

**CROSS-BORDER HEALTHCARE SERVICES IN THE  
UNITED KINGDOM UNDER EU DIRECTIVE  
2011/24/EU AND REGULATION (EC)  
NO. 883/2004: LESSONS  
FOR THAILAND**

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**ABSTRACT**

At the present time, Thailand has problems that need to be solved which are inequity in accessing to healthcare services and difference of the benefits packages of insured persons under the three Thailand's healthcare models: National Health Security Scheme, Civil Servant and State Enterprise Scheme, and Social Security Scheme. The system that covers most Thai people is the National Health Security Scheme, which is aimed to create security in healthcare for all Thai people. Thai people should have efficient healthcare treatment, and they should not have problems pertaining to monetary or financial issues as obstacles to receiving basic healthcare treatment. Besides, management in healthcare system still needs to be developed to take care of people. Patients' rights, including reimbursement right, should not be ignored but be considered in both the domestic and international perspectives.

Healthcare itself on domestic level involves complex issues, but when it is in the international context or cross-border context, it becomes even more complicated. Therefore, there should be legal mechanisms to facilitate cross-border healthcare services. The possible solution is learning from the United Kingdom under European Union's experience. EU legislation might be an appropriate model for arrangements of cross-border healthcare services including patient's reimbursement, control quality and safety, and cooperation across borders.

**Keywords:** cross-border healthcare, patients' rights, patient's reimbursement

## บทคัดย่อ

ในปัจจุบัน ประเทศไทยมีปัญหาที่จำเป็นจะต้องแก้ไขในเรื่องของความเท่าเทียมกันในการเข้าถึงการรักษาทางการแพทย์ และความแตกต่างกันของชุดสิทธิประโยชน์ของผู้ประกันตามระบบสุขภาพของไทยทั้งสามระบบคือ ระบบสวัสดิการรักษายาบาลข้าราชการ ระบบประกันสังคม และระบบระบบประกันสุขภาพแห่งชาติ ประชาชนส่วนมากในประเทศไทยอยู่ภายใต้ระบบระบบประกันสุขภาพแห่งชาติที่มีจุดประสงค์ในการสร้างความมั่นคงทางด้านสุขภาพให้แก่ประชาชนทุกคน ประชาชนชาวไทยควรได้รับการรักษาที่มีประสิทธิภาพโดยปราศจากอุปสรรคใดๆ ในการเข้าถึง โดยเฉพาะอย่างยิ่งปัญหาทางการเงิน นอกจากนี้การจัดการระบบสุขภาพยังคงต้องมีการพัฒนาเพื่อการดูแลและประชาชนรวมทั้งเรื่องของสิทธิของผู้ป่วยและที่สิทธิในการเบิกจ่ายไม่ควรได้รับการเพิกเฉยทั้งในระดับภายในประเทศและในระดับนานาชาติ

เรื่องของสุขภาพแม้ภายในประเทศมีความซับซ้อนและเมื่อเป็นเรื่องของระบบประกันสุขภาพในมุมมองของระหว่างประเทศยิ่งซับซ้อนยิ่งนัก ดังนั้นมีความจำเป็นอย่างยิ่งที่จะต้องมีการมาตรฐานทางกฎหมายที่ช่วยส่งเสริมระบบสุขภาพระหว่างประเทศ การศึกษาประสบการณ์จากประเทศอังกฤษในบริบทของสมาชิกของสหภาพยุโรป รวมทั้งการศึกษากฎหมายของยุโรป อาจจะเป็นต้นแบบที่เหมาะสมในการเตรียมความพร้อมในเรื่องระบบสุขภาพระหว่างประเทศที่อาจจะเกิดขึ้นในอนาคต ทั้งในเรื่องของสิทธิในการเบิกจ่ายของผู้ป่วย การควบคุมคุณภาพและความปลอดภัยในการรักษา และความร่วมมือข้ามพรมแดน

**คำสำคัญ :** ระบบสุขภาพระหว่างประเทศ, สิทธิผู้ป่วย, สิทธิในการเบิกจ่ายของผู้ป่วย

## 1. The healthcare systems around the world

In general, the healthcare systems can be divided into three main systems, which are Bismarck system, Beveridge system, and private insurance model.<sup>1</sup> The Bismarck system or sickness fund is the

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<sup>1</sup>Robert Kulesher, Elizabeth Forrestal. "International models of health systems financing." *Journal of Hospital Administration*, 2014, Vol. 3, No. 4. <http://www.ecu.edu/ah/upload/Kulesher-Forrestal-2014-International-Models-of-Health-Systems-Financing.pdf>, Accessed on November 1, 2015.

system which employers and employees fund national health social insurance through compulsory contribution. The providers are public and private providers. The countries that apply the Bismarck scheme are Germany, France, Belgium, etc.<sup>2</sup> The second system is private insurance model which can only be found in the United States.<sup>3</sup> Its funding is based on premiums paid to private insurance companies, and predominantly, the providers are private sectors. The last model is the Beveridge system: the system which is funded from general government revenues.<sup>4</sup> The services are provided mainly by public health providers. It is a universal healthcare which covers all people.<sup>5</sup> The Beveridge system offers healthcare service as benefits in kind, which patients can receive healthcare services for free.<sup>6</sup>

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<sup>2</sup>Penguin Press. *"The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care"*  
<http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/models.html>, Accessed on November 1, 2015.

<sup>3</sup>N. Lameire, P. Joffe1 and M. Wiedemann. *"Healthcare systems — an international review: an overview."*  
[http://ndt.oxfordjournals.org/content/14/suppl\\_6/3.full.pdf](http://ndt.oxfordjournals.org/content/14/suppl_6/3.full.pdf), Accessed on November 1, 2015.

<sup>4</sup>Physicians for a National Health Program. *"Health Care Systems - Four Basic Models."*  
[http://www.pnhp.org/single\\_payer\\_resources/health\\_care\\_systems\\_four\\_basic\\_models.php](http://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php), Accessed on November 19, 2015.

<sup>5</sup>Joseph Kutzin. *"Bismarck vs. Beveridge: is there increasing convergence between health financing systems?"*,  
<http://www.oecd.org/gov/budgeting/49095378.pdf>, Accessed on November 1, 2015.

<sup>6</sup>Laura Nistor. *"Public Services and the European Union."*  
[https://books.google.co.th/books?id=V\\_NYaVhgNzUC&pg=PA20&lpg=PA20&dq=reimbursement+system+benefit+in+kind+system&source=bl&ots=Zi3PxZqTtxt&sig=vW\\_TSYw3sX-qRuses0dkgLev6l8&hl=th&sa=X&ved=0ahUKEwixv8SbKpLKAhWFBY4KHZIVD2IQ6AEILjAD#v=onepage&q=reimbursement%20system%20benefit%20in%20kind%20system&f=false](https://books.google.co.th/books?id=V_NYaVhgNzUC&pg=PA20&lpg=PA20&dq=reimbursement+system+benefit+in+kind+system&source=bl&ots=Zi3PxZqTtxt&sig=vW_TSYw3sX-qRuses0dkgLev6l8&hl=th&sa=X&ved=0ahUKEwixv8SbKpLKAhWFBY4KHZIVD2IQ6AEILjAD#v=onepage&q=reimbursement%20system%20benefit%20in%20kind%20system&f=false), Accessed on November 1, 2015.

## **2. The healthcare systems in the United Kingdom and European Union**

### **2.1 Concept of the healthcare systems in the United Kingdom**

In the United Kingdom, the concept of the rights to healthcare has been changed from labor right to one of the human rights after World War 2. This right is embedded in the constitution.<sup>7</sup> Consequently, the National Health Service or NHS was set up in 1946 in order to respond to the ideal that good healthcare should be provided for all persons free of charge, except for some types of healthcare treatment that would require some charges such as prescriptions and optical and dental services. The National Health Service has a responsibility to manage the public healthcare sector in the United Kingdom with no discrimination according to the NHS Constitution.<sup>8</sup>

### **2.2 United Kingdom as the Member State of European Union**

The United Kingdom is one of the twenty-eight Member States of the European Union. As a single market, people in the European Union can move around within its national territory and also outside their homeland or residence. Although, in theory, most people choose to receive healthcare in their homeland or the country of residence or the country in which they are covered or insured,<sup>9</sup>

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<sup>7</sup>*Ibid.*

<sup>8</sup>NHS. “*Guide to the Healthcare System in England Including the Statement of NHS Accountability.*”

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/194002/9421-2900878-TSO-NHS\\_Guide\\_to\\_Healthcare\\_WEB.PDF](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194002/9421-2900878-TSO-NHS_Guide_to_Healthcare_WEB.PDF), Accessed on November 19, 2015.

<sup>9</sup>Department of Health of England. “*Cross-Border Healthcare and Patient Mobility in Europe.*”

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/252940/Cross\\_Border\\_Healthcare\\_Information.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252940/Cross_Border_Healthcare_Information.pdf), Accessed on November 1, 2015.

some of them choose to receive healthcare in other countries within the European Union.

Some people travelled within the European Union and found a necessity to get a treatment in such country within the European Union. For example, Mr. A who resides in France travelled to Germany (on vacation or business visit), and got into a car accident; he then needed to receive a healthcare treatment in Germany. Some people plan to receive a healthcare treatment in a country within the European Union due to cheaper cost, availability of expertise, or avoidance of long waiting-list in their countries. Another example, Ms. B who resides in Belgium wanted to have a hip replacement, but she had to wait for one year. She suffered from the pain and decided to have an operation in the Netherlands, due to the shorter waiting-list there. Some people require specific medical needs or highly specialized treatments which may not be provided in their country or may be available but they have uncertainty to get those treatments in their land. These situations are examples of the various factors that patients determine to travel for care.<sup>10</sup>

The world is more integrated. In recent years there is an increasing mobility of patients across international borders.<sup>11</sup> When this phenomenon occurs, there are many legal issues arising. Variations in education and professional standard between countries may impact the quality of care. Moreover, healthcare services are not like other services because patients who receive healthcare services need continuity of care. It means patients need a follow-up in their home countries. Thus, it becomes the reason why cross-border healthcare needs collaboration and communication between countries.

Cross-border healthcare services have both positive and negative effects. In the European Union, the recent Member States

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<sup>10</sup>Willy Palm and Irene A. Glinos. *“Enabling patient mobility in the EU: between free movement and coordination.”*

[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/138181/E94886\\_ch12.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/138181/E94886_ch12.pdf), Accessed on November 1, 2015.

such as Czech Republic, Slovakia, Slovenia, and Croatia have less potential at providing healthcare services than other Member States. And they also have problems accessing to healthcare services domestically. Thus, people from these countries choose to use healthcare services elsewhere within the European Union<sup>12</sup> because countries in the European Union share similarities in language and culture.<sup>13</sup> They can also cross the boundaries with convenience as there is no need for visa and there are many modes of transportation. Due to the wide extension of cross-border healthcare services within the European Union, the European Union has researched problems especially reimbursement on cross-border healthcare services and launched their legislations and policies in order to achieve the goal of efficient cross-border healthcare by determining administrative procedures and establishing the reimbursement system.<sup>14</sup> Besides, they attempt to increase the potential of providing healthcare services with the same healthcare standard throughout the European Union, focusing on safety and quality standard.<sup>15</sup>

The problem is that the Member States want to control their budget on healthcare. If they allow patients to receive healthcare abroad while having to pay for higher price, it will cause the imbalance of their controlling budget. On the other hand, patients have the rights to healthcare. If the Member State cannot provide healthcare within a reasonable time, patients have the rights to seek healthcare anywhere within the European Union. In the past, the European Court of Justice established that health care is a national

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<sup>11</sup>Matthias Helbe. "*The movement of patient across border.*" <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3040015/#>, Accessed on November 1, 2015.

<sup>12</sup>Österle A. Health care across borders: Austria and its new EU neighbours. *Journal of European Social Policy*2007;17(2):112–24.

<sup>13</sup>Legido-Quigley H, Glinos I, Baeten R, McKee M. Patient mobility in the European Union. *BMJ*2007 Jan 27;334(7586):188-90.

<sup>14</sup>Evers S, Paulus A, Boonen A. Integrated care across borders: possibilities and complexities. *Int J Integr Care*2001;1:e18.

<sup>15</sup>Cucic S. European Union health policy and its implications for national convergence. *Int J Qual Health Care*2000Jun;12(3):217-25

policy. If patients seek healthcare anywhere in the European Union, they need to be allowed by the Member State of affiliation through the pre-authorization process.

Later, pre-authorization policies were contested by citizens, who successfully challenged the refusal of national social insurance system to reimburse the costs of planned, unauthorized treatments undertaken in another Member State. ECJ decided that prior authorization acts as a barrier to the principle of free movement.<sup>16</sup> In the case of *Watts*,<sup>17</sup> ECJ established the principles of reimbursement for cross-border healthcare services: it should be done regardless of what system of individual country is, and a treatment can proceed in spite of no prior authorization on the ground that the refusal has no justified reason. If it is not possible for the State of residence to receive a healthcare service within a period compatible with the disease and the clinical situation of the patient, the national institution cannot refuse to allow cross-border healthcare.<sup>18</sup> The ECJ scrutinized the ultimate goal of the freedom to supply and receive services as a higher interest.<sup>19</sup>

As a result from this case, the EU legislations which concern the cross-border healthcare services, including the planned care, need to be crystal-clear, to scrutinize which situations require a prior authorization, and to assure that there should not be any barriers and should be no restrictions of patients' rights to obtain cross-border healthcare. Consequently, the Directive 2011/24/EU of the European

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<sup>16</sup>Katharine Footman. "*Cross-border health care in Europe.*" [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0009/263538/Cross-border-health-care-in-Europe-Eng.pdf](http://www.euro.who.int/__data/assets/pdf_file/0009/263538/Cross-border-health-care-in-Europe-Eng.pdf), Accessed on November 19, 2015.

<sup>17</sup>Case C-372/04 *Watts* [2006] ECR I-04325.

<sup>18</sup>Monica Cappelletti. *Healthcare Right and Principle of "Minimum Standards: The Interpretation of the Judiciary in A Comparative Perspective.* Switzerland: Springer International Publishing, 2015.

<sup>19</sup>Flaminia Tacconi. "*Freedom of Health and Medical Care Services within the European Union.*"

[http://www.zaoerv.de/68\\_2008/68\\_2008\\_1\\_b\\_195\\_208.pdf](http://www.zaoerv.de/68_2008/68_2008_1_b_195_208.pdf), Accessed on November 12, 2015.

Parliament on the application of patients' rights in cross-border healthcare was launched.

The Directive has been launched to clarify the legal certainty of reimbursement criteria and also confirm the entitlement of the patients' rights when they seek healthcare services abroad in order that they acknowledge the cost and level of the cost of their medical treatment that can be reimbursed. Many essential principles of cross-border healthcare have been formed in the Directive, for instances, the doctrine of undue delay. Its definition is that the treatment must be provided within a time limit which is medically justifiable by measuring the patient current state of health and probable course of illness. It is also based upon an objective clinical assessment of the patients and their individual circumstances.<sup>20</sup>

The reimbursement of cost is only one of the issues of cross-border healthcare services. Beyond that, there are provisions concerning the responsibilities of the Member States, and the cooperation in healthcare among the Member States are comprised in the Directive as well. The EU seems to have adopted the readiness of applying its economy to make the improvement of healthcare for all European patients.<sup>21</sup>

### **3. The healthcare systems in Thailand**

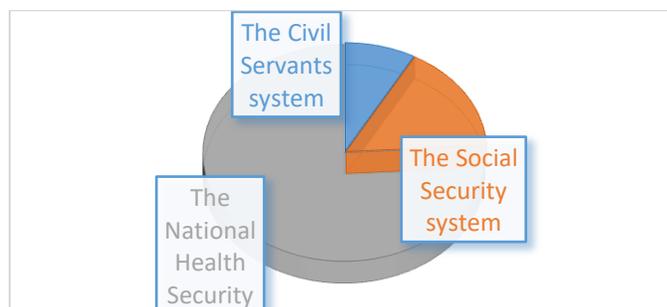
#### **3.1 Category of healthcare system in Thailand**

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<sup>20</sup>Claire Donovan and others. "*REQUESTS FOR TREATMENT IN COUNTRIES OF THE EUROPEAN ECONOMIC AREA WALES PROCEDURE.*", <http://www.wales.nhs.uk/sitesplus/862/opendoc/231756>, Accessed on November 1, 2015.

<sup>21</sup>Miek Peteers. "*Free Movement of Patients: Directive 2011/24 on the Application of Patients' Rights in Cross-Border Healthcare.*" <http://booksandjournals.brillonline.com/content/journals/10.1163/157180912x615158>, Accessed on November 1, 2015.

In Thailand, there are three health insurance systems,<sup>22</sup> which are the Social Security system (SSS), the Civil Servant system (CSS), and the National Health Security Program (NHSP).



*Figure 1 Healthcare System in Thailand*

The chart above illustrates population in Thailand who has the rights under each system: 5 million people (8%) benefit from the Civil Servants system; 9.84 million people (15.8%) benefit from the Social Security system; 47 million people (75%) benefit from the National Health Security system, which is the Beveridge system.

### **3.2 The current situation in Thailand**

The current situation in Thailand appears that the Thai government supports the country to be a medical hub of the Southeast Asian region. There is a medical tourism which is a sub-set of cross-border healthcare, and it generates much income to Thailand. However, there is no concrete legal instrument to facilitate cross-border healthcare services. Therefore, if we analyze the EU law, it will be useful for Thailand in creating a model law for guaranteeing the cross-border patients' rights and placing obligations on healthcare service providers.

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<sup>22</sup>Health Insurance System Research Office. *“Health Insurance system in Thailand.”* <http://www.hisro.or.th/main/?name=knowledge&file=readknowledge&id=14>, Accessed on November 19, 2015.

While the Thai government's policy supports healthcare business, it also helps foreign patients on the principle of humanity. In areas near the border of Thailand, Thai hospitals and facilities are confronting with the problems of inflowing Lao patients seeking healthcare in Thailand without ability to pay for the treatment fee, thus affecting the controlling budget in Thailand. Therefore, if we have a reimbursement system, it will help Thailand manage its resource and budget more effectively and increase the potential in providing healthcare service by finding a consensus between these two countries.<sup>23</sup> Cooperation between healthcare providers in border regions can avoid duplicate tasks and wasting resources.

The ASEAN has initiated coordination and harmonization of laws in many areas. There is a directive concerning medical device and a cosmetic directive, while healthcare services which are important for the ASEAN's economy still lack cooperation in this field to support cross-border healthcare services. The benefits will be for patients to exercise their rights within the ASEAN. Besides, it will be beneficial for managing and delivering healthcare services among the Member States in the ASEAN. Like the EU, the ASEAN also supports the free movement of services and, in the future, a plan to be a single market. The principles experienced in the EU might be useful for establishing ASEAN cross-border healthcare services structure, and it will be a guideline for Thailand and the ASEAN to implement a model law that is efficient and appropriate for Thailand and ASEAN's context.

As Thailand has the policy toward becoming a medical hub of the Asian region and participation in the ASEAN Economic Community (AEC), it is likely that legal problems regarding cross-border healthcare services might emerge in the future. These problems could be the results of patients from the neighboring countries entering Thailand to receive medical services as well as

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<sup>23</sup>Research Institute for Thai Healthcare Security. *"Effect of Laotian seek healthcare in Thailand."*  
<http://www.hisro.or.th/main/modules/research/attachservices/174/Full-text.pdf>,  
Accessed on November 24, 2015.

Thai residents moving or travelling to other countries in the ASEAN to seek medical treatment. Accordingly, the healthcare services in the United Kingdom under the EU laws and regulations are interesting for study and research – they will be lessons for future healthcare services in Thailand which is a part of the ASEAN Economic Community (AEC).

#### **4. The current problem of healthcare systems in Thailand**

Due to the fact that these three systems vary in many aspects, they cause some problem as will be described in the following details.

##### **4.1 Gaps in benefit package**

Due to the difference in benefit package, it creates inequality of patients' rights in Thai healthcare system. Despite some high-cost treatments, people who are insured under the Civil Servant and State Enterprise and Social Security System can receive such treatments, while people who are insured under the Universal Health Coverage cannot afford. For example, Renal Replacement Therapy (RRT) is excluded from the Universal Health Coverage because of its high cost, but it can prolong life and improve quality of life. This problem also leads to ethical concerns as well, since some healthcare treatments are excluded from the coverage, but they actually can save life of people.

##### **4.2 Difference in facilities of healthcare**

Payment method affects incentives of service providers to provide healthcare treatment. The Civil Servant Medical Benefit Scheme is on the basis of free service. Therefore, the budget is open and leads to an increase in healthcare spending from the healthcare service providers. Besides, service providers are likely to be prompted to provide high-technology treatment for patients, because they can get repayment from the government no matter how much they spend on providing the service. On the other hand, the Universal Health Coverage is a closed-end payment service. Some service providers may not be willing to offer high technology treatment in

order to reduce the cost and gain more profits. Therefore, determining a proper rate of payment needs a balance between restricted budget spending and consideration of appropriate access and quality of care of patients.

#### **4.3 Limited access to healthcare**

Under the Universal Healthcare Coverage and Social Security Scheme, patients must go to the registered hospital or healthcare facility that they chose. Some people who live in rural areas are not convenient to go to the registered hospital that is far away from their home. On the other hand, patients under the Civil Servant and State Enterprise scheme's benefits can go to any public hospital and get reimbursed. Further convenience is that, if they go to the registered public hospital, they do not have to pay upfront.

### **5. The current cooperation in healthcare in the ASEAN in the form of Directive**

There is not much cooperation in ASEAN's healthcare system. But there are some aspects that are now in preparation for the advent of the ASEAN Economic Community (AEC). So far, the ASEAN Medical Device Directive or AMDD has been launched in 2012. The unofficial time of its implementation was anticipated by 2015 with all of the ten Member States' compliance. But now there is only Singapore who is the first leading country to implement its national law in compliance with this AMDD, while the second country that has implemented the AMDD is Malaysia. At least it shows that the ASEAN is interested in the field of healthcare and tends to establish a harmonized legal framework. They see the importance of a unified system that could support cross-border healthcare, not only for financial benefit but also for improving ASEAN people's health quality.

The origin of this AMDD was adjusted from the European Medical Devices Directive (MDD 93/42/EEC) and other European guidelines. Therefore, researching on the European Union Directive would be helpful as an introduction for a directive of the ASEAN on

cross-border healthcare as well. In spite of the fact that in the near future the Directive may not be spontaneously appropriate for the ASEAN's context due to differences in cultural, economic, technological, and political situations, the approaches from European Union legislation study would be adaptable to Thai law pertaining to agreements such as in bilateral treaty or multilateral treaty with other countries that are ready for cross-border healthcare.

Although the government policy nowadays highlights medical tourism and tries to attract foreigners to receive healthcare in Thailand, the advent of the AEC and its free trade in services include the Thais mobility to other countries in the ASEAN as well. It means that when the Thais move to other countries, whether permanently or temporary, it cannot be considered as a free movement without adjustment of health policy.

## **6. Obstacles to cross-border healthcare in Thailand and ASEAN's context**

### **6.1 Absence of harmonized models of healthcare system in Thailand**

In Chapter 3, we can see that even in the domestic level of reimbursement of healthcare in Thailand, there are many problems of inequality. Before we promote cross-border healthcare, we have to make sure that it will not intensify the problem of inequality. In our healthcare, Thailand tries to promote healthcare as a universal right that can be enjoyed by all citizens regardless of their economic status. Therefore, the principle is how we can harmonize the models of healthcare system in Thailand under one supervising unit, and after that we can set up a cross-border healthcare arrangement through legal instruments.

### **6.2 Difference in economic status and cohesiveness in the ASEAN community**

The European Union can have cross-border healthcare because there is cohesiveness of the European Union, which supports mobility of persons across Members' territories. For

example, there is no visa requirement. Additionally, cross-border healthcare works well perhaps because there is not much difference in economic status. From the European Union's experience, although the European Union is harmonized in economic perspective, the small country still gets problems from the effects of cross-border healthcare. The principle is that although patients need to get treatment within appropriate time of access, which is about the life of people and human rights, resources allocation, government's administrative procedure, including finance management have to be considered. Healthcare spending has been high in recent years; therefore, cross-border healthcare certainly could save life in the view of a country that lacks medical treatment. On the other hand, how we balance public management and people's life is quite a difficult and complex issue which needs interdisciplinary consideration.

### **6.3 No central judicial organization to promote cross-border healthcare**

The first concrete cross-border healthcare rule came out in the form of European Union Regulation, which originally did not give much freedom in seeking cross-border healthcare; in other words, receiving healthcare abroad within the European Union countries needs permission from the state that one is insured – only in exceptional cases is there no need of such permission, for example on an emergency basis. Later, the European Court of Justice took another role, an active role, as a true promoter of cross-border healthcare by granting the right to receiving healthcare abroad – this time the scope was broader than it had been provided in the Regulation. Therefore, it came out later in the form of the Directive, whereby each Member State of the European Union has to implement in its own domestic legislation.

Comparing to Thailand and the ASEAN, we do not have the central court which will be the main actor in cross-border healthcare. According to the ASEAN Charter, the way we settle disputes is also reliant on arbitration. Moreover, if we try to promote cross-border healthcare in the ASEAN, it will need more progress in legal instruments, whereas in the ASEAN we normally use

negotiation which takes time to find consensus because of our diversity in healthcare system. However, bilateral arrangement of the countries that have similar contexts can occur such as the Singapore and Malaysia Arrangement.

## **7. The suggested provision in case of Establishing Cross-border Healthcare Services Legislation**

### **7.1 Provision of information**

The information must be accessible including in the formats for disabled persons such as braille, large print, and audio. Also, nowadays' technology has an important role in providing information; therefore, electronic format should be available. The information that should be arranged does the function of informed choice. Moreover, the information about quality and safety of providers, complaints and redress procedure, and price should be arranged for patients.

Suggested information of other countries that should be available for patients is as detailed below:

- Healthcare system in other Member States
- Professional standard and guideline
- Treatment price and choices
- Healthcare provider's registration status
- Assurance of professional indemnity
- Complaints and redress procedure
- How reimbursement will be performed (direct payment on government-and- government level, or the patient has to pay upfront)

### **7.2 Provision of direct payment from the government**

There is a drawback in claiming under the Directive that patients have to pay upfront. This will lead to an incapability of payment. There should be a provision that exceptional

cases, such as in emergency cases, can get direct payment from the government. Similarly, in the case of treatment with high cost, people should be able to request for direct payment, otherwise they will not have enough money for paying upfront. The vulnerable groups such as low-income people should be able to request for direct payment as well. This will decrease equity issues and eliminate fraudulent claims. It will be very useful for patients who seek treatment of addictive diseases so that they do not have to claim for the reimbursement many times.

### **7.3 Provision of clarity of patients' rights**

The United Kingdom's model shows us that there is the problem of uncertainty in recognizing what are the rights that patients have or not. Therefore, there must be crystal-clear information about what healthcare services they are entitled to seek abroad.

### **7.4 Provision of prior authorization**

Some may disagree with the prior authorization system which is considered as a barrier to obtain healthcare abroad. In the writer's opinion, it goes on the contrary that the prior authorization can diminish the risk of fraud. However, the discretion of authority has to be set by the regulatory, otherwise it may create bureaucracy. But certain healthcare of which cost is not high can leave the room for receiving healthcare without permission from the government.

### **7.5 Administrative procedure**

The lesson learned from the United Kingdom shows that the procedure needs to determine an appropriate limit of time for decision making from the government, otherwise it will be too slow for patients to receive healthcare abroad. However, some cases cannot adopt the normal timeframe due to the complexity in case-by-case basis of healthcare treatment.

### **7.6 Shared information by establishing network for medical professionals' qualification.**

-Registered status of medical professