The King's Fund
Ideas that change
health care

Authors
Sarah Harvey
Jo Maybin

Patient mobility in the European Union

Supported by

MILLS & REEVE

Contents

Introduction

European patients may seek publicly funded health care abroad within Europe in various circumstances – as tourists requiring urgent care; when living and working abroad; or by travelling especially to receive care. A draft European Union (EU) Directive, currently the subject of debate between the Council of Ministers and the European Parliament, aims to set out definitively patients' rights to receive publicly funded health care in other European countries.

An existing 2004 Regulation together with various European Court of Justice rulings relating to the freedom to provide services across borders within Europe mean that patients already have a range of rights to seek planned health care abroad within the European Economic Area (EU countries plus Iceland, Liechtenstein and Norway) and Switzerland. The Directive is an attempt to codify the various court rulings and to clarify current grey areas.

In 2009 The King's Fund, supported by one of our corporate partners, the law firm Mills & Reeve, organised an expert seminar to consider the implications of the existing rules for patients in the United Kingdom and for NHS providers and commissioners. The seminar was attended by policy-makers, lawyers, commissioners, and managers from NHS and private health care providers.

This briefing provides a summary of the current legal situation and the contents of the draft Directive, and outlines some of the issues raised by seminar participants.

The current legal situation

There are two main legal routes through which European nationals can request and access publicly funded health care abroad within the European Economic Area (EEA). One is based on a 2004 Regulation about the transferability of social security rights, formerly known as the E112 route (now the S2), after the administrative form that has to be issued before travel (Article 22, Regulation EEC 1408/71, recently reformulated as Articles 20 and 27(3) of Regulation EC 883/2004). The other comes from the ban on any restrictions to providing services across EU borders, set out in Article 56 of the Lisbon Treaty (*see* Consolidated Version of the Treaty of the Functioning of the European Union). What this means for patients and health services has been defined by various judgements of the European Court of Justice, and the Department of Health has recently introduced legally binding regulations and directions for primary care trusts (PCTs), setting out their obligations.

Patients seeking health care abroad within the European Economic Area currently have the following rights.

- **Travel abroad for non-hospital health care**. If patients are using the E112 route, the treatment they are seeking must be something they would be entitled to receive at home and they must usually seek prior authorisation from their home commissioner or insurance scheme before travelling (which must be granted if the patient has faced 'undue delay'). The home commissioner pays the provider direct and must pay the amount usually reimbursed by the state in the country the patient is travelling to, even if that is more than the cost of the treatment on the NHS. The patient can access care only in public facilities. Under the Article 56 route and the related new 2010 Regulations, the patient pays for the treatment themselves, can use private or public facilities, and is then reimbursed by their home commissioner up to the level the treatment would have cost at home (or the actual cost, whichever is less) (ECJ 1998 C-158/96, ECJ 1998 C-120/95, ECJ 2003 C-385/99). Prior approval is not required provided that the treatment is medically necessary, is the same as or equivalent to treatment they would have received at home, and does not require an overnight stay, or sedation, or certain kinds of anaesthesia.

- **Travel abroad for planned hospital care**. E112 patients will require prior authorisation from their home commissioner (ECJ 2001 C-157/99). Under the 2010 Regulations relating to patients using the Article 56 route, prior authorisation is required for treatment involving sedation, anaesthesia or an overnight hospital stay and for any service that is not the same as or equivalent to a service that the PCT would make available to the patient. Just as for non-hospital care, E112 patients have the costs paid direct from their commissioner to the provider whereas Article 56 patients must pay the costs themselves and seek reimbursement. Again, Article 56 patients can access privately provided services, whereas E112 patients are restricted to public facilities.
- **Access health care in a country where they are working and living**, either in the EEA or Switzerland, on the same basis as citizens of that country (Regulation EC 883/2004). The patient’s commissioner or insurer (for example, their PCT) must pay the provider direct.
- **Access any urgent treatment they need** while they are a visitor in an EEA country or Switzerland on the same basis as citizens of that country, provided that they have a European Health Insurance Card (EHIC) (Regulation EC 883/2004). The patient’s commissioner or insurance scheme must pay the provider direct. This right does not apply if the sole reason for travelling is to receive medical care abroad (although this may be difficult to prove).

So the main differences between the two routes are that:

- under the E112 route, the patient can go to only public and not private facilities, the patient must almost always seek prior permission from their commissioner, and the provider of care is paid direct by the patient’s commissioner
- under the Article 56 route, the patient can go to private as well as public facilities and needs prior permission for certain types of both ‘hospital’ and ‘non-hospital’ treatments, but they must pay for the care themselves and then seek reimbursement from their commissioner.

In addition, the E112 route includes travel to and from Switzerland as well as within the EEA, but the Article 56 route only applies to the EEA countries.

The **draft EU Directive on patient mobility** currently going through the European legislative process is intended to clarify how these rights can be applied in practice and to ensure that when patients travel within the EU for their health care, the care they receive is safe and efficient.

It was originally expected that both of the existing legal routes for accessing care would remain in force after any Directive were ratified. However, there is some lack of clarity on this, and the House of Lords European Union committee recommended in 2009 that EU decision-makers should consider incorporating the relevant parts of the 2004 Regulation into the text of the Directive (House of Lords European Union Committee 2009).

At the time of writing, the Directive has not yet been passed into law and its content is still being debated. If and when it is passed, it will then need to be transposed into national law. This briefing draws on the latest draft of the Directive, published in April 2009 (The Council of the European Union 2009).

- The rules for **reimbursement** for health treatment abroad have been clarified. The principle is that costs incurred by patients should be reimbursed to the level of the cost of the treatment in their home state, provided that this is not more than the actual cost of treatment. Patients should have to pay these costs upfront only if they would do so normally, otherwise a direct payment should be organised between the home commissioner and the provider. This would mean most NHS patients travelling abroad for treatment under Article 56 would no longer have to seek retrospective reimbursement. Member states could also choose to cover other related costs, such as therapeutic treatment, accommodation and travel expenses.
- Providers would not be obliged to provide or prioritise care for **non-resident EU citizens** where it would negatively affect the treatment of nationals with similar levels of need. For example, if an increase in demand for a particular treatment by non-residents led to local residents waiting longer to access that treatment, this provision would allow providers to discriminate in favour of their resident citizens.
- In the event of **complications** or required **follow-up** treatment, the home state should provide care to someone who has received their treatment abroad in the EU.
- **Prescriptions** issued in another EU state would have to be recognised in all EU states.
- National **contact points** would have to be established in all EU countries to provide information to patients and professionals on available care in their respective country and in languages and formats that can be understood by all EU citizens.
- **Information and communication systems** within health care systems across the EU should be made inter-operable.

In the meantime, the **Department of Health has recently issued new interim Regulations** (which amend the NHS Act 2006), **Directions and Guidance** on the Article 56 route, setting out how the NHS should manage patients wanting to seek care abroad and patients from other EEA countries seeking care from NHS providers, pending further clarification by the EU (The National Health Service (Reimbursement of the Cost of EEA Treatment) Regulations 2010; Department of Health 2010). These include legal requirements for PCTs to:

- establish and publish **procedures for reaching decisions** on applications for prior authorisation and for reimbursement, including a mechanism for reviewing decisions if they are appealed

© The King's Fund 2010

- publish and make available the list of the types of hospital treatment which do require prior authorisation (‘**special services’**)
- make available the information and **forms** required to make applications for prior authorisation and reimbursement and provide **advice and assistance** to individuals on the process
- reach decisions on prior authorisation within a **maximum of 20 working days**, and on reimbursement within 20 working days (with extensions where more information is needed)
- provide **reasons for decisions** to the applicant in writing if their request has been turned down.

The current scale of patient mobility

There are no centrally collected data on the total number of NHS-funded patients travelling to other EEA countries for care, or on the number of patients from other EEA countries who travel to receive care in the United Kingdom. The government does, however, record the number of E112 forms issued each year: in 2009, 1,379 UK patients travelled abroad for NHS-funded treatment using the E112 route – the majority (89 per cent) for maternity care services (Hansard 2010). But this does not include the number of patients leaving or arriving in the United Kingdom using the Article 56 freedoms.

The Department of Health also produces estimates of the total financial value of inflows and outflows of patients from the NHS – that is, how much the United Kingdom claims back from governments and insurance systems in other countries for care provided by the NHS to non-UK EEA nationals, and how much the UK pays out to health providers in other countries for care they provide to NHS-funded patients (*see* Table 1).

Table 1: Estimate of total cost of EEA health claims 2007-08

Claims by EEA member states against UK for NHS patients treated abroad	£630,400,000
Claims by UK against EEA member states for EEA citizens treated by the NHS	£45,900,000

Source: Department of Health (2008)

Some independent estimates of the total numbers of UK patients seeking health care abroad (for both publicly and privately funded care) have been made on the basis of surveys, and they have produced very different results. For example, a survey conducted across all EU countries in 2007 for the European Commission found that 3 per cent of UK respondents reported receiving medical treatment in another EU country in the past 12 months, slightly below the EU average of 4 per cent (The Gallup Organization 2008). If that were representative of the UK population as a whole, that would mean 1.8 million UK patients receiving (publicly and privately funded) care abroad in the EU that year.

Other sources have produced lower estimates. The health tourism website

Treatment Abroad, which commissioned a survey of health care tourism companies and providers in 30 countries (including countries outside the EU) put the number of UK patients travelling abroad for care at 50,500 in 2006 (Treatment Abroad 2007). The International Passenger Survey, conducted by the Office for National Statistics, asks passengers about their reasons for travelling. In 2008, it found 51,000 UK residents were travelling to seek medical care abroad, and 61,000 overseas residents arriving to seek medical care in the UK (*see* Table 2). Again, this does not distinguish between those travelling for private or publicly funded care, and also includes patients travelling to and from outside the EU.

Table 2: Patients travelling to and from the United Kingdom for medical care, 2000-2008

	Overseas residents visiting UK for medical care	UK residents travelling overseas for medical care
2000	34,000	13,000
2001	46,000	23,000
2002	45,000	19,000
2003	35,000	32,000
2004	49,000	25,000
2005	50,000	59,000
2006	66,000	77,000
2007	67,000	71,000
2008	61,000	51,000

Source: Office for National Statistics 2010

A survey conducted in 2007 found that many more people may be willing to travel for care within the EU than currently do so: over half (53 per cent) of all EU respondents to the European Commission survey, including 54 per cent of UK respondents, said they would be willing to travel to another EU country to seek medical treatment (The Gallup Organization 2008). Of those who said they would be willing to travel, the vast majority said they would do so in order to receive a treatment that they could not get at home (94 per cent of UK respondents; 91 per cent of all EU respondents). Other reported motivations included to receive treatment from a renowned specialist (88 per cent of UK respondents; 69 per cent of all EU); to receive treatment more quickly than at home (86 per cent of UK respondents; 64 per cent of all EU); and to receive a higher quality of care (81 per cent of UK respondents; 78 per cent of all EU).

For those who say they would not travel abroad for care, the most commonly cited reasons were convenience (98 per cent of UK respondents; 86 per cent of all EU respondents); satisfaction with their home health system (86 per cent of UK respondents; 83 per cent of all EU); not having enough information about care abroad (70 per cent of UK respondents; 61 per cent all EU); and concerns about the language barrier (64 per cent of UK respondents; 49 per cent all EU) (The Gallup Organization 2008).

© The King’s Fund 2010

The implications for patients of the current arrangements

The rights of NHS patients in England to receive health care abroad have been set out in the NHS Constitution and accompanying handbook, and most recently in the 2010 Regulations and Directions, but are not straightforward.

If people access urgent care as a visitor or tourist with a European Health Insurance Card (EHIC), they do not need prior authorisation. It is for planned health care that the situation becomes more complex. Hospital care for example, usually requires prior authorisation under both the E112 and Article 56 routes, treatments performed outside hospitals under the Article 56 route generally do not. The differentiation between hospital and non-hospital care, however, is not hard and fast. An increasing range of health care that has traditionally been provided in hospitals can now be safely and cost-effectively delivered outside the hospital environment. There are also differences in what community facilities are called – two facilities offering a similar range of treatments might be called a polyclinic in London and a community hospital in a shire county. In the new Regulations, the Department of Health has used the term 'special services', rather than 'hospital' services to distinguish those which it says require prior authorisation before patients seek treatment abroad (The National Health Service (Reimbursement of the Cost of EEA Treatment) Regulations 2010). It defines these services as:

(a) a service that involves a stay in hospital accommodation for at least one night;

(b) medical treatment that involves general anaesthesia, epidural anaesthesia or intravenously administered sedation;

(c) dental treatment that involves general anaesthesia or intravenously administered sedation; or

(d) a service whose provision involves the use of specialised or cost-intensive medical infrastructure or medical equipment.

However, no formal definition of 'hospital' care, which is the key term used in ECJ case law, has yet been set out by the EU.

A further potential source of confusion is what treatments patients are entitled to access. Patients cannot generally access treatment in another part of Europe if that treatment is not available at home (although in certain specific circumstances – for example, in the case of a new type of treatment – PCTs may decide to approve requests where the NHS simply cannot commission services at home). But there is no comprehensive national description of what treatments patients can receive on the NHS. As with care at home, entitlement is based on what a patient's PCT decides to commission for their population or agrees to fund on an individual basis. So, even if a service is available in other PCT areas, if the patient's own PCT has excluded that treatment from funding or has imposed certain thresholds, then rules will apply equally to NHS-funded care being sought outside the United Kingdom.

A key motivation for some patients seeking care in other countries is to reduce the time that they have to wait for treatment. The law states that people who have experienced 'undue delay' in receiving care should not be refused permission to be treated abroad. As waiting times have fallen in line with national targets it may become more difficult to claim an 'undue' delay in accessing care. But here the law is on the individual's side; a ruling by the European Court of Justice in 2006 found that compliance with a national waiting time target is not in itself sufficient to demonstrate that a patient is not experiencing undue delay in receiving care, there must be an objective medical assessment of the particular clinical circumstances of the individual case in question (Yvonne Watts *v* Bedfordshire PCT [2006]). The 2010 Regulations say that such assessments should include consideration of the extent to which the disability or suffering makes it 'impossible or extremely difficult' to carry out daily tasks and the extent to which the treatment would help (The National Health Service (Reimbursement of the Cost of EEA Treatment) Regulations 2010).

In summary, patients seeking treatment outside the UK cannot use EU law to access care that their PCT does not fund or to bypass any restrictions around eligibility. They might, however, look at treatment abroad as a means of getting faster or better quality care. The main challenge here is the availability of reliable information on quality and outcomes.

The issues that the patient mobility provisions raise for the NHS

The current patient mobility rules have different implications for commissioners and providers of care and for both groups they offer potential opportunities as well as risks. The following sections summarise issues raised by delegates at The King's Fund seminar in 2009. No doubt the latest Department of Health Guidance, Regulations and Directions (and the Directive itself, if and when it finally becomes law) will raise many more issues.

Opportunities and challenges for commissioners

In theory, the rules open up opportunities for commissioners to make use of providers in other parts of Europe. A few PCT representatives attending The King's Fund seminar reported that they have actively commissioned care from providers in France, the Netherlands and Belgium – primarily as a means of reducing waiting times and, in one case, the availability of community dentistry.

In other parts of Europe, health care commissioners and insurers have been more innovative in exploiting opportunities to get better and/or cheaper health care. Several examples were given: German insurers AOK/TKK are buying spa treatment from providers in the Czech Republic; Finland has commissioned plastic surgery from providers in Estonia; and health commissioners in both Norway and the Netherlands have arrangements to buy retirement support for their residents who prefer to live in Spain. While this *could* be a route for commissioners in England to consider, it seems unlikely that many PCTs will pursue this option given the relatively low uptake of private sector capacity in delivering NHS-funded care. It is also interesting to note that most of the examples do not relate to 'health care' of the kind the NHS tends to commission for its patients.

Currently, relatively few people in the United Kingdom seek NHS-funded treatment abroad in the EU. While numbers may increase, the level of demand is unlikely to require PCTs to enter into formal contracts with providers in other countries.

The main issues that commissioners may face in handling individual requests relate to equity of access to care for the populations they serve; the complexities of handling the two-tier arrangements; their duty to ensure that the care delivered by European providers is safe and effective; and added challenges around rationing treatment.

Equity. As waiting times have fallen and with the current legal rights to maximum waits there is less likelihood that people will seek treatment abroad on the grounds of unreasonable delay. But there are still some services where long waiting times persist and where delays may affect the outcome of treatment. Infertility treatment is one example. Where commissioners offer only a limited number of cycles for fertility treatment and/or have tight age thresholds for accessing these services, long waiting times become increasingly problematic for women as they approach those age thresholds. Not all women will be willing to travel abroad for treatment, but commissioners may need to consider the equity issues involved in potential applications. First, there is the issue of awareness of the option to seek treatment abroad. Second, there are the financial implications for those who might want treatment but who cannot afford the travel costs or any additional premiums they may have to pay if the treatment is more expensive than the NHS equivalent. Third, there are considerations about whether people who can access treatment abroad should be supported to gain faster access to treatment than those who remain at home. There are no easy answers here but commissioners should ensure that their duty to treat patients equitably is reflected in their local procedures for considering applications for treatment abroad if they are to avoid claims of discrimination or unwittingly contribute to widening inequalities in health and access to care.

Quality and the duty of care. A significant proportion of patients who make requests for treatment abroad are likely to have done their homework about which country they want to travel to and which provider they want to deliver their care. But clearly overseas providers are not covered by the same regulations as those in England, and it will be more difficult for commissioners to verify the safety and quality of services provided abroad. Each individual query from patients may need several hours of research in areas where data may be hard to come by and language may present a barrier. In the fertility example above, for instance, the Human Fertilisation and Embryology Authority in England sets and monitors tight standards for clinics providing these services. The same level of scrutiny may not exist in other countries. Commissioners need to consider the quality of the care that they are funding and any likely associated costs for health services back in England.

Funding treatment abroad under the two-tier system. The implications of having two parallel systems under which patients can seek funding for treatment abroad are not yet clear. There are potential risks, for example, that patients may try to access non-hospital care as tourists or visitors, using the Article 56 route as a fast-track approach rather than going through the more complex approval processes required under E112 arrangements. But this is likely to be a relatively small risk, with no guarantee that clinicians in the country to which the individual travels will agree to their requests for treatment and a financial disincentive for patients as they have to pay for the costs of care upfront. Commissioners will need systems for establishing that procedures have been completed to an acceptable standard and that

© The King’s Fund 2010

the claims are not fraudulent and for calculating their obligations for cost reimbursement. Reimbursement rates may be straightforward where procedures are covered by tariff but for a large proportion of non-hospital care prices are less well defined, not least because there is greater scope for variation in the package of care provided to meet an individual's needs.

Treatment rationing. The imminent pressures on NHS finances could add a further level of complexity to processes for approving and reimbursing treatment abroad. PCTs may seek to exclude some treatments or introduce tighter referral management thresholds as a means of reducing their expenditure. This could well trigger greater interest from patients in getting treatment elsewhere in Europe if they perceive this as a way of 'getting round the rules'. Local PCT policies can be used as a justification for refusing E112 requests from patients seeking treatment abroad but they do not prevent claims for non-hospital treatment (which mainly require no prior authorisation) being sought under the Article 56 route. A further area of risk for PCTs is where they do not explicitly exclude treatments but refuse requests from patients seeking treatments abroad on financial rather than clinical grounds, running the risk of potential legal challenge.

Opportunities and challenges for providers

Patient mobility across Europe presents three particular challenges for NHS providers who care for non-resident EU nationals, relating to reimbursement, clinical governance and increased demand for services.

Reimbursement. Securing reimbursement for treatments under either the European Health Insurance Card or E112 route may be difficult. Not all countries will have systems for approving and transferring the necessary funds and it may take time for claims to be settled. Where there are pre-authorised planned treatments, providers may encounter multiple co-morbidities that can escalate the actual cost of care way beyond the funded limit. While the patient's insurer/commissioner is required to pay, these situations could add delays to the reimbursement processes.

Clinical governance. Providers must be clear where their responsibilities for patient care start and end. Health care cannot be a completely menu-driven activity. While patients may have prior approval for a specific treatment, complications may arise, clinicians may differ in their interpretation of a patient's needs or the risks associated with treatments, and patients can suffer from multiple conditions other than those for which they have sought treatment.

Arrangements for sending and receiving medical records need clarification, particularly where these are in a different language. Moreover, it is unclear whether responsibility for funding the translation of clinical records lies with the referring provider organisation, the commissioner or the recipient health provider.

Increased demand. The patient mobility Directive may encourage more patients to travel to the United Kingdom for treatment; where demand for services is high, there is a risk that local residents might be disadvantaged. Given the relatively high costs of health care in the UK and the relatively balanced inflow and outflow of patients to date, this fear may not be well

© The King's Fund 2010

founded. Furthermore, the Directive would allow providers to refuse to provide or prioritise care for non-resident EU citizens where providing treatment would negatively affect the home population. This provision may be more relevant for providers in mainland Europe, where there is greater movement of people across country borders.

The patient mobility Directive also presents opportunities to health care providers, both in **marketing their services** to patients in other EU countries and in seeking **co-operation agreements** or **joint ventures** with other health care providers. Seminar delegates gave several examples of provider alliances and joint ventures, such as providers close to national borders in Italy and Slovenia, and France and Belgium, developing new services and sharing facilities and staff. Such alliances are more straightforward for organisations working in mainland Europe. However, developments in telemedicine, such as the sharing of digital radiological images allowing remote interpretation, also present opportunities for cross-border alliances, without the patient having to travel out of country.

There is also an opportunity for trusts with a strong brand or offering specialist treatments with high success rates to encourage applications from health tourists as a means of boosting income.

Conclusion

The new Regulations, Guidance and Directions issued by the Department of Health in 2010 have provided some clarity in this complex area. As for the EU Directive, at the time of writing a timetable had not been established for the remaining legislative stages, though the Department of Health estimated in spring 2010 that an agreement may be ‘possible’ in 2010 or early 2011 (Department of Health 2010).

The impact of the Directive for the NHS and its patients will depend on how it is implemented and, in particular, whether it increases public awareness and take-up of existing rights to travel abroad for care, among both NHS patients and patients in other EEA countries.

Demand among UK patients has so far been relatively low, and unless this changes, the impact of the Directive itself on NHS commissioners may be fairly minimal. However, the rules the Directive seeks to clarify already raise important issues for PCTs around satisfying themselves about the quality and safety of services provided to NHS patients abroad in Europe and managing the possible risks to equity which may arise if, in practice, only some patients are able to exercise these rights.

References

Consolidated Version of the Treaty of the Functioning of the European Union. Official Journal of the European Union, C 115/49. Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0047:0199:EN:PDF (accessed on 25 May 2010)

The Council of the European Union (2009). European Parliament legislative resolution of 23 April 2009 on the proposal for a directive of the European Parliament and of the Council on the application of patients' rights in crossborder healthcare. COM(2008)0414 – C6-0257/2008 – 2008/0142(COD). Available at: www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2009-0286+0+DOC+XML+V0//EN (accessed on 2 June 2010).

Department of Health (2010a). Cross-border Healthcare and Patient Mobility: Revised advice on handling requests from patients for treatment in countries of the European Economic Area - guidance for the NHS [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_115256 (accessed on 25 May 2010).

Department of Health (2010b) National Health Services (Reimbursement of the Cost of EEA Treatment) (England) Directions 2010 (online). Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_115257 (accessed on 2 June 2010).

Department of Health (2008). 'Resource Accounting and Budgeting (RAB) exercise'. Reproduced in Hansard, HC Debates, 15 Dec 2008: Column 452W. Available at: www.publications.parliament.uk/pa/cm200809/cmhansrd/cm081215/text/81215w0030.htm#08121553000032 (accessed on 27 April 2010).

The Gallup Organization (2008). Cross-border Health Services in the EU. Analytical Report. Eurobarometer Flash EB No210 [online]. Available at: http://ec.europa.eu/public_opinion/flash/fl_210_en.pdf (accessed on 27 April 2010).

Hansard (House of Commons Debates) (2009-10) 9 Mar 2010 col 191W. Available at: www.publications.parliament.uk/pa/cm200910/cmhansrd/cm100309/text/100309w0008.htm#100309127000862 (accessed on 27 April 2010).

House of Lords European Union Committee (2009). Healthcare across EU borders: a safe framework. HL 30-I (2008-09). London: The Stationery Office. Available at: www.publications.parliament.uk/pa/ld200809/ldselect/ldeucom/30/9780104014356.pdf (accessed on 25 May 2010).

The National Health Service (Reimbursement of the Cost of EEA Treatment) Regulations 2010. Statutory Instrument 2010 no. 915. Available at: www.opsi.gov.uk/si/si2010/uksi_20100915_en_1 (accessed on 25 May 2010).

Office for National Statistics (2010). Extract from International Patient Survey 2000-2008. Provided in personal communication 20 April 2010.

Regulation (EC) No 883/2004 of the European Parliament and of the Council. Official Journal of the European Union, L 166. Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:166:0001:0123:EN:PDF (accessed on 25 May 2010).

Treatment Abroad (2007). 'Medical Tourism Survey 2007' . Treatment Abroad website. Available at: www.treatmentabroad.com/about/medical-tourism-survey/ (accessed on 27 April 2010).

Yvonne Watts v Bedfordshire Primary Care Trust. Case C-372/04. Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:62004J0372:EN:HTML (accessed on 27 April 2010).

© The King's Fund 2010

The King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel 020 7307 2400

Registered charity: 1126980

www.kingsfund.org.uk