

Activity Report

**Implementation of National Contact Points for cross-border healthcare in
EU Member States: a comparative analysis using websites and short
interviews**

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Table of Contents

Acknowledgements	3
Executive Summary	4
1. Background.....	5
2. Methodological approach	7
Limitations.....	10
3. Results	11
3.1 Formal requirements	11
Language.....	15
Number of NCPs.....	15
Communication channels.....	16
Formats for disabled persons.....	16
3.2 Information provision	16
3.3 Cooperation.....	19
4. Recommendations	21
References.....	24

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Executive Summary

Previous research on the implementation of the Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (PRD) has focused on the transposition of the PRD into national law (Nys, 2014). This study analysed the practical implementation of National Contact Points for cross-border healthcare (NCP) using websites and short interviews. Our analysis reveals that, first; the majority of Member States (MS) had established NCP as of October 25th 2013, few were working to set up the NCP and many countries were still completing their services and infrastructures after the transposition date. Second, the structure of NCP websites and information provided is quite similar between member states. This is unsurprising, as the PRD sets out uniform legal requirements in terms of the goals that need to be achieved. Third, some differences exist regarding the formats of NCP which arguably reflect national differences in organising healthcare in general, patterns of cross-border care and the locus of pre-existing knowledge. Fourth, MS vary in the efforts they make to rearrange existing information for the NCP versus the reliance on using links to existing websites. Fifth, cooperation between NCP is still largely lacking and consultation of stakeholders reflects pre-existing links implying that patient organisations have been less extensively consulted compared to health insurers and providers of care.

1. Background

Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (PRD) aims at '*facilitating the access to safe and high-quality cross-border healthcare and promotes cooperation on healthcare between Member States...*' (European Parliament and Council of the European Union, 2011). The Directive was due to be transposed into national laws by 25th October 2013. The PRD codifies existing European Court of Justice case law regarding patient mobility and defines the responsibilities, rights and procedures for cross-border healthcare provision (De La Rosa, 2012). In addition, Chapter IV of the PRD sets out a structure for cooperation on ehealth, health technology assessment, e-prescriptions and European reference networks to facilitate cross-border care (Peeters, 2012) (Sauter, 2011). Additionally, the PRD requires member states to establish National Contact Points for cross-border healthcare (NCP) to provide patients with information on their rights and entitlements to receive cross-border healthcare (Article 6) and for mutual assistance and collaboration among member states (Article 10). Member States (MS) are obligated to designate national institutions to perform the described tasks. This generally involves the establishment of a website through which patients can retrieve relevant information (Price Waterhouse Coopers, 2012).

Provision of information to enable patients to exercise their right to make choices about various aspects of their healthcare has gained attention since the 1990ies (Vrangbaek, Robertson, Winblad, Van de Bovenkamp, & Dixon, 2012). Not surprisingly, empowering the patient through information provision has been high on the agenda in European health system over the past decade (Dixon & Poteliakhoff, 2012). In many European countries publication of comparative information, often web-based, on the features of services providers and on the quality of services based on performance indicators or user experiences has been made increasingly available (Damman, van den Hengel, van Loon, & Rademakers, 2010; Delnoij & Sauter, 2011; Vrangbaek et al., 2012). It forms the background on which the PRD requires member states to provide information to patients on cross-border care via NCPs.

The goal of this study was to assess how the Member States comply with the legal requirement to establish a NCP according to Directive 2011/24/EU. In addition to analysing whether NCP websites were operational as of the 25th of October 2013, our focus was on the formats, information provision and cooperation of NCPs.

2. Methodological approach

To study the practical implementation of the NCP in EU member states this study combined a content analysis of NCP websites with interviews of national key informants on the implementation process. For the content analysis, operational NCP websites were used as a data source. Websites were identified via contact information of NCPs provided by the Commission Directorate General on Health and Consumers (DG SANCO) (European Commission -DG Health & Consumers, 2014). We employed raters with a health background and very good proficiency in both the official language of the respective country and in English. A hand-out to instruct raters was used outlining a standard protocol to be followed for the analysis. In addition, a data extraction form covering the various requirements on NCP helped to ensure comparability and minimise inter-rater variability. Websites were assessed on the content provided including all subpages and the links provided on the NCP website itself. Content in the official language of a Member State was assessed and then inserted in the data extraction form in English.

