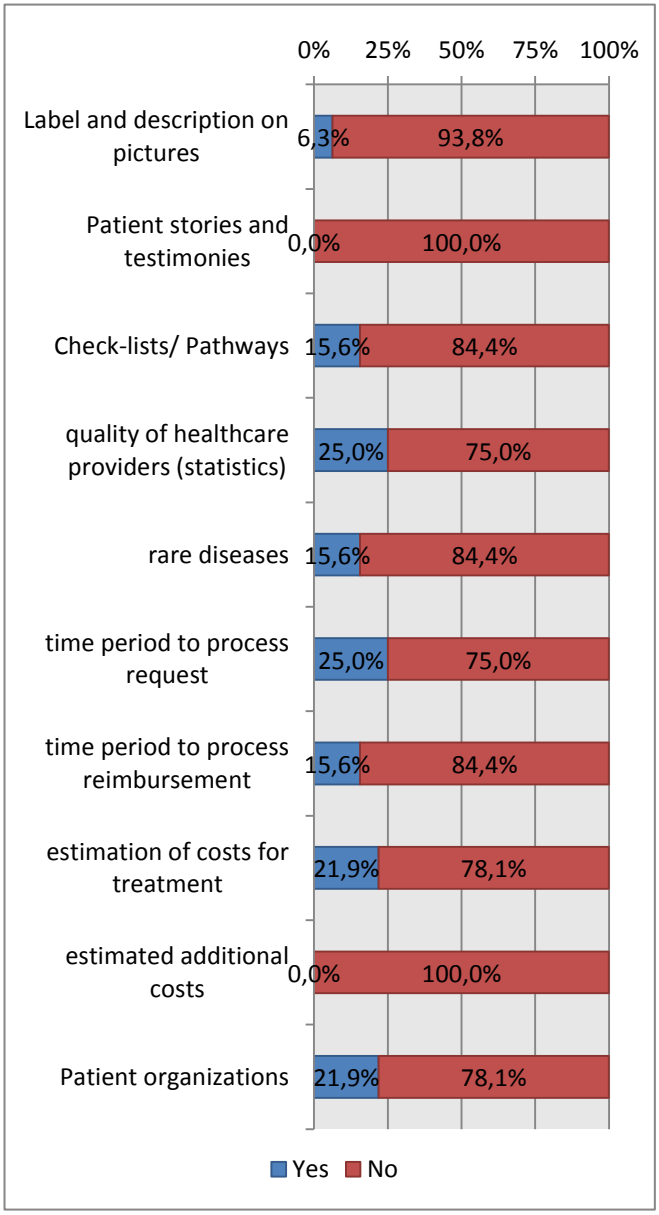


FIGURE 9 INFORMATION MISSING

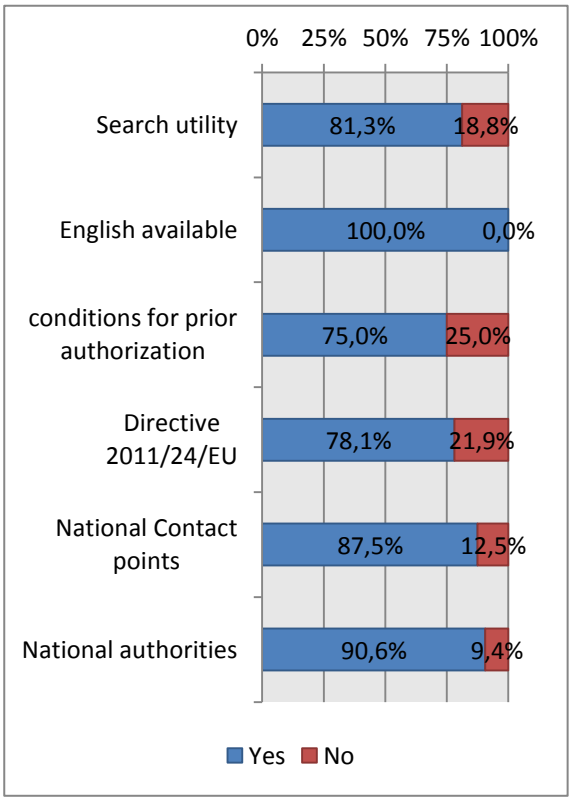


FIGURE 10 INFORMATION PROVIDED

p.118) In contrast, the websites also had in common, that mostly there was a lack of information on the time periods to process a request (75%) or the reimbursement (84.5%). Only five NCPs could be counted providing information on the necessary time for reimbursement, slightly different to the evaluative study where seven had been spotted. (Zucca et al., 2015, p.119) Moreover, most of the Contact Points did not include information on the estimated treatment costs (78.1%), although they often encouraged the users to seek direct contact for further information. An estimation of additional costs could not be found on any of the websites. As Zucca et al. found, most of the platforms (29 NCPs) provided general information on patients' rights, but only one website included information for patients with rare diseases. (Zucca et al., 2015, p.117) Although the re-assessment revealed a total of five NCPs that had this information included, there is still 87.4% of the websites lacking this information. Among others, the Directive includes the right of information on the "quality and safety of the healthcare they provide in the Member State" (European Commission, 2011, p.56 Art.4.2.b). Although some NCPs provide information on general standards and legislations on the quality and safety, specific statistics or evaluations are not available in 75% of the cases. Therefore it is difficult for the user of a different Member State to estimate the actual quality of a certain healthcare provider that is considered. However, the majority of the websites (78.1%) included the legislation text of Directive 24/2011/EU to enable users to get further information on their specific rights as defined by the Commission. Finally, the websites were rather similar in some aspects of contact information they provided. As found in the evaluative study, 23 of the websites had lists of other NCPs with links to contact them online. (Zucca et al., 2015, p.119) In the re-assessment, an increase of five NCPs could be found in this area. Although a majority included links to other NCPs (87.5%) or national authorities (90.6%), they mostly did not include patient organizations (78.1%). Therefore, the participation of patient organization still seems to be a major challenge as discussed in section three.

Altogether, most of the websites had in common that they were easy to find and provide several channels of communication. They gave basic information, also on the conditions for prior authorization, and provided an English alternative as well as a search utility. For further information a large share of the websites included the actual Directive in their content and had contact information on other NCP and national authorities. In contrast, almost none of the NCPs provided a contact to patient organizations, or information on estimated costs or bureaucratic time frames. Especially information on rare diseases and statistics on the quality and safety were missing, as well as check-lists, patient testimonies and labels on pictures. However, in contrast to these distinct results, many indicators revealed differences between the websites that shall be discussed in the following.

What are the differences in the provided information by the National Contact Points on the established websites?

Whereas some distributions of the variables were rather unambiguous, most of them turned out to be more heterogeneous. In terms of user-friendliness, Zucca et al. found 17 websites that included a FAQ section and nine providing a media library or videos on the topic. (Zucca et al., 2015, p.114) In the second assessment of these indicators, a small increase could be noted, that can be considered as a slight improvement but might also be a random error. Although a majority of the NCPs provided FAQ sections (59.4%) and tools to enlarge the text (56.3%), there is still a large share of the websites that could be improved by these tools. To emphasize the validity and up-to-date nature of information provided, 15 of the websites (46.9%) might include information on the latest update, which could not be found in these cases. As a comparison, in the evaluative study, there have been 17 websites without this information. (Zucca et al., 2015, p.123) Moreover, out of these websites that provided information on updates, only seven (21.9%) had been updates in the current year. Regarding the several conferences and evaluations recently, revising of the provided information might be advisable.

Although all of the websites offered elements in English as a second language, only 56.3% provided all of the given content in English. Many other websites only translated parts of the information or provided links to crucial information without an option on an English version. Nevertheless, ten of the NCPs (31.3%) also established information in other foreign languages, mostly those of countries with mutual borders. Comparing the results of the evaluative study and the re-assessment, the information in cases of harm or complaints, is almost without any difference. As Zucca et al. found, 20 websites informed on procedures in cases of complaints and 19 of them in cases of harm. (Zucca et al., 2015, p.115) In this second attempt, two websites could be found in addition with content concerning complaints (71.9%) and the same amount concerning cases of harm (59.4%). Even less websites included information on the entitlement to medical records (50%) or data protection (40.6%). Therefore, the information on the patients' rights is more exhaustive on some websites of the NCPs than others. Similar results can be found in the area of finical or bureaucratic aspects. In the assessment of the evaluative study, it has been found that only 11 of the websites provided information on requirement documents. (Zucca et al., 2015, p.119) Regarding the information provided on documents for prior authorization (19NCPs) or for reimbursement (16NCPs), it can be said, that for a large share of the websites, this information is still missing. The difference of the distribution in the two studies, however, is most likely to be the result of a difference in the design of the indicators. Finally it could be found that for 59.4% of the websites, there was no information included on the specific treatment that requires prior authorization. Although some NCPs included this list, in most of the cases only a general categorization is given, so that the user has to put further

effort in research on the desired treatment. To collect further information, some contact information is to be found especially on other National Contact Points and national authorities, but only sometimes on healthcare providers (71.9%), insurers (31.3%) or European authorities (46.9%). Especially in the context of a multi-stakeholder approach connected on a single platform, this information might be advisable to include. Finally, there are differences to be found regarding the indicators on public interaction and awareness-raising. Only 12 NCPs (37.5%) established a possibility to connect with social media, whereas in 19 cases (59.4%) printable media could be found. This might also be an opportunity for further development of the websites. Thus, it can be said, that there are many differences to be found on the informational content of the investigated websites and some are more exhaustive than others. However, a comparison and closer cooperation might reveal opportunities to further improvement and mutual learning.

6. CONCLUSION

With the principle of free movement and high level of health protection on the one hand and limited competences in the healthcare policies on the other, the European Union has to rely on the cooperation of its Member States when negotiating and implementing changes in this area. This paradox influences the choice of policy instruments to frame common agreements. Regarding the variety of healthcare systems and financing in the EU, it is more likely to find common agreements in softer instruments that contain recommendations for national policies than in binding regulations. With the Directive 2011/24/EU, the Member States agreed on an instrument that is binding to its results, but open to individual adjustments. In the light of legal uncertainties in the area, the Directed has provided a framework on cross-border care with an attempt to empower the patients' rights, the quality of healthcare and the overall cooperation between the Member States. As described above, however, the Directive claims to respect the national competences, but still gives explicit targets in many areas that leave little leeway. This blurred composition of the instrument might give a hint at the connection behind the variations in the results of the analysis.

6.1. THE ADOPTION IN THE MEMBER STATES

Although the data base on the cross-border healthcare is rather limited, some attempts have been made to analyze the impact of the Directive. In general it can be said, that the awareness towards the right to cross-border care is still very low, although the majority is rather satisfied with the care in retrospect, despite the expenses to be borne and the formalities. Combining the results of the evaluative study of Zucca et al., with the re-assessment in this paper, some

similarities and differences in the establishment of the websites can be found. Although this analysis has covered only some elements of the Directive, it can be seen as an attempt to assess the major aspects of patients' rights in this legislation and thereby to contribute to a broader field of research. In sum, it could be found that all of the Member States have established a functioning website, although two websites of the original sample had to be excluded. Nevertheless, the sample is still highly representative and the results therefore generalizable. Most the established websites have in common, that general information is provided in the native language as well as on an English alternative. Moreover, the websites offered several contact possibilities to access further information, provided the Directive 2011/24/EU it is based on and included a search utility. Then again they have in common that some information or tools are generally missing, like estimated costs or time frames. Despite that, the websites show more differences than similarities, which reflects the nature of the underlying policy paradox and the limitation of the Directive. The information provided on some websites is more exhaustive than on others, leaving the user with the task to gather all the important details. The national deviations uncover gaps between the requirements of the Directive and the practical transformation. Although it is defined that the information should be "accessible to people with disabilities, as appropriate" (European Commission 2011, p.57 Article 6.5), many websites did not include suitable tools or contents. Similar results could be found in every other category that has been investigated (see section 5). Summarizing it can be said, that the Directive has been implemented superficially in every Member States, but there is still a variety of differences in the adoption. This might contain the possibility for individual solutions but also contribute to the uncertainty of the individual patient considering cross-border care.

