Response to Consultation on Cross Border Healthcare
Cross Border Healthcare Directive 2011/24/EU

The Optical Confederation represents the 12,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of five optical representative bodies: the Association of British Dispensing Opticians, the Association of Contact Lens Manufacturers, the Association of Optometrists, the Federation of Manufacturing Opticians and the Federation of Opticians. As a Confederation, we work with others to improve eye health for the public good.

Introduction

We would like to thank the Department of Health for inviting us to its workshop held on 2nd May and welcome the opportunity to respond to this consultation on the plans for implementation of the Directive on the application of patients' rights in cross border healthcare (2011/24/EU) into UK law, hereafter referred to as the 'Cross Border Healthcare Directive'.

As a Confederation, we support the overarching objectives in the Directive which provide positive steps to clarify citizens' rights when accessing healthcare across borders and to allow them to exercise choice and access to the most appropriate care for their needs across borders.

We welcome the provisions to ensure that patients have access to safe and high quality services wherever such care is received across Europe. Our members pride themselves on delivering, as mentioned previously, high quality and accessible care in the UK, which is underpinned by sector specific legislation and NHS requirements.

We are also pleased to see that the UK Government will not seek to duplicate existing requirements on healthcare providers and will rely on sector specific and other provisions for example the requirements on NHS providers. We also welcome the requirements to have sufficient indemnity cover in place and that pricing information be transparent across healthcare providers.

NHS and Private Providers

Optical Confederation members already operate in a highly competitive retail market environment. A key to their success is setting transparent prices for their patients in accordance with consumer protection legislation. Over 99% of community optical practices provide NHS services to their patients and accordingly already comply with

provisions for NHS providers. In order to provide NHS services, community optical practices have to satisfy the NHS authorities in the four countries of the UK regarding their professional staff (who also have to be NHS listed) and the quality of their premises, equipment and record-keeping to ensure receive high quality care.

Eligibility for NHS primary eye care is determined by the Government based on need and ensures that those most at risk of problems with their vision and eye health, and those on limited means, are eligible for NHS care. A full list of eligibility criteria for NHS eye care is available on the NHS Choices website.[1]

Those who are not eligible for NHS care must pay privately for their eye care services. These are governed by the provisions in the Opticians Act 1989, by our sector specific regulation and compliance with the rules and Codes of Conduct of our specific eye care regulator – the General Optical Council (GOC). Prices for private eye care services are market-determined and transparent, with a receipt which details the breakdown of the services and products supplied. This means that eye care providers already apply their fees in a non-discriminatory way including to citizens from other Member States who wish to attend for their primary eye care in the UK.

We believe that our members should be able to charge EEA patients the comparable fee to their UK counterparts which is their standard private fee, rather than the discounted NHS fee and would be grateful if the implementing legislation made this clear**.**

Optical Practitioners

We agree with the Government's definition of a healthcare professional in the context of the UK, which, for clarity, includes optometrists and dispensing opticians, both being registered professions regulated by the GOC. For clarity these should be included within Annex A (where they appear to have been missed out).

We can also confirm that holding professional indemnity insurance is a requirement of registration with the GOC and as such all optical practitioners are appropriately covered in the very rare event that something goes wrong.
[Include something on varied scope of practice across Europe?]

As is clear from the above, the community optical sector already meets all of the provisions for healthcare providers contained within the Cross Border Directive (from Article 4, reproduced in Paragraph 6.6), viz

- provision of information about the treatment options they provide and if necessary, reassurances about their quality or safety
- quality and safety criteria for the provision of their primary eye care services (governed by the GOS contracts)
- operating a transparent complaints procedures
- having appropriate liability cover in place
- compliance with Data Protection legislation and sector specific guidance on patient records

[1] http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Eyecarecosts.aspx

- supplying patients with a copy of the results of their sight test, with patient records available on request.