Second, short interviews with persons in charge of the NCP were conducted following an interview guide to direct the dialogue towards the practical implementation and perception of requirements for NCP. The interviews were conducted in two phases according to a pretest-posttest design taking the implementation deadline of 25th October, 2013, as an intervention measure. Initially, because no contact details of NCPs were available at the time the project started, the National Focal Points of the Action Programme for health were approached (Consumers Health and Food Executive Agency, 2014) to identify the relevant interview partners for this study. For the second phase, the contact details of NCPs provided by DG SANCO (European Commission -DG Health & Consumers, 2014) were used. Interviews helped to verify the information gained from the website analysis, to reveal how NCP offices have been set up and how they meet the requirements regarding collaboration with other NCPs and relevant stakeholders in the country itself.

For the data analysis information and additional requirements set out by the PRD (see Table 1) were used as predefined categories for a directed content analysis (Hsieh & Shannon,

2005). Content Analysis was performed jointly by the three principal investigators. Interview and website data were first pooled and analysed per country. In case of contradictory information website raters were approached again and asked to validate findings by looking back at the NCP website in question. Subsequently, a cross-country analysis was undertaken to identify similarities, differences and patterns in the data (Miles & Huberman, 1994).

Table 1: Directive 2011/24/EU – Provisions with relevance for National Contact Points

<p>Article 4 Responsibilities of the Member State of treatment</p> <p>1. Taking into account the principles of universality, access to good quality care, equity and solidarity, cross-border healthcare shall be provided in accordance with: (a) [...] (b) standards and guidelines on quality and safety laid down by the Member State of treatment; (c) [...]</p> <p>2. The Member State of treatment shall ensure that:</p> <p>(a) patients receive from the national contact point referred to in Article 6, upon request, relevant information on the standards and guidelines referred to in paragraph 1(b) of this Article, including provisions on supervision and assessment of healthcare providers, information on which healthcare providers are subject to these standards and guidelines and information on the accessibility of hospitals for persons with disabilities; [...]</p>
<p>Article 5 Responsibilities of the Member State of affiliation</p> <p>The Member State of affiliation shall ensure that: [...]</p> <p>b) there are mechanisms in place to provide patients on request with information on their rights and entitlements in that Member State relating to receiving cross-border healthcare, in particular as regards the terms and conditions for reimbursement of costs in accordance with Article 7(6) and procedures for accessing and determining those entitlements and for appeal and redress if patients consider that their rights have not been respected, in accordance with Article 9. In information about cross- border healthcare, a clear distinction shall be made between the rights which patients have by virtue of this Directive and rights arising from Regulation (EC) No 883/2004; [...]</p>
<p>Article 6 National contact points for cross-border healthcare</p> <p>1. Each Member State shall designate one or more national contact points for cross-border healthcare and communicate their names and contact details to the Commission. The Commission and the Member States shall make this information publicly available. Member States shall ensure that the national contact points consult with patient organisations, healthcare providers and healthcare insurers.</p> <p>2. National contact points shall facilitate the exchange of information referred to in paragraph 3 and shall cooperate closely with each other and with the Commission. National contact points</p>

shall provide patients on request with contact details of national contact points in other Member States.

3. In order to enable patients to make use of their rights in relation to cross-border healthcare, national contact points in the Member State of treatment shall provide them with information concerning healthcare providers, including, on request, information on a specific provider's right to provide services or any restrictions on its practice, information referred to in Article 4(2)(a), as well as information on patients' rights, complaints procedures and mechanisms for seeking remedies, according to the legislation of that Member State, as well as the legal and administrative options available to settle disputes, including in the event of harm arising from cross-border healthcare.

4. National contact points in the Member State of affiliation shall provide patients and health professionals with the information referred to in Article 5(b).

5. The information referred to in this Article shall be easily accessible and shall be made available by electronic means and in formats accessible to people with disabilities, as appropriate.

Article 10 Mutual assistance and cooperation

1. Member States shall render such mutual assistance as is necessary for the implementation of this Directive, including cooperation on standards and guidelines on quality and safety and the exchange of information, especially between their national contact points in accordance with Article 6, including on provisions on supervision and mutual assistance to clarify the content of invoices.

2. Member States shall facilitate cooperation in cross-border healthcare provision at regional and local level as well as through ICT and other forms of cross-border cooperation. 3. [...] 4. [...]

Recital 48

[...] Information that has to be provided compulsorily to patients should be specified. However, the national contact points may provide more information voluntarily and also with the support of the Commission. Information should be provided by national contact points to patients in any of the official languages of the Member State in which the contact points are situated. Information may be provided in any other language.

Recital 49

The Member States should decide on the form and number of their national contact points. Such national contact points may also be incorporated in, or build on, activities of existing information centres provided that it is clearly indicated that they are also national contact points for cross-border healthcare. National contact points should be established in an efficient and transparent way and [...] The existence of national contact points should not preclude Member States from establishing other linked contact points at regional or local level, reflecting the specific organisation of their healthcare system.

Limitations

This research was meant to check for compliance with the legal requirements regarding NCPs. We analysed the availability of information in one of the official languages of a MS. However, the quality or completeness of that information has only to a certain degree been investigated. Nor did we check or compare systematically the information offered in other languages, as information provision in non-national languages is not obligatory. Raters felt that there is a considerable information gap between information in the official language and other language versions on many of the websites. Moreover, we used raters with a health background to be able to check if the legal requirements have been met. Using patients or lay persons, the potential users of NCP websites, was not applicable but should be considered in the future to check for the quality and accessibility of information. Lastly, the quality of information provided by NCP offices was not inquired, analysing answers in response to questions from individual persons seeking cross-border care would be an interesting point for future research.

3. Results

In total, 24 NCP websites were operational in the study period between January 8 and February 12, 2014. For the remaining four countries (PT, IT, RO, GR), NCP websites were not available during this period. Moreover, 22 short interviews were performed in two phases between February and July, 2013, and January and March, 2014, including six responses in writing (Cox, 2013). Overall, there is a high level of resemblance between MS regarding the organisation of NCPs and the information NCP websites provide. National differences in the implementation of NCPs corresponded with differences in the organisation of health systems in general, in the prevailing patterns of cross-border mobility, or existing structures for patient information. We will point to some differences with regard to adherence to the formal requirements, provision of information and collaboration activities of NCPs in particular.

3.1 Formal requirements

An overview of adherence to formal requirements and characteristics of NCPs in EU Member States (MS) is shown in Table 2. We point to language availability, number of contact points and communication channels more specifically in this subsection.

Table 2: Basic characteristics of NCPs & formats of providing information

Table 2 Part A

Country	NCP website established	URL Main page	Date accessed	Host institutions	Number of NCPs
Austria	✓	www.gesundheit.gv.at	30.01.2014	private/MoH	1
Belgium	✓	www.crossborderhealthcare.be	19.01.2014	MoH	1
Bulgaria	✓	www.nhif.bg	14.01.2014	NHIF	1
Croatia	✓	www.hzzo.hr	23.01.2014	NHIF	1