6.2. RECOMMONDATIONS

Considering the collected results, recommendations can be given towards the websites of the National Contact Points as well as towards further research in the field of cross-border healthcare. Although national deviations may be conductive to keep the content of the website adaptable, it might be recommendable to work on a standard web design for the National Contact Points to make sure all the required information is included and the comparison and navigation for the user is simplified. Moreover, this might promote the cooperation and communication among the NCPs and other stakeholders and enhance the transparency of the process. Furthermore, it is recommendable to provide the same information in alternative languages and keep them updated on a regular basis to reach different target groups with recent development and to guarantee credibility. As adressed by Zucca et al. as well as by the EPF, a closer cooperation with other stakeholders, especially patient organizations might be recommendable in general, but also benefits the consideration of users with disabilities in the

web design. Frequent conferences like held by the EPF might be a suitable basis to find common solutions and measures of best practice. Similar recommendations can be given towards common standards for quality and safety in the European Union. Regarding the difficulties to find information on this topic, it might be even more challenging to compare or interpret the given data for a single user. As the EPF points out: "Information on the quality of care and patient safety should be made comparable across institutions (within countries) and across member states. Convergence of national standards should be encouraged." (European Patients Forum, 2015, p.15) However, binding healthcare standards in the EU would probably require the Member States to agree on a common regulation, which is unlikely because of the difficulties to find common ground in social policies.

For further research it can be said, that the adaption of the Directive 2011/24/EU can be analyzed from many different perspectives, whereas this study has chosen only one option with and a limited focus. Other possibilities might include interviews with the National Contact Points to get insight into the main challenges from this perspective or to approach insurers, healthcare providers or patients that got treatment abroad. Apart from investigating, what kind of information is provided on the websites, it could also be useful to evaluate the quality of the provided content to give insight into this aspect in supporting patients' rights. As mentioned above, the data basis on this topic is still rather small and especially the differences or the absence of data collection concerning patients that seek cross-border care is a major obstacle to come to insightful conclusions in this area. Focusing on the National Contact Points, this attempt provides insight into the adaption of the Directive in the institutional context highlighting similarities and differences and thereby limitations of the European legislation. However, further research with other approaches might be beneficial to provide a more exhaustive picture.

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ANNEX

	Evaluative Study	European Commission
Austria	https://www.gesundheit.gv.at/Portal.Node/ghp/public/content/kontaktstellepatientenmobilitaet.html	https://www.gesundheit.gv.at/Portal.Node/ghp/public/content/kontaktstellepatientenmobilitaet.html
Belgium	http://www.health.belgium.be/eportal/Aboutus/crossborder_healthcare/index.htm?fodnlang=en	www.crossborderhealthcare.be
Bulgaria	http://www.nhif.bg/web/guest/home	www.nhif.bg
Croatia	http://www.hzzo.hr/en/travel-insurance/english-emergency-care-in-the-e	www.hzzo.hr
Cyprus	http://www.moh.gov.cy/moh/cbh/cbh.nsf/index_en/index_en?OpenDocument	www.moh.gov.cy/cbh
Czech Republic	http://www.cmu.cz/	www.cmu.cz
Denmark	https://www.patientombuddet.dk/Klage-_og_sagstyper/International_Sygesikring/Nationalt_kontaktpunkt_for%20_behandling%20_i%20_EU_EOES.aspx?sc_lang=en	https://www.patientombuddet.dk/Klage-_og_sagstyper/International_Sygesikring/Nationalt_kontaktpunkt_for%20_behandling%20_i%20_EU_EOES.aspx
England	http://www.nhs.uk/NHSEngland/Healthcareabroad/Pages/Healthcareabroad.aspx	www.nhs.uk/nationalcontactpoint
Estonia	http://kontaktpunkt.sm.ee/eng/home.html	http://kontaktpunkt.sm.ee
Finland	http://www.kela.fi/yhteyspiste	http://www.kela.fi/yhteyspiste
France	http://www.sante.gouv.fr/point-de-contact-national-pour-la-france.html	http://www.cleiss.fr/presentation/pcn.html
Germany	http://www.eu-patienten.de/	www.eu-patienten.de
Gibraltar	http://www.crossbordercare.gi/cms_two.aspx?pageID=2	
Greece	http://www.eopyy.gov.gr/Home/StartPage?a_HomePage=Index	www.eopyy.gov.gr
Hungary	http://www.eubetegjog.hu/ http://www.patientsrights.hu/	http://www.patientsrights.hu/ http://www.eubetegjog.hu/
Ireland	http://hse.ie/eng/services/list/1/schemes/cbd/CBD.html	http://hse.ie/eng/services/list/1/schemes/cbd/CBD.html
Iceland		http://www.sjukra.is/english
Italy	http://www.salute.gov.it/portale/temi/p2_6.jsp?lingua=english&id=3811&area=healthcareUE&menu=vuoto	http://www.salute.gov.it/portale/temi/p2_4.jsp?lingua=english&area=healthcareUE
Latvia	http://www.vmnvd.gov.lv/en/news	www.vmnvd.gov.lv
Lithuania	http://www.lncp.lt/en	www.lncp.lt http://www.vaspvt.gov.lt/en http://www.vlk.lt/vlk/en/
Luxembourg	http://www.cns.lu/?&language=en	www.mediateursante.lu
Malta	https://ehealth.gov.mt/healthportal/chief_medical_officer/eu_healthcare_entitlement_unit/applying_ehic.aspx	https://ehealth.gov.mt/HealthPortal/chief_medical_officer/cross_border_healthcare/information.aspx
Northern Ireland	http://www.hscboard.hscni.net/publications/Policies/270%20Information%20for%20patients%20travelling%20outside%20Northern%20Ireland%20for%20treatment.html	
Norway		https://helsenorge.no/norwegian-national-contact-point-for-healthcare1
Poland	https://www.ekuz.nfz.gov.pl	http://www.kpk.nfz.gov.pl/en/
Portugal	http://diretiva.min-saude.pt/inicio-4/	http://diretiva.min-saude.pt/home-2/
Romania	http://www.cnas-pnc.ro/?l=en	www.cnas-pnc.ro
Scotland	http://www.nhsinform.co.uk/rights/europe	
Slovakia	http://www.nkm.sk/	www.udzs-sk.sk
Slovenia	http://www.nkt-z.si/wps/portal/nktz/home	http://www.nkt-z.si/wps/portal/nktz/home
Spain	http://www.msssi.gob.es/pnc/home.htm	http://www.msssi.gob.es/pnc/home.htm
Sweden	http://www.socialstyrelsen.se/healthcare-visitors-sweden/about-swedish-healthcaresystem/nbhw-national-point-contact http://www.forsakringskassan.se/privatpers/utomlands/om_du_planerar_vard_utomlands/er	www.forsakringskassan.se www.socialstyrelsen.se
The Netherlands	http://www.cbhc.nl	www.cbhc.nl
Wales	http://www.nhsdirect.wales.nhs.uk/travelhealth/NCPs/	

TABLE 2 OVERVIEW WEBSITES. (ZUCCA ET AL. 2015, P.76-77) (EUROPEAN COMMISSION, 2014)

