Health Policy 120 (2016) 1233–1239

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

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

Iwona Kowalska-Bobko[a,*], Anna Mokrzycka[a], Anna Sagan[b], W. Cezary Włodarczyk[a], Michał Zabdyr-Jamróz[a]

[a] Jagiellonian University Medical College, Faculty of Health Science, Institute of Public Health, Poland
[b] European Observatory on Health Systems and Policies, United Kingdom

ARTICLE INFO

Article history:
Received 8 October 2015
Received in revised form 15 June 2016
Accepted 14 July 2016

Keywords:
Health policy
Europe
Health care reform
International law
Directive 2011/24/EU
Health care rationing
Treatment abroad
Cross-border health care
Patients' right

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.

☆ Open Access for this article is made possible by a collaboration between Health Policy and The European Observatory on Health Systems and Policies.

* Corresponding author. Fax: +48 12 421 74 47.
E-mail addresses: iw.kowalska@uj.edu.pl, ikowalska72@gmail.com (I. Kowalska-Bobko).

http://dx.doi.org/10.1016/j.healthpol.2016.07.011

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-

Table 1
Key differences between the regulation on the coordination of social security systems and the directive on cross-border care.

Regulations on the coordination of social security systems	Directive on cross-border care
Legal framework Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April, 2004 on the coordination of social security systems Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September, 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems	Cross-border healthcare directive 2011/24/EU of the European Parliament and of the Council of 9 March, 2011 on the application of patients' rights in cross-border healthcare
Who is covered? EU/EFTA nationals who are or who have been covered by the social security legislation of one of EU/EFTA countries who are living or staying temporarily in another EU/EFTA country	EU nationals who are or have been covered by the social security legislation of one of the EU countries and who are living or staying temporarily in an EU country
What is covered? Medically necessary care during a temporary stay; full range of healthcare benefits covered within the statutory healthcare system of the country of residence in case of permanent residence; planned treatment abroad; healthcare benefits related to the treatment of work accidents or occupational diseases	All health benefits covered within the statutory healthcare system of the country of origin
What documents are necessary to prove the right to healthcare? European Health Insurance Card (EHIC) or Provisional Replacement Certificate (PRC); E 112/S2 form (for planned treatment abroad) E106/E109/E120/E121/S1 form and a certification issued on their basis(for persons permanently residing in another EU or EFTA member state)	Documents required by the legislation of the member state of origin in case of prior-authorization and/or cost reimbursement
Which healthcare facilities and pharmacies can be used? Only those facilities that provide services within the statutory healthcare system of the country where services are provided	All facilities that are legally approved in the country where services are provided (including facilities that provide healthcare services outside of the statutory healthcare system)
Which costs are covered? Services covered by the statutory healthcare systems in the country where services are provided; any statutory cost-sharing that is applied in that system continues to apply	All costs must be initially covered out-of-pocket; costs will be reimbursed up to the cost of the same service in the country of origin

Source: Based on Ref. [10].
Note: EFTA = European Free Trade Association.

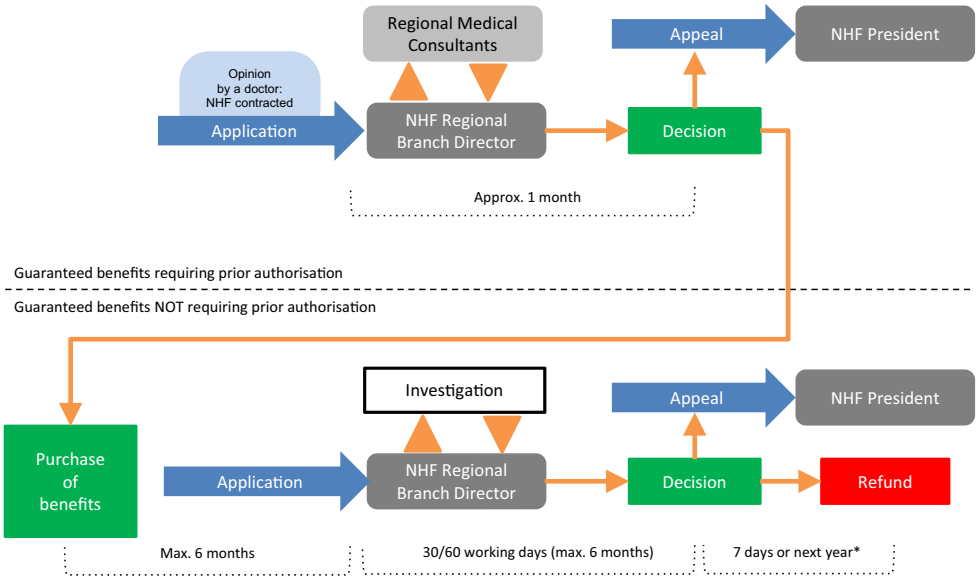

Fig. 1. Implementation of directive 2011/24/EU in Poland: pre-authorization and reimbursement pathways.
Note: * If the annual reserve has been depleted.
Source: Authors.

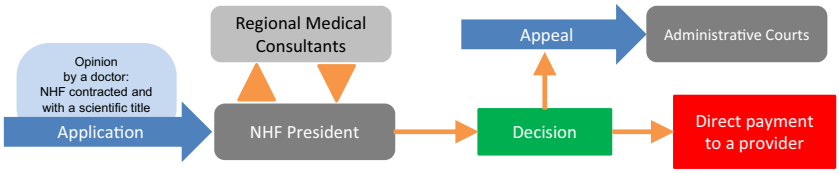

Fig. 2. Implementation of directive 2011/24/EU in Poland: pathway for financing of guaranteed benefits currently not provided in Poland. Source: Authors.

onance. The rationale behind the list was to ensure that the NHF has enough resources to guarantee access to services to Polish patients seeking care at home. A similar authorization is also required if the patient wishes to obtain reimbursement of the transportation costs. Having provisionally approved the application for a pre-authorization the director may choose to indicate a domestic provider, who has the medical competence to perform the service sought by the patient abroad. If it is established that the domestic provider can indeed perform the service, the application will be turned down [9]. Patients applying for a pre-authorization must obtain an opinion from a medical specialist. Pre-authorization is also a condition for cost reimbursement of selected cross-border benefits. In case of pre-authorized care, the beneficiary must first cover the full cost of cross-border care out of their pocket and then apply for reimbursement [9].

3.2. Barrier 2: annual reimbursement limit for cross-border care

The second barrier is the annual reimbursement limit for cross-border care. The amendment introduces an annual financial reserve that can be used for reimbursement of cross-border care by the NHF. The reserve applies for the period between 2014 and 2023. When the reserve is depleted, reimbursement is postponed until next year or later [9].

3.3. Barrier 3: need for a referral or prescription

In order to obtain reimbursement the patient needs to have a referral or a prescription from a Polish or other EU doctor. While any EU doctor, including private doctors who operate outside the statutory health systems, can provide a referral or prescription that can be considered for reimbursement in Poland, among Polish doctors only those who are contracted by the NHF may give such referrals and prescriptions [9]. This is the case in only four other member states [5] and can be seen as the third barrier to accessing healthcare abroad.

3.4. Barrier 4: complexity of the reimbursement process

Another barrier is the complexity of the reimbursement process, with many formal requirements that have to be met, and the reimbursement limits for treatments accessed abroad. It may take over a year to obtain reimbursement (Fig. 1). Each application for cost reimbursement undergoes a process of careful evaluation. Applicants must include all referrals, medical records and certificates. Unless issued in English, these documents have to be translated into Polish and – in case of drugs and medical appliances – notarized [11]. With the exception of benefits for which the rules of coordination of social security systems apply and benefits not provided in Poland, the costs that are covered cannot exceed the reimbursement limits established within the Polish system. This means that if a given procedure costs more than the reimbursement limit applied in Poland, any excess costs will have to be covered by the patient. The actual amount that is reimbursed will be the weighted average of the costs of given procedure in the voivodship (i.e. region) of patient's residence and will thus vary across the voivodships. This is because the voivodship branches of the NHF negotiate prices with each provider individually and there are no uniform prices that apply to all providers [11]. The costs of benefits not provided in Poland are paid directly by the NHF to the provider. For Polish patients who accessed healthcare abroad before the directive was implemented the only way of obtaining reimbursement from the NHF is through judicial action [11].

4. Health policy processes and stakeholders' positions during directive's implementation at the EU level and its transposition into Polish legislation

4.1. Polish government/Ministry of Health

During the negotiations phase, Poland clearly opposed the provisions proposed by the European Commission. The draft directive was strongly criticized by Ewa Kopacz—the Minister of Health at that time. The main cause of this opposition was the threat that the implementation of the directive would pose to the financial stability of the public payer (NHF). The Ministry of Health argued that unlimited demand for healthcare abroad from Polish patients would provoke uncontrolled outflows of money and would negatively affect the contracts concluded with the national providers and reinforce the problem of waiting lists. These fears were shared by other member states, e.g. Malta [1] and Spain [15].

The rulings by the ECJ cited above (e.g. Kohll and Decker judgements), stipulated that European Community nationals may obtain medical treatment in another member state without a prior-authorization and be reimbursed in accordance with the tariffs of the state in which they are insured. This can be interpreted as giving the interests of individual patients superiority over the interests of public payers and reinforced the conviction of the Ministry of Health that the implementation of the directive would have a damaging

effect on the NHF's budget [14]. Because the idea of 'undue delay' was included in the draft – as it was in the final version of the directive – the authorities were concerned that the large numbers of patients waiting for treatment and diagnostic tests in Poland[1] would seek treatment abroad. The reimbursement of treatment abroad for these patients would be fully justified on the grounds of undue delay [13]. What the government feared even more was that, since the directive requires that patients are reimbursed for care provided by non-contracted healthcare providers abroad, Polish patients would also demand to be reimbursed for care provided by non-contracted healthcare providers at home [3].

During the negotiations and the implementation stage, the government and the Ministry of Health seemed to overlook potential monetary benefits which the implementation of the directive could bring. Other countries, such as Malta, also focused more on damage control rather than exploiting opportunities that cross-border healthcare could bring [1]. For example, Poland could be promoted as a destination for health tourism as it has renowned medical specialists and relatively low costs of treatment compared to western Europe. The directive could also lower the cost of some publicly funded healthcare services as they could be performed more cheaply abroad. For example, anecdotal evidence suggests that the cost of and waiting times for cataract treatment in the Czech Republic are lower than in Poland. The position and actions of the Ministry of Health were against those of the Ministry of the Economy who was keen to promote Poland as a destination for medical tourism: medical tourism was included in the project "Promotion of the Polish economy on international markets" co-financed by European Regional Development Fund [3] and has been promoted in a number of countries, including the Nordic countries, Germany and the United Kingdom.

The influence of Poland and other countries that were against the directive in the negotiation's phase was not very strong, though it has slowed down the process of it adoption. The main gain from this opposition was that member states were allowed to implement a system of prior-aurhorizations for certain cross-border healthcare services (see Section 3), in order to avoid the risk of undermining the planning and/or financing of their health system. The fears of high costs of reimbursing cross-border care and of the associated organizational and technical burden were the key reasons for the delay in the directive's implementation [2]. This negative stance, shared with some other member states (e.g. Malta, see Ref. [1]) was reflected in the restrictive nature of the regulations transposing the directive into Polish law (see Section 3).

4.2. Patients and healthcare providers

4.2.1. EU level

Other stakeholders, such as patients and healthcare providers, were strongly in favor of the directive, both during the negotiations at the EU level and during the transposition phase, and expressed this in open letters to the Polish Members of the European Parliament (MEPs) and the Polish Prime Minister (see Ref. [3]). For patients, the implementation of the directive would mean faster access to treatment, given the long waiting times for some medical procedures in Poland, and better access to some procedures, such as abortion.[2] The Polish Chamber of Physicians and Dentists hoped that the implementation of the directive would force the government to introduce long awaited changes, such as the abolishment of administrative funding limits by the NHF; introduction of a fair valuation of healthcare services and of a realistic estimation of the financial resources needed to cover the provision of the basket of guaranteed healthcare services. These stakeholders had little (if any) influence on the Polish MEPs and thus on the policy process at the EU level.

4.2.2. National level

During the transposition of the directive into Polish legislation, as with any other legislation, only the government had real influence on the final shape of the regulations and the influence of other stakeholders was minimal. Patients are one of the weakest stakeholder group in the healthcare sector as they lack a strong, organized representation at the national level. The influence of healthcare providers is usually stronger as they are better organized and can resort to strike actions. While the latter were overall strongly in favor of the directive,[3] the issue was somewhat of lesser importance to them compared to other issues of more 'domestic', as opposed to European, nature (such as working conditions, etc.). Apart from some attempts to exert pressure on the Civil Rights Ombudsman to partake in the debate on the directive, little was done to influence the policy process. The government was in full control over this process and did not enter into open discussions with the representatives of the key stakeholders. The extremely short time that the government foresaw for public consultations (seven days), reflects the low influence of the public on the policy process.

5. Accessing planned healthcare under the directive

Overall, the volume of patient mobility for planned healthcare under the directive and also under the Social Security Regulations appears to be low [5]. This low volume seems to be due to the low number of applications

[1] According to the latest NHF data analysing waiting times for five types of ambulatory clinics and five types of hospital wards increased over the 2013–2014 period, by up to 35% and 33%, respectively. In ambulatory care, particularly long waiting times among the five types of ambulatory clinics were observed for cardiology outpatient clinics (median waiting time of 97 days with over 138 thousand patients waiting), while in inpatient care, longest waiting times were noted in trauma–orthopaedic wards (median waiting time of 106 days with over 124 thousand patients waiting) [12].

[2] Directive 2011/24/EU refers to unethical treatments (amongst others) explicitly in the 7th recital, which means that member states can exclude those treatments from the directive's rules (see for example Ref. [17].

[3] However, they questioned some aspects of the directive. For example the Chief Medical Chamber criticized the exclusion from reimbursement of drugs within national drug programmes, the mechanisms for legal recourse if a negative reimbursement decision was made, etc. See Ref. [8] for more information.

for reimbursement as available data suggest that approximately 85% of reimbursement claims are in fact granted. One explanation for this may be the low awareness of EU citizens of their cross-border rights [6].

According to the latest NHF's data, between the 15th of November 2014 and the 27th of March 2015 the NHF received 777 applications for reimbursement of medical expenses abroad amounting to approximately PLN 4.2 million (approx. EUR 950 000). The majority of the applications (81%) were for the reimbursement of cataract surgery, which is a day surgery not requiring a pre-authorization. In the first quarter of 2015 the NHF received ten applications for planned treatment abroad that fell within the provisions of the directive. The majority of these applications were returned to the applicants because they did not meet the formal requirements [9].

The number of applications for the reimbursement of cataract surgery would likely have been even greater had the government not introduced measures to discourage patients from seeking such treatment abroad. In 2012 reimbursement rates for cataract surgery were reduced substantially and since cross-border healthcare is reimbursed according to domestic tariffs, this made going abroad for a cataract surgery less attractive as patients that do so could be faced with paying differences in prices out of pocket. Moreover, statutory benefits in the area of cataract treatment were reduced, making less severe cases of cataract not eligible for public reimbursement. This means that only the most severe cases would qualify for public coverage, which would dramatically reduce waiting lists for cataract surgery, and that patients with less severe cases of cataract would not be eligible for reimbursement within the cross-border directive [18].

6. Conclusions

Regulations transposing the directive were clearly meant to protect the NHF's budget from the extra costs of cross-border care by minimizing or postponing them. This was to be achieved by imposing many restrictions on the directive's application, including requiring an obligatory pre-authorization for most procedures; not allowing non-contracted providers to issue referrals for care abroad, imposing many formal requirements on the applications for treatment abroad, making the application process cumbersome and costly and imposing a cap on the annual budget for the reimbursement of cross-border care under the directive.

It is difficult to judge how restrictive Polish regulations implementing the directive are compared to those put in place in other member states. A recent (September 2015) report by the European Commission indicates that most member states among the 26 member states that provided information imposed some sort of requirements restricting patient mobility [5]. For example, only seven member states did not require a prior-authorization, while others imposed some form of prior-authorization, ranging from prior-authorization for a detailed list of treatments (six member states), through prior-authorization for overnight stay and highly specialized care (14 member states, including Poland and Spain [15]), to prior-authorization for everything, with the exception of one specialist consultation per patient per year (one member state). In 12 member states, including Poland, patients must obtain a referral from a GP or family doctor in order to access specialist care abroad. At least four member states, including Poland, require patients to provide a sworn translation of invoices.

It appears that government's fears of the 'exodus' of Polish patients abroad have largely not materialized so far. This is not surprising and was expected by many analysts. Considering the cumbersome reimbursement process and the differences in the prices of healthcare services in Poland and in other (especially western) member states and other costs associated with obtaining healthcare abroad, seeking healthcare abroad is and will likely remain not affordable to many Polish patients.

Acknowledgements

The article is based on the work conducted within the grant from the Polish National Science Centre (NCN) no UMO-2011/01/D/HS5/03399 (Quality assessment of the legislation process).

References

[1] Azzopardi-Muscat N, Aluttis C, Sorensen K, Pacel R, Brand H. The impact of the EU Directive on patients' rights and cross border health care in Malta. Health Policy 2015;119(October (10)):1285–92.
[2] Bach-Golecka D. Obawy rządu, oczekiwania pacjentów. O implementacji dyrektywy o transgranicznej opiece zdrowotnej w Polsce [Government' concerns, expectations of patients. The implementation of the Directive on cross-border healthcare in Poland]. European Union: Polish and Czech Perspectives; 2015. Available at: http://forum-pl-cz.com/index.php/cs/home/22-polska/polityki-publiczne/54-dobrochna-bach-golecka-obawy-rzadu-oczekiwania-pacjentow-o-implementacji-dyrektywy-o-transgranicznej-opiece-zdrowotnej-w-polsce.
[3] Baeten R. Europeanization of national health systems National impact and EU codification of the patient mobility case law. Report in the context of the EPSU Project "Europeanisation of health policies and health care systems and common challenges for the health care workforce—options for trade unions and the role of social dialogue to address them in the next decade"; 2012. Available at: http://www.epsu.org/IMG/pdf/Baeten-Europeanisation-Healthcare-Systems_Patient-Mobility-26-09-12.pdf.
[4] Borek E, Chwiałkowska A, Turkiewicz J. Raport podsumowujańcy konsultacje Raport podsumowujańcy konsultacje społeczne przeprowadzone społeczne przeprowadzone w sprawie wdrożénia w Polsce w sprawie wdrożénia w Polsce Dyrektywy o prawach pacjentoíw Dyrektywy o prawach pacjentoíw w transgranicznej opiece zdrowotnej. Warsaw: Fundacja MY Pacjenci; 2014. May. Avaiable at: http://www.opzz.org.pl/documents/1137115/0/Raport+My+pacjenci+Dyr.+transg.+2014r.pdf.
[5] EC. Commission report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare. Report from the Commission to the European Parliament and the Council. COM(2015) 421 final. Brussels, 04/09/2015; 2015. Available at: http://ec.europa.eu/health/cross_border_care/docs/2015_operation_report_dir201124eu_en.pdf.
[6] EC. Patients' rights in cross-border healthcare in the European Union. Special Eurobarometer 425 Wave EB82.2—TNS Opinion & Social. Published May; 2015. Available at: http://ec.europa.eu/public_opinion/archives/ebs/ebs_425_sum_en.pdf.
[8] Goscinska D. Transposition of the. Patients' Rights Directive 2011/24/EU. A discourse analysis in. Germany, Poland and Austria in Working Papers in Health Policy and Management, volume 8, February; 2014. Available at: https://www.mig.tu-berlin.de/fileadmin/a38331600/2014.publications/Working_Paper_vol.8.pdf.
[9] Kowalska-Bobko I, Mokrzycka A, Zabdyr-Jamróz M. Implementation of EU Directive 2011/24/EU on patients' rights in cross-border healthcare. Published on 16 February 2015 in Health Systems

and Policy Monitor; 2015. Available at: http://www.hspm.org/countries/poland27012013/countrypage.aspx.
[10] Krajowy Punkt Kontaktowy. Czym różni się leczenie na podstawie przepisów o koordynacji systemów zabezpieczenia społecznego od leczenia na podstawie przepisów implementujących dyrektywę transgraniczną? [What is the difference between treatment based on the rules of coordination of social security systems and and treatment based on the regulations implementing the Directive on cross-border care]. Krajowy Punkt Kontaktowy do Spraw Transgranicznej Opieki Zdrowotnej [The National Contact Point for Cross-border Healthcare]; 2015. Available at: http://www.kpk.nfz.gov.pl/pl/leczenie-w-innym-panstwie/mozliwosci-leczenia-w-ue.html.
[11] Mypacjenci.org (undated). Dyrektywa o prawach pacjentów w transgranicznej opiece zdrowotnej [Directive on patient rights in cross-border healthcare]. Available at: http://mypacjenci.org/aktualnosci/12-strony/120-dyrektywa.html.
[12] NIK. Realizacja zadań Narodowego Funduszu Zdrowia w 2014 roku [Implementation of the tasks of the National Health Fund in 2014]. Najwyższa Izba Kontroli [Supreme Audit Office] KZD.410.002.01.2015; 2016 https://www.nik.gov.pl/kontrole/P/15/059/.
[13] Pracodawcy RP. Pacjenci wymuszą implementację dyrektywy transgraniczne [Patients force the implementation of cross-border healthcare directive]. Published on August 29; 2014. Available at: http://www.pracodawcyrp.pl/stanowiska/art,5847,pacjenci-wymuszaimplementacje-dyrektywy-transgranicznej.html.
[14] Pracodawcy RP. Dyrektywa transgraniczna – obawa o budżet NFZ wygrała z prawami pacjenta [Cross-border healthcare directive – fears about NHF's budget won over patient rights]. Published on March 21; 2014. Available at: http://www.pracodawcyrp.pl/stanowiska/art,5760,dyrektywa-transgraniczna-obawa-o-budzet-nfz-wygrala-z-prawami-pacjenta.html.
[15] Requejo MT. Cross-border healthcare in Spain and the implementation of the Directive 2011/24/EU on the application of patient's rights in cross-border healthcare. European Journal of Health Law 2011;21(March (1)):79–96.
[16] Sagan A, Panteli D, Borkowski W, Dmowski M, Domaniński F, Czyżewski M, et al. Poland: health system review. Health Systems in Transition 2011;13(8):1–193.
[17] Van Hoof W, Pennings G. Extraterritorial laws for cross-border reproductive care: the issue of legal diversity. EJHL 2012;19(2):187–200.
[18] Wyborcza.pl. Ostre cięcie kolejek do leczenia zaćmy [Sharp cuts of queues for cataract surgery]. By Judyta Watoła. Published on August 28; 2014. Available at: http://wyborcza.pl/1,76842,16541888,Ostre_ciecie_kolejek_do_leczenia_zacmy.html.