Cyprus	✓	www.moh.gov.cy/cbh	30.01.2014	MoH	1
Czech Rep.	✓	www.cmu.cz	25.01.2014	9 insurers	1
Denmark	✓	www.patientombuddet.dk/	20.01.2014	gov. agency	1*
Estonia	✓	www.kontaktpunkt.sm.ee	19.01.2014	MoSocAff	1
Finland	✓	www.kela.fi/yhteyspiste	17.01.2014	SHI institute	1
France	✓	www.sante.gouv.fr/point-de-contact-national-pour-la-france.html	19.01.2014	MoH	1
Germany	✓	www.eu-patienten.de	30.01.2014	HI associations	1
Greece	✗		13.01.2014	NHS (assigned)	
Hungary	✓	www.eubetegjog.hu www.patientrights.hu	12.01.2014 18.01.2014	gov. Agency	2 websites
Ireland	✓	www.hse.ie/eng/services/list/1/schemes/cbd/CBD.html	26.01.2014	NHS	1
Italy	✓		03.01.2014		
Latvia	✓	www.vmnvd.gov.lv/	11.02.2014	MoH & gov agency	1
Lithuania	✓	www.lncp.lt/	12.02.2014	NHIF & gov. Agency	1
Luxemb.	✓	www.cns.lu	19.01.2014	MoH	1
Malta	✓	www.gov.mt/en/Pages/gov.mt%20homepage.aspx	30.01.2014	MoH	1
Netherlands**	✓	www.cbhc.nl	30.01.2014	gov. agency	1
Poland	✓	www.nfz.gov.pl/new/index.php	21.01.2014	NHIF	1
Portugal	✗		17.01.2014		
Romania	✗		18.02.2014	NHIF (assigned)	
Slovakia	✓	www.udzs-sk.sk	25.01.2014	MoH & HI	1
Slovenia	✓	www.nkt-z.si/wps/portal/nktz/home	23.01.2014	NHI institute	1

Spain	✓	www.msssi.gob.es/	08.01.2014	MoH	1
Sweden	✓	www.socialstyrelsen.se	20.01.2014	gov. agency	2
UK (England) ***	✓	www.nhs.uk/nationalcontact_point	26.01.2014	NHS UK	1****

Table 2 Part B

Country	NCP website established	URL Main page	Languages	Communication channels	Formats for disabled persons	Consultation of patient organisations
Austria	✓	www.gesundheit.gv.at	de	post, tel, @	letter size	✓
Belgium	✓	www.crossborderhealthcare.be	fr, nl, de, en	tel, form, @	✗	✗
Bulgaria	✓	www.nhif.bg	bg, en	post, tel, @	✗	⊖
Croatia	✓	www.hzzo.hr	hr, en, de, fr, sl, it	tel, form	✗	⊖
Cyprus	✓	www.moh.gov.cy/cbh	el, en	tel, fax, @	✗	✓
Czech Rep.	✓	www.cmu.cz	cs & 20 others	tel, form	contrast view	✗
Denmark	✓	www.patientombuddet.dk/	da, en, de	tel, form, @, office	✗	✓
Estonia	✓	www.kontaktpunkt.sm.ee	et, en, ru, fi	tel, form, @	letter size, contrast view	✓
Finland	✓	www.kela.fi/yhteyspiste	fi, se, en	tel, @	✗	✓
France	✓	www.sante.gouv.fr/point-de-contact-national-pour-la-france.html	fr	post, @	letter size	✓
Germany	✓	www.eu-patienten.de	de, en	tel, fax, form	letter size	✓
Greece	✗					

