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Implementation of the cross-border healthcare directive in Poland: How not to encourage patients to seek care abroad?☆

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ABSTRACT

In October 2014, after over 12 months of delay, Poland finally implemented directive 2011/24/EU on the application of patients' rights in cross-border healthcare. The implementing legislation in the area of cost reimbursement and prior authorization is very restrictive. The goal is to either defer the public payer's expenses into the future or to discourage patients from seeking care abroad or from seeking care altogether. The Polish government and the Ministry of Health, the key stakeholders in the implementation process, seemed to overlook the potential monetary benefits that the implementation of the directive could bring, for example, by promoting Poland as a destination for health tourism. Other stakeholders, such as patients and healthcare providers, had no real influence on the policy process. So far, the number of applications for planned treatment abroad has been very low and the majority of them were actually turned down as they did not meet the formal requirements. This number is likely to remain low in the future as accessing such care is cumbersome and not affordable for many patients. Overall, while the directive does not aim to encourage patients to seek cross-border healthcare, the current national regulations in Poland do not seem to facilitate access to cross-border healthcare, which is the main goal of the directive.

1. Introduction

In March 2011, directive 2011/24/EU on the application of patients' rights in cross-border healthcare was adopted by a decision of the European Parliament and the Council of the European Union (EU). The deadline for its implementation by the member states was set for 25 October, 2013. Poland, one of the main opponents of the directive, took just over a year longer to transpose it into national legislation. In fact, one of the key factors that motivated the Polish government to implement the directive was the increasing number of lawsuits against the National Health Fund (NHF) by patients demanding to be reimbursed for medical treatment obtained abroad [13]. This article describes the process of translating directive 2011/24/EU into Polish law; the content of the Polish legislation transposing the directive, and the implications of this new law for the patients. While the paper also describes differences between the content of the national law and the content of the directive it does not assess the legality of the Polish provisions in the light of the EU law.

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2. Policy background: receiving care in another EU member state since Poland's EU accession and since coming to life of directive 2011/24/EU

As of its EU accession on 1 May, 2004, Poland has been subject to EU regulations on the coordination of social security systems (EC No 883/2004 and EC No 987/2009) [16]. By virtue of these regulations, socially insured Polish citizens residing in another EU member state are fully entitled to benefits in-kind provided by health care institutions in their place of residence at the expense of the Polish public payer (NHF). Similarly, a person insured in another member state who resides in Poland is fully entitled to services at the expense of their public insurer. Articles 19–20 of EC No 883/2004 also provide for statutory coverage of treatment received outside the state of residence or affiliation, i.e. cross-border health care. Access to cross-border healthcare is subject to certain conditions, such as prior authorization, which depend on the type of care (emergency or planned).

Rulings of the European Court of Justice (ECJ) in cases such as Kohll and Decker (1998) and Smits-Peerbooms (2001) have created legal uncertainty for the member states in terms of reimbursement of health services outside the state where the patient is socially insured [3]. Several attempts were made at the EU-level to put forward policy responses to this legal uncertainty. Although the initial approach was to support European cooperation in this area and a High Level Group on Health Services and Medical Care was set up to this end in 2004, the European Commission (EC) included healthcare services in its proposal for a services directive—the so-called Bolkestein directive. In 2006, after two years of heated policy debates, healthcare services were finally excluded from the scope of this directive and the EC announced it would put forward a specific legal initiative for the health sector. After a lengthy and painful policy process, the European Parliament and the Council adopted the proposal for a directive in July 2008, with provisions presented as 'patients' rights' and not as 'services' as in the Bolkenstein directive.

Until the very last moment in the debate on the directive in the Council, the choice of the providers to be covered by the directive was the major outstanding issue. Many member states preferred to exclude non-contractual healthcare providers from the scope of the directive, since, in their view, this would give rise to 'reverse discrimination'. This is because treatment of such providers is not reimbursed at the national level, while they would have to be reimbursed it in cross-border situations. This issue was at the core of the Polish objection to the directive (see Section 4 below). It was not until early-2011 that the European Parliament, the Commission, and the Council finally agreed on a heavily amended version—directive 2011/24/EU [3]. Besides Poland, Austria, Portugal and Romania voted against it and Slovakia abstained [16]. The key differences between the rules of coordination and directive 2011/24/EU are summarized in Table 1.

Each of the avenues of accessing healthcare abroad, within the coordination system and under directive 2011/24/EU is governed by different laws and imposes various obligations on the individuals who benefit from them. The choice of the avenue is at the discretion of the patient.

3. Implementation of directive 2011/24/EU in Poland

In October 2014, Poland passed the law implementing directive 2011/24/EU, which was the amendment of the Act on Healthcare Services Financed from Public Sources, and set up a National Contact Point (NCP) for cross-border healthcare within the NHF. Three executive regulations implementing the provisions of this amendment were issued by the Minister of Health in November 2014: on the procedures for issuing authorization for reimbursement and on pre-authorized care (regulation no 1551); on the reimbursement application form (regulation no 1538); and on the list of guaranteed benefits requiring a prior-authorization (regulation no 1545). The amendment and the executive regulations came into force on 15 November, 2014 [9].

The amendment and the executive regulation no 1551 distinguish among three main sets of rules of financing of guaranteed benefits provided outside the borders of Poland concerning the cross-border care directive [9]:

(1) For benefits already purchased: cost reimbursement (see Fig. 1);
(2) For selected guaranteed benefits exempted from (1): prior-authorization (see Fig. 1);
(3) For guaranteed benefits (treatment and diagnostic procedures) not currently provided in Poland (e.g. due to the lack of adequate medical infrastructure): direct payment to provider (see Fig. 2).

Fearing that a large number of people may try to seek healthcare abroad to avoid long waiting times in Poland, access to healthcare abroad has been limited by a number of restrictions [8]. We summarize these barriers below.

3.1. Barrier 1: pre-authorization requirement

The first barrier is the need to obtain a pre-authorization for most healthcare services, including simple therapies and diagnostics, such as pharmaceuticals included in the national drug programmes, computer tomography and magnetic resonance, for which there are long waiting times in Poland [4]. A pre-authorization from the director of the voievodeship branch of the NHF (in the voievodeship of patient's residence) is required for healthcare services that require a hospital stay of at least one night regardless of the type of service (i.e. almost any surgery will require a prior approval of the NHF); treatment within national drug programmes listed in the 2011 Act on the Reimbursement of Pharmaceuticals, Foodstuffs for Special Nutritional Use and Medical Devices; and a number of therapies and diagnostic tests: isotopic therapy; stereotactic teleradiotherapy; hadronic teleradiotheraphy with the bundle of protons; hyperbaric therapy; grafting the baclofen pump (if resistant to pharmacological treatment); genetic examination; positron emission tomography (PET); nuclear medicine examinations; computer tomography; and magnetic res-