Short Report

Obtaining health care in another European Union Member State: how easy is it to find relevant information?

Alessio Santoro1, Andrea Silenzi2, Walter Ricciardi3, Martin McKee4

1 Institute of Hygiene, Catholic University of Sacred Heart, Rome, Italy
2 Institute of Hygiene, Catholic University of Sacred Heart, Rome, Italy
3 Institute of Hygiene, Catholic University of Sacred Heart, Rome, Italy
4 Faculty of Public Health and Policy, European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, London, United Kingdom

Correspondence: Alessio Santoro, Institute of Hygiene, Catholic University of Sacred Heart, Rome, Italy, Largo Agostino Gemelli 8, 00168, Rome, Italy, Tel: +44 (0) 207 927 2594, Fax: +44 (0) 207 927 2701, e-mail: alessio.santoro@lshtm.ac.uk

The European Union Directive on cross-border health care places an obligation on member states (MSs) to establish one or more national contact points (NCPs). We evaluated whether MSs were meeting their legal obligations. Two researchers created a set of criteria, drawn from the Directive, to evaluate the information that 18 MSs provide on their NCP websites. Some 15 of the 18 MSs evaluated provided >75% of the information sought. This report shows examples of best practices that could be used to encourage other MSs to improve the quality and quantity of information provided.

Introduction

The European Union Directive on cross-border health care, finally adopted in March 2011, was designed to clarify what had been a complex and confusing body of legislation. A series of judgements by the European Court of Justice had extended patients’ rights to obtain health-care-related goods and services in other Member States (MSs) but in a way that left many questions unanswered. The Directive sets out the conditions under which patients may seek treatment abroad and, recognizing the complexity facing patients, places an obligation on MSs to establish one or more national contact points (NCPs) to inform patients on their rights in relation to cross-border health care. These should have been established by 25 October 2013, when the Directive came into force. We asked whether MSs were meeting the legal obligations set out in the Directive by providing appropriate information to patients who might seek care in their own health system or abroad.

Methods

The Directive was subject to exceptionally detailed scrutiny during the legislative process, to reflect the challenge of reconciling views of different actors. Even though the text does not clearly specify the format and content of the information to be provided by NCPs, Article 6 states that ‘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’. Thus, we have interpreted this as meaning that information that is not on a website is, in practical terms, not easily accessible to potential patients.

Additionally, the Directive outlines the information to be provided by NCPs in Articles 6 and 8, which differentiate topics that should be ‘publicly available’ or available ‘on request’. We used these topics to create a set of criteria, reported hereafter, to evaluate the information that MSs provide on their NCP websites. The existence of an NCP for an MS and its contact details were retrieved from the European Commission website on cross-border care.

With regard to the ‘publicly available’ information, the following items have been extracted from the NCP websites:

(i) Mechanisms to identify health-care providers in the MS;
(ii) Description of patients’ rights to seek treatment in other MSs;
(iii) Description of procedures for complaints against health-care providers and methods of seeking remedies;
(iv) Description of procedures to settle disputes against health-care providers;
(v) Description of either the categories of health care or the detailed list of services for which prior authorization is required;
(vi) Description of mechanisms to apply for prior authorization.

With regards to the ‘on request’ information, the NCP’s websites have been assessed to seek:

(a) Information on mechanisms to ensure quality and safety in the MS;
(b) Information on entitlement to reimbursement for treatment sought under the conditions set out by the Directive;
(c) Details of NCPs in other MSs.

The list of NCPs websites was retrieved from the European Commission website on cross-border care on the 24th of February. The evaluation of the websites was independently
conducted by two researchers between 24 February and 7 March 2014. Information was assessed in any of the official languages of the MS in question, through the use of machine translation, when information was provided in languages different from English, Spanish, French, Italian and Portuguese. This was necessary for Austria and Slovakia. Simple links to the Directive or the European Commission Q&A section were not considered to be ‘information provided’.

Of the 28 MSs, 10 were excluded from the evaluation for the following reasons:

(i) No website was recorded by the European Commission (Italy, Malta, Poland, Portugal and Romania), although all but the last did supply an e-mail address;
(ii) The websites were either ‘under construction’ or not been fully implemented yet (Belgium, Greece and the Netherlands);
(iii) Specific sections on the cross-border Directive could not be retrieved from within the website (Bulgaria and Luxembourg).

Finally, some MSs provided more than one website (Hungary, Lithuania and Sweden) and, in these cases, information was deemed to be available if it could be found on at least one of the websites. Overall, 22 websites were evaluated, containing information on 18 MSs.

Results

The main findings are summarized in Table 1. All 18 MSs had provided an email address for their NCPs to the Commission; additionally, details of NCPs in other MSs were available in 16 websites. All MSs provided information on patients’ rights and entitlements. Furthermore, 17 included information on complaints procedures and mechanisms to seek remedies whereas 14 described mechanisms to settle disputes. Lists or search engines to identify health-care providers were provided in 13 websites. Twelve MSs described quality and safety standards while 11 specified the list of procedures requiring prior authorization and 10 included a mechanism to apply for such authorization. In all, 15 of the 18 MSs provided >75% of the information sought (8 indicators out of 9; the reporting of NCPs to the European Commission was received separately from the Commission website).

Discussion

The Directive emerged from a need to clarify the legal situation with respect to cross-border health care, which was uncertain in many respects, as it had evolved through a series of judgements by the European Court of Justice. Thus, it was unclear whether a prescription issued in one MS must be dispensed in another.6 There was also considerable variation in approaches to quality assurance7 and regulation of professions.8

When the evaluation was conducted, over 6 months after the Directive came into force, 18 MSs had developed NCPs websites, recognizing that this is an extremely efficient way of providing information that is accessible while not precluding the direction of specific questions to NCP staff. A further three websites were in the process of development. The websites that do exist provide much of the information required by the Directive, including that which must only be provided on request. Thus, most NCPs with websites would easily be able to fill the remaining gaps. However, five MSs have no websites, and the Commission has no information on two NCPs. It should, however, be noted that this is a dynamic situation, and the information included in this article was correct as of 24 February 2014.

Although the Directive allows governments to decide how the NCPs will operate, it does make provision for the European Commission to ‘work together with the Member States in order to facilitate cooperation regarding national contact points for cross-border health care, including making relevant information available at Union level.1 There is clear scope for more to be done to encourage such cooperation, and it is hoped that this article will encourage MSs to share their experiences and, thus, examples of good practice.

Conflicts of interest: None declared.
Cultural, social and intrapersonal factors associated with clusters of co-occurring health-related behaviours among adolescents

Mariska Klein Velderman¹, Elise Dusseldorp¹, Maroesjka van Nieuwenhuijzen², Marianne Junger³, Theo G. W. M. Paulussen¹, Sijmen A. Reijneveld¹, ⁴

1 TNO (Netherlands Organization for Applied Scientific Research), Behavioural and Societal Sciences, Leiden, The Netherlands  
2 Department of Clinical Child and Family Studies, and the EMGO Institute for Health and Care Research and LEARN! Research institute for learning and education, VU University of Amsterdam, Amsterdam, The Netherlands  
3 School of Management and Governance, University of Twente, The Netherlands  
4 Department of Health Sciences, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands

Correspondence: Mariska Klein Velderman, TNO Child Health, P.O. Box 2215, 2301 CE Leiden, The Netherlands, Tel: +31 888 666 023, e-mail: mariska.kleinvelderman@tno.nl

Background: Adverse health-related behaviours (HRBs) have been shown to co-occur in adolescents. Evidence lacks on factors associated with these co-occurring HRBs. The Theory of Triadic Influence (TTI) offers a route to categorize these determinants according to type (social, cultural and intrapersonal) and distance in the causal pathway (ultimate or distal). Our aims were to identify cultural, social and intrapersonal factors associated with co-occurring HRBs and to assess the relative importance of ultimate and distal factors for each cluster of co-occurring HRBs. Methods: Respondents concerned a random sample of 896 adolescents aged 12–18 years, stratified by age, sex and educational level of head of household. Data were collected via face-to-face computer-assisted interviewing and internet questionnaires. Analyses were performed for young (12–15 years) and late (16–18 years) adolescents regarding two and three clusters of HRB, respectively. Results: For each cluster of HRBs (e.g. smoking, delinquency), associated factors were found. These accounted for 27 to 57% of the total variance per cluster. Factors came in particular from the intrapersonal stream of the TTI at the ultimate level and the social stream at the distal level. Associations were strongest for parenting practices, risk behaviours of friends and parents and self-control. Conclusion: Results of this study confirm that it is possible to identify a selection of cultural, social and intrapersonal factors associated with co-occurring HRBs among adolescents.