	FAQ	Visual tools (videos)	Tools to enlarge the text	Label and description on pictures	Search utility	Patient stories and testimonies	Check-lists/ Pathways
x (yes)	19	13	18	2	26	0	5
0 (no)	13	19	14	30	6	32	27
Austria	x	x	x	0	0	0	0
Belgium	0	0	0	0	x	0	0
Bulgaria	x	0	0	0	0	0	0
Croatia	x	0	0	0	x	0	0
Cyprus	x	x	0	0	x	0	0
Czech Republic	0	0	x	0	x	0	0
Denmark	x	0	x	0	x	0	0
England	x	0	0	0	x	0	x
Estonia	x	0	x	0	x	0	0
Finland	x	0	0	0	x	0	0
France	0	x	x	x	x	0	0
Germany	0	0	x	0	x	0	x
Gibraltar							
Greece	x	x	0	0	x	0	0
Hungary	x	x	x	0	x	0	0
Ireland	x	0	x	x	x	0	x
Iceland							
Italy	x	x	x	0	x	0	0
Latvia	0	0	x	0	x	0	0
Lithuania	0	x	x	0	x	0	0
Luxembourg	x	x	x	0	x	0	x
Malta	x	0	x	0	x	0	0
Northern Ireland	0	0	0	0	x	0	0
Norway	0	0	0	0	x	0	0
Poland	0	x	x	0	x	0	0
Portugal	x	0	0	0	0	0	0
Romania	0	x	0	0	0	0	x
Scotland	0	x	x	0	x	0	0
Slovakia	x	0	0	0	0	0	0
Slovenia	x	0	x	0	x	0	0
Spain	x	x	0	0	x	0	0
Sweden	0	0	0	0	x	0	0
The Netherlands	0	0	x	0	0	0	0
Wales	x	x	x	0	x	0	0

TABLE 3 OVERVIEW USER-FRIENDLINESS

x → Yes

0 → No

	Information on Update	Latest Update	English available	All English content	Other foreign languages available
x (yes)	17	17	32	18	10
0 (no)	15	15	0	14	22
Austria	x	25.09.2014	x	x	0
Belgium	x	29.07.2015	x	x	x
Bulgaria	0	0	x	x	0
Croatia	0	0	x	0	x
Cyprus	x	21.11.2014	x	x	0
Czech Republic	x	29.06.2014	x	0	0
Denmark	x	16.03.2015	x	0	x
England	x	24.09.2013	x	x	x
Estonia	0	0	x	0	x
Finland	x	31.10.2013	x	x	x
France	x	27.03.2015	x	0	0
Germany	x	15.07.2015	x	x	0
Gibraltar					
Greece	0	0	x	0	0
Hungary	0	0	x	x	0
Ireland	0	0	x	x	0
Iceland					
Italy	x	04.04.2014	x	0	0
Latvia	x	17.07.2014	x	x	x
Lithuania	x	03.10.2013	x	0	0
Luxembourg	x	29.08.2015	x	x	x
Malta	0	0	x	0	0
Northern Ireland	0	0	x	x	0
Norway	x	17.03.2015	x	x	0
Poland	x	02.09.2015	x	0	0
Portugal	0	0	x	0	0
Romania	0	0	x	x	0
Scotland	x	24.01.2014	x	x	x
Slovakia	0	0	x	x	0
Slovenia	x	23.12.2014	x	0	0
Spain	0	0	x	0	x
Sweden	0	0	x	x	0
The Netherlands	0	0	x	0	0
Wales	0	0	x	x	0

TABLE 4 OVERVIEW UPDATES AND LANGUAGES

x → Yes

0 → No

	quality of healthcare providers (statistics)	quality of healthcare providers (standards)	cases of harm	complaints	data protection	entitlement to medical records	rare diseases
x (yes)	8	14	19	23	13	16	5
0 (no)	24	18	13	9	19	16	27
Austria	0	0	0	0	0	x	0
Belgium	0	x	x	x	x	x	0
Bulgaria	0	0	0	0	0	0	0
Croatia	0	0	0	0	0	0	0
Cyprus	0	0	x	x	0	x	0
Czech Republic	x	x	x	x	x	x	0
Denmark	0	0	x	x	0	0	0
England	0	0	0	x	0	0	0
Estonia	0	x	x	x	0	x	x
Finland	0	0	0	0	0	x	0
France	x	x	x	x	0	0	x
Germany	x	x	x	x	x	x	x
Gibraltar							
Greece	0	0	0	0	0	0	x
Hungary	x	x	x	x	x	x	0
Ireland	x	x	x	x	x	x	0
Iceland							
Italy	0	0	x	x	0	0	0
Latvia	0	x	x	x	x	x	0
Lithuania	0	0	x	x	x	x	0
Luxembourg	0	0	0	x	0	0	0
Malta	0	0	x	0	x	x	0
Northern Ireland	0	0	0	0	0	0	0
Norway	0	0	x	0	0	0	0
Poland	0	x	x	x	0	0	0
Portugal	x	x	0	x	0	0	0
Romania	0	0	0	0	0	0	0
Scotland	x	x	0	x	x	0	0
Slovakia	0	0	x	x	x	x	0
Slovenia	x	x	x	x	x	x	0
Spain	0	0	x	x	x	x	0
Sweden	0	0	x	x	0	0	x
The Netherlands	0	x	0	x	0	x	0
Wales	0	x	0	x	x	0	0

TABLE 5 OVERVIEW INFORMATION

x → Yes

0 → No

	conditions for prior authorization	treatments that need prior authorization	time period to process request	time period to process reimbursement	required documents for request	required documents for reimbursement	estimation of costs for treatment	estimated additional costs
x (yes)	24	13	8	5	19	16	7	0
0 (no)	8	19	24	27	13	16	25	32
Austria	x	0	0	0	0	0	0	0
Belgium	x	0	x	0	x	0	x	0
Bulgaria	x	0	0	0	x	x	0	0
Croatia	x	0	0	0	x	0	0	0
Cyprus	x	0	x	0	x	x	0	0
Czech Republic	x	0	0	0	0	0	0	0
Denmark	x	x	0	0	x	x	0	0
England	x	x	0	x	x	x	0	0
Estonia	x	x	x	x	x	x	x	0
Finland	x	0	0	0	x	x	0	0
France	x	x	x	0	0	0	0	0
Germany	x	0	0	0	x	0	0	0
Gibraltar								
Greece	0	0	0	0	x	0	0	0
Hungary	x	0	0	0	0	0	0	0
Ireland	x	x	x	0	x	x	0	0
Iceland								
Italy	x	0	0	0	0	0	0	0
Latvia	x	x	0	0	x	x	0	0
Lithuania	0	0	0	0	x	x	x	0
Luxembourg	x	0	0	0	x	0	0	0
Malta	x	x	0	0	0	0	0	0
Northern Ireland	0	0	0	0	0	0	0	0
Norway	0	x	0	0	0	0	0	0
Poland	x	0	0	0	x	x	x	0
Portugal	x	0	x	x	x	x	x	0
Romania	0	0	0	0	x	x	0	0
Scotland	x	x	0	0	0	0	x	0
Slovakia	0	0	0	x	0	x	0	0
Slovenia	0	x	0	0	0	0	0	0
Spain	x	x	x	0	0	x	0	0
Sweden	x	x	0	0	x	x	x	0
The Netherlands	0	0	0	0	0	0	0	0
Wales	x	x	x	x	x	x	0	0

TABLE 6 OVERVIEW FINANCES

x → Yes

0 → No

	Directive 2011/24/EU	Publications	National Contact points	Healthcare providers	Insurers	National authorities	European authorities	Patient organizations	Connection to social media	Ready-to-print information
x (yes)	25	9	28	23	10	29	15	7	12	19
0 (no)	7	23	4	9	22	3	17	25	20	13
Austria	x	0	x	x	x	0	0	0	0	x
Belgium	x	0	x	x	0	0	0	0	0	0
Bulgaria	x	0	x	0	0	x	0	0	0	x
Croatia	x	0	x	x	x	x	0	x	0	x
Cyprus	x	0	x	x	0	x	0	0	0	x
Czech Republic	x	0	x	x	x	x	x	0	x	0
Denmark	x	0	0	x	x	x	0	0	0	0
England	x	x	x	x	0	x	0	0	x	0
Estonia	0	x	x	x	x	x	0	x	0	0
Finland	x	x	x	0	x	x	x	0	x	x
France	x	0	x	x	0	x	x	x	0	x
Germany	x	x	x	x	0	x	0	0	0	x
Gibraltar										
Greece	x	0	x	0	0	x	x	x	0	x
Hungary	x	0	x	x	0	x	x	0	0	0
Ireland	x	x	x	x	x	x	x	0	x	x
Iceland										
Italy	0	0	x	0	0	0	0	0	x	x
Latvia	0	0	0	x	0	x	0	0	x	x
Lithuania	x	0	x	0	x	x	x	0	x	x
Luxembourg	x	0	x	0	0	x	0	0	0	x
Malta	0	x	0	0	0	x	x	0	0	0
Northern Ireland	0	0	0	0	0	x	x	0	x	0
Norway	0	0	x	0	0	x	0	0	x	0
Poland	x	0	x	x	x	x	x	x	0	0
Portugal	x	0	x	x	0	x	0	0	0	0
Romania	x	0	x	x	0	x	x	0	0	x
Scotland	x	x	x	x	x	x	0	0	x	x
Slovakia	0	0	x	x	0	x	0	0	0	0
Slovenia	x	0	x	x	0	x	x	x	0	0
Spain	x	x	x	x	0	x	x	0	0	x
Sweden	x	x	x	x	0	x	0	0	0	x
The Netherlands	x	0	x	x	0	x	x	x	x	x
Wales	x	0	x	x	0	x	x	0	x	x

TABLE 7 OVERVIEW CONTACT

x → Yes

0 → No

	x (yes)		0 (no)		total	
FAQ	19	59,4%	13	40,6%	32	100,0%
Visual tools (videos)	13	40,6%	19	59,4%	32	100,0%
Tools to enlarge the text	18	56,3%	14	43,8%	32	100,0%
Label and description on pictures	2	6,3%	30	93,8%	32	100,0%
Search utility	26	81,3%	6	18,8%	32	100,0%
Patient stories and testimonies	0	0,0%	32	100,0%	32	100,0%
Check-lists/ Pathways	5	15,6%	27	84,4%	32	100,0%
Information on Update	17	53,1%	15	46,9%	32	100,0%
Latest Update	17	53,1%	15	46,9%	32	100,0%
English available	32	100,0%	0	0,0%	32	100,0%
All English content	18	56,3%	14	43,8%	32	100,0%
Other foreign languages available	10	31,3%	22	68,8%	32	100,0%
quality of healthcare providers (statistics)	8	25,0%	24	75,0%	32	100,0%
quality of healthcare providers (standards)	14	43,8%	18	56,3%	32	100,0%
cases of harm	19	59,4%	13	40,6%	32	100,0%
complaints	23	71,9%	9	28,1%	32	100,0%
data protection	13	40,6%	19	59,4%	32	100,0%
entitlement to medical records	16	50,0%	16	50,0%	32	100,0%
rare diseases	5	15,6%	27	84,4%	32	100,0%
conditions for prior authorization	24	75,0%	8	25,0%	32	100,0%
treatments that need prior authorization	13	40,6%	19	59,4%	32	100,0%
time period to process request	8	25,0%	24	75,0%	32	100,0%
time period to process reimbursement	5	15,6%	27	84,4%	32	100,0%
required documents for request	19	59,4%	13	40,6%	32	100,0%
required documents for reimbursement	16	50,0%	16	50,0%	32	100,0%
estimation of costs for treatment	7	21,9%	25	78,1%	32	100,0%
estimated additional costs	0	0,0%	32	100,0%	32	100,0%
Directive 2011/24/EU	25	78,1%	7	21,9%	32	100,0%
Publications	9	28,1%	23	71,9%	32	100,0%
National Contact points	28	87,5%	4	12,5%	32	100,0%
Healthcare providers	23	71,9%	9	28,1%	32	100,0%
Insurers	10	31,3%	22	68,8%	32	100,0%
National authorities	29	90,6%	3	9,4%	32	100,0%
European authorities	15	46,9%	17	53,1%	32	100,0%
Patient organizations	7	21,9%	25	78,1%	32	100,0%
Connection to social media	12	37,5%	20	62,5%	32	100,0%
Ready-to-print information	19	59,4%	13	40,6%	32	100,0%

TABLE 8 SHARES (PERCENTAGE)

Declaration of Academic Integrity

I hereby confirm that the present thesis on

Cross-border Healthcare in the European Member States – An exploratory study on the adaption of the Directive 2011/24/EU

is solely my own work and that if any text passages or diagrams from books, papers, the Web or other sources have been copied or in any other way used, all references – including those found in electronic media – have been acknowledged and fully cited.

Christine Jäkel