Hungary	✓	www.eubetegjog.hu www.patientrights.hu	hu, en	tel, form, @, office	letter size, contrast view	✗
Ireland	✓	www.hse.ie/eng/services/list/1/schemes/cbd/CBD.html	en	tel, fax, form, @	✗	✗
Italy	✗					
Latvia	✓	www.vmnvd.gov.lv/	lv, en, ru	tel, fax, @, Twitter	letter size	⊖
Lithuania	✓	www.lncp.lt/	lt, en	tel, form, @	letter size	✓
Luxemb.	✓	www.cns.lu	fr,de, en	tel, @	letter size	✓
Malta	✓	www.gov.mt/en/Pages/gov.mt%20homepage.aspx	mt, en	tel, fax, @	✗	✓
Netherlands**	✓	www.cbhc.nl	nl, en	form	✗	✓
Poland	✓	www.nfz.gov.pl/new/index.php	pl, it, fr, es, en, de	tel, form, @	letter size, contrast view, voice reader, easy content	⊖
Portugal	✗					
Romania	✗					
Slovakia	✓	www.udzs-sk.sk	sk, en	tel, form	✗	✗
Slovenia	✓	www.nkt-z.si/wps/portal/nktz/home	sl, en	tel, @	letter size	✓
Spain	✓	www.msssi.gob.es/	es, en, fr	tel, post, fax, @	✗	⊖
Sweden	✓	www.socialstyrelsen.se	sv & 12 other	tel, form	voice reader, sign language , easy content, letter size	✗
UK (England) ***	✓	www.nhs.uk/nationalcontactpoint	en	tel, post, @	✗	✓

- ✓ available or done
- ✗ not available or not done
- ⊖ information missing

* 1 webpage with 4 regional NCP offices

** website operational, but content under construction

*** Information presented retrieved from NCP England accessed at www.nhs.uk/NHSEngland/Healthcareabroad/Pages/Healthcareabroad.aspx
Characteristics and information can differ on the other regional webpages

**** 1 umbrella webpage referring to 5 regional NCP offices & webpages for Scotland, Wales, Northern Ireland, England, & Gibraltar)

Language.

Only four out of 24 countries opted to adhere to the minimum requirement presenting information only in one of the official languages of the respective country. The majority of MS offered information in at least one, and up to three other languages. English was the preferred second choice of a non-domestic language. Providing information in more than four languages was quite exceptional – only four out 24 NCPs did so. While we did not assess the information provided in different language versions per country, a scan of a selection of NCP websites hinted to a gradient in the information provided. English version websites offered considerably less information compared to native language websites.

Number of NCPs.

The vast majority of member states opted for a one NCP solution. Only Denmark (one website and four regional NCP offices) and the UK (five regional websites), have created multiple regional contact points reflecting decentralised responsibilities in their health systems. Hungary chose for two different websites separating more clearly information for incoming EU citizens provided in English and information in Hungarian for own citizens seeking care abroad.

Communication channels.

A majority of countries provided access to the NCP office via telephone, email and an internet based contact form. In some countries the postal route was still among the options. Two member states (HU, DK) stated that they offered a walk-in possibility to the NCP office. Quite exceptional, the Latvian NCP has its own Twitter account. Two countries (FR, NL) did not provide the possibility of calling the NCP office, but relied on written routes of communication only.

Formats for disabled persons.

Twelve out of 24 NCPs did not provide any formats to support the access of the websites' content by people with disabilities. Change of letter size was the most common feature to increase accessibility for persons with disabilities. A high contrast view was offered on five NCP website, voice reader and easy content view on two and sign language on one NCP webpage respectively. The Swedish and Polish NCP website provided each four different formats. They stood out from the remaining NCP websites in terms of the number of formats they offered.

3.2 Information provision

Table 3 gives an overview of the extent to which member states complied with the mandates for information set out by the Directive. Items were assessed as satisfactory in case at least some content information was available either on the website itself or via a direct link. In some cases, NCP websites provided only short overviews and incomplete information. Moreover, a number of MS used links to existing web sources. In some cases, information on linked websites was completing short introductions to the topic on the NCP website. In other cases, only the link was given and the respective website was the single information source available. However, raters indicated that information often became very technical and less accessible. Linked information was more frequently only available in the official language of a country. In general, for these information domains MS relied on links with institutions, laws and existing website dealing with respective information. Moreover,

information provided under a certain heading differed among member states and often did not give a complete picture, but dealt only with parts of a system.

Information on provider rights was only available on half (13/24) of the operational websites. When it was available at all, information was in most cases provided via links to professional or medical associations. The same applied to information on quality and patient safety (18/24) where links were provided frequently to the organisations, laws and other sources dealing with quality and patient safety. Member states (20/24) addressed diverse topics under patient rights like access to medical records, patients' right to information, informed consent or data protection regulations. Furthermore, information on dispute settlement procedures (18/24) appeared to be incomplete referring often only to a selection of complaint procedures such as an ombudsman, civil and criminal law procedures, the medical code of practice, or via medical associations. On many NCP websites (23/24) we found good, accessible ways of presenting the rights and procedures regarding reimbursement of cross-border healthcare including an explanation of the differences between the Directive 2011/24/EU and Regulation 883/2004 on the coordination of social security systems. Some MS outlined the pros and cons of the different procedures to access care abroad. The required forms could already be downloaded from a few other NCP websites. Despite a complex topic, raters regarded the information as well-organised on many websites, indicating experience with communicating such procedures.

Table 3: Information provided on NCPs website

Country	quality and safety standard	provider rights	patient rights	disputes procedures	entitlements for crossborder care	contact details of other NCPs
Austria	✓	✓	✓	✓	✓	✓
Belgium	✓	✗	✓	✓	✓	✗
Bulgaria	✗	✗	✓	✓	✓	✗

Croatia	✓	✗	✓	✓	✓	✓
Cyprus	✓	✗	✓	✓	✓	✓
Czech Republic	✗	✓	✓	✓	✓	✓
Denmark	✓	✓	✓	✓	✓	✗
Estonia	✓	✗	✓	✓	✓	✓
Finland	✓	✓	✓	✗	✓	✓
France	✓	✓	✓	✓	✓	✓
Germany	✓	✓	✓	✓	✓	✗
Greece	⊖	⊖	⊖	⊖	⊖	⊖
Hungary	✓	✓	✓	✓	✓	✓
Ireland	✓	✗	✗	✗	✓	✓
Italy	⊖	⊖	⊖	⊖	⊖	⊖
Latvia	✓	✓	✓	✗	✓	✓
Lithuania	✓	✓	✓	✓	✓	✓
Luxembourg	✗	✗	✗	✗	✓	✗
Malta	✓	✗	✓	✓	✓	✓
Netherlands*	✗	✗	✗	✗	✗	✗
Poland	✗	✗	✓	✓	✓	✓
Portugal	⊖	⊖	⊖	⊖	⊖	⊖
Romania	⊖	⊖	⊖	⊖	⊖	⊖
Slovakia	✓	✓	✓	✓	✓	✓
Slovenia	✓	✓	✓	✓	✓	✓

Spain	✓	✓	✓	✓	✓	✓
Sweden	✓	✓	✓	✓	✓	✗
UK (England)**	✗	✗	✗	✗	✓	✗



available or done



not available or not done



information missing – meaning no NCP online available

* website operational, but content under construction

** Information presented retrieved from NCP England accessed at www.nhs.uk/NHSEngland/Healthcareabroad/Pages/Healthcareabroad.aspx
Characteristics and information can differ on the other regional webpages.

3.3 Cooperation

This section deals with two instances of cooperation required by the PRD. First, MS should consult with relevant stakeholders such as health insurers, healthcare providers and patient organisations to provide patients with information. Second, NCP are supposed to cooperate amongst each other and with the Commission to achieve the goals of the PRD.

From the analysis of host institutions it became apparent (see Table 1) that in quite a number of countries health insurer were already involved in running the NCPs. As patient organisations were rather a new player to support provision of patient information we investigated in the interviews in particular how far patient organisations were consulted. Half of member states did so, whereas half did not. The timing and purpose of consulting patient organisations differed considerably. Some member states consulted patient organisations during the actual transposition process into national law. Some employed them as a source of information and others as evaluators of the final website. Some MS set up specific

channels, such as seminars, consultations or questionnaires, to receive their feedback or input.

Cooperation among NCPs themselves is still in its infancy. Only a few MS reported that they have established formal contacts with other NCPs – most often along pre-existing cooperation on cross-border care. Others reported some informal contacts and some interview partners referred to a coordination meeting in February 2014 organised by the European Commission (European Commission, 2014b, 2014c) to do so.

4. Recommendations

First, knowledge needs to be strengthened on the way information is presented to patients to allow well-informed choices. Despite patient information increasingly available online the effectiveness of different formats to inform patients' choices is largely not understood (Damman et al., 2010; Vrangbaek et al., 2012)_ENREF_8. Problems in comprehending complex information – which some of our raters referred to – led patients to regard it as irrelevant (Faber, Bosch, Wollersheim, Leatherman, & Grol, 2009). And rather than presenting generic information more tailored information adapting to local settings and particular groups is suggested to be more appropriate (Jones, Cassie, Thompson, Atherton, & Leslie, 2014; Zwijnenberg, Damman, Spreeuwenberg, Hendriks, & Rademakers, 2011). In that context, the PRD invites MS to use existing information infrastructures (Recital 49) and is explicit on the domains of information to be provided to patients, but it does not – and most likely cannot so far - determine how information should be edited to be '*easily accessible*' (Article 6(5)) for patients (Palm & Baeten, 2011). To partly fill that gap, the EC has commissioned two studies to advise on effective ways of information provision by NCPs (European Commission, 2014c). MS may review their display approaches to and the quality of patient information in general in response to the implementation of the PRD (Delnoij & Sauter, 2011). All patients, those seeking care at home and abroad, would profit from improved accessibility of information by well-founded formats, presentation options and selection of information to be able to make informed choices.

Second, initiating cooperation among NCP has not been a focal point during the implementation process, but the PRD endorses cooperation beyond NCP in other areas mentioned in Chapter IV. To support collaboration between the different NCPs the Commission organised a meeting for NCP coordinators in February 2014, which is supposed to be held on a regular basis from now on. Work on a minimum voluntary data set for invoices and further exchange on good practices of communication with citizens is

envisaged. In contrast, quality and safety are not considered in the short-term agenda (European Commission, 2014c). Other areas of cooperation like ehealth (eHealth Network), health technology assessment (EUnetHTA) or European Reference Networks (ERNs) have a longer history of cooperation. Networks and work agendas are established and concrete outputs in response to the provisions of the PRD are realised. In addition, these networks have overlaps with the work of NCPs. For example, the intended minimum data set for invoices is related to the targets of the EU's eHealth Network. Likewise, the design and information provided by NCP websites will be helpful in the future to patients treated in European Reference Networks. Thus, cooperation among NCP is likely to intensify to contribute to the smooth operation of cross-border care in the first place.

Third, taking further the considerations above, the implementation of the PRD is an example of how law and new governance modes are deliberately joined to assist the EU in advancing its health care agenda (Hervey & Vanhercke, 2010). Chapter IV does not prescribe the legislative rules for cooperation per se, but sets out a structure of objectives, principles and conditions in which these rules are developed between national and EU officials, experts and concerned stakeholders (Sabel & Zeitlin, 2008). In addition, the Commission is invited to support that cooperation by means of technical support and expertise as the examples of Commission actions indicate. Moreover, three thematic priorities of the current 3rd Action Programme for health 2014-2020 include an explicit reference to the PRD (European Parliament and Council of European Union, 2014). Quite a number of activities are likely to be financed to assist and advance the work of the different networks in the upcoming years. It may lead to a 'formalisation of OMC [Open Method of Coordination] based cooperation'(Sauter, 2011, p. 24) at EU level justifying sustained involvement of the EU in areas relevant to cross-border care and health systems in general.

Finally, beyond the facilitation of cross-border care the optimal implementation of the PRD is referred to as one measure to support the EU's broader agenda towards more effective,

accessible and resilient health systems in Europe (European Commission, 2014a). The provisions of Chapter IV are another piece in the EU's move towards an established arena for discussing ideas, support and joint actions on health systems (Clemens et al., 2014). A spot the EU itself is likely to join more and more actively.

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