As a sector therefore we

- very much welcome the Government's intention to implement the legislation without duplicating other requirements,
- confirm that optical practitioners and practices are already complaint with the requirements for healthcare providers established in the Cross Border Directive, and
- would be opposed for these reasons to the imposition of further requirements.

We would like to add for clarity that medical devices such as those prescribed or specified by prescribed by optometrists or contact lens opticians are not subject to the requirements in the Directive governing recognition of prescriptions issued in another Member State (governed by Article 11 which specifies medicinal products only). The list of elements to be included in medical prescriptions are therefore not required for prescriptions and specifications for medical devices, and implementation should avoid the imposition of these requirements on medical devices.

Against that background, we believe that the plans for implementation are clear and sensible, but we have included some specific and more detailed comments in response to the questions below.

We would be happy to meet with Departmental officials to discuss any of the points raised in more detail.

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Consultation Questions

General

1. **What proportionate measures can we take so that all patients/citizens, regardless of age, race or ethnicity, disability, religion or belief, gender, sexual orientation or socio-economic status feel a) reassured they will be treated with respect and their specific needs considered b) they are fully informed to make the right choice for them?**

   A. This is already a requirement under the GOC's codes of conduct for individual practitioners and optical bodies corporate and under our NHS contracts. This reassurance will be reinforced by the Government's plans to provide the key information online and through trained and experienced National Contact Points. It would be helpful to complement this with guidelines for healthcare practitioners and providers who might also be asked for information about the best option for a particular patient. To support this, the Optical Confederation will produce guidelines for our members when advising patients about their rights and delivering healthcare services, under the Directive.

2. To what extent do you think that these proposals will have a positive or an adverse impact on equity? What can be done to manage any adverse impact?

A. Since the Government plans to put in place provisions to ensure patients on limited means can have their cross border healthcare reimbursed directly to the provider in another country, we do not foresee any adverse impacts on equity.

3. Please provide any evidence you may have on the reasons for which patients travel abroad to receive healthcare, the likely uptake (current and future) of cross-border healthcare by NHS patients as well as the impacts this has on the NHS (budget, administrative costs, commissioning etc).

A. The provision of cross border healthcare in the optical sector is limited. Our patients might seek out healthcare should they encounter urgent problems with their eye health, vision, spectacles or contact lenses, while travelling or working overseas, which we support as it ensures prompt access to treatment or replacement vision correction if required. Delay can result in infection, deterioration and in serious cases loss of sight. In our experience, such patients have traditionally chosen to pay privately for their primary eye care services or via their travel insurance.

Responsibilities of Member State of treatment (pages 13 -22)

4. Are there any other "health professions" in the UK to which the provisions of the Directive will apply when treatment is supplied in the UK?

A. As stated above, we agree with the Government's definition of a healthcare professional in the context of the UK, which for clarity includes optometrists and dispensing opticians. Both professions are regulated by the GOC. For clarity both should be included within Annex A (where, as previously stated, they appear to have been missed out).

Responsibilities of Member State of affiliation (pages 22 -26)

5. Do you agree that this broad requirement would ensure that the NHS is able to deliver the required clarity on entitlements and thereby respond appropriately to patient requests?

A. Yes. It seems sensible to have a single national contact point for England, Scotland, Wales and Northern Ireland which ensures that these individuals can be appropriately trained and experienced to assist patients in making decisions about their healthcare.

National Contact Points (pages 26 -27)

6. Do you agree that the Commissioning Board is best placed to deliver the NCP function for England?

A. Yes.

7. **What information, and presented in what format(s), do you think patients need to make an informed decision on receiving treatment in another EU Member State?**

   A. The consultation document makes reference to the variation in scope of practice for certain professions, for example osteopaths. Within eye care, the scope of practice for optometrists and opticians varies considerably across the EEA therefore we believe that UK patients travelling overseas should have reassurances that the professional providing their care is adequately qualified to do so, has adequate insurance in place, and that there is clarity about the complaints procedure and means of redress if something goes wrong. It would also be important to let patients know in advance whether they would need to travel back to the country of treatment for follow up care, for example following cataract surgery.

   This information should be provided online and for partially sighted or blind individuals it should be available in a variety of formats on request.

   A. **What will be the impact of providing clear and transparent information on the volume of patients who may wish to access cross-border healthcare and the treatments they may wish to obtain? Please provide evidence where possible.** We do not envisage that large numbers of UK patients will choose to access their eye care in other EEA countries and do not believe that the volume of information provided will greatly influence this decision.

   A challenge we foresee is the provision of quality information about healthcare providers in all EEA countries, given linguistic, cultural and legal differences in healthcare systems. We can see that there might be risks to over-provision (confusion through information overload) and under provision (ill-informed decision making) of information for patients. For this reason we feel it would be sensible periodically to review the volume and quality of information provided at least for the first few years.

General principles for reimbursement of costs (pages 28 -33)

8. **Do you agree that the NHS Commissioning Board should have discretion to make payments direct to overseas providers, where this would be beneficial for patients with limited financial means?**

   A. We agree that this is fair.

9. **If so, what safeguards would you like to see put in place?**

   A. Patients requesting overseas treatment should provide evidence of their limited means and ideally a reason why the NHS alternative is not appropriate for their needs. The provider should demonstrate that appropriate treatment has been provided. To reinforce this, it might be helpful to speak to the patient in advance of authorising such direct payments.

10. **How might any adverse impact be managed?**

    A. No comment.

Healthcare that may be subject to prior authorisation (pages 33 -42)

11. Do you agree that the UK should continue to operate a system of prior authorisation for patients requiring certain types of treatment?

A. We agree that it is sensible to allow a provision that treatment can be refused where treatment can be provided within a medically justified period of time within the UK. There is sufficient capacity within, and access to community optical practices in the UK in order to ensure that no eye care patient need wait to access an optometrist or optician for care.

12. In addition to specialist services and services such as diagnostics requiring considerable planning and financing what other services might come within the scope of treatments / services that should be subject to prior authorisation?

A. Not applicable to our response.

13. What is the evidence to support this inclusion?

A. Not applicable to our response.

14. Do you have a view on whether or how the Government should adopt the derogation Art.8(6)(d) derogation?

A. Not applicable to our response.

15. Should the derogation (if taken) be limited to the list of highly specialised services only?

A. Not applicable to our response.

16. Do you believe this Article can be made to work in practice without being unduly burdensome?

A. Not applicable to our response.

Administrative procedures (pages 42 -43)

17. Is the current decision making timescale reasonable, or should it be amended?

A. 20 working days seems reasonable for non-urgent conditions.

18. Would a system of voluntary prior notification for some services not subject to mandatory authorisation be helpful in creating dialogue where cross-border healthcare is being considered?

A. This might be helpful in the initial stages as we anticipate a steep learning curve for National Contact Points and patients. For many patients, a key concern will be the potential for a differential between the amount they pay for

their cross border care, and the amount they are reimbursed. Allowing such patients to have a written estimate of how much they are likely to be reimbursed will assist their decision-making.

19. What would such a system look like and how could it work in practice?

A. We feel that it would be reasonable to include general information about conditions online, with the option of speaking to the National Contact Points in advance of requesting written prior notification.

Mutual assistance and cooperation (pages 43 -48)

20. What information should be shared between competent authorities on treating practitioners, and in what circumstances?

A. It will be important for the National Contact Points and competent authorities to understand the variation in the scope of practice between EEA countries. We feel strongly that competent authorities must await the outcome of an investigation into a practitioner's fitness to practice before sharing this information with others as the practitioner in questions will not have been found to have been impaired.

21. How do you think the European reference networks and proposed ehealth and health technology assessment networks might best add value to the UK?

A. Not applicable to our response

22. What impact might these have on current UK systems?

A. Not applicable to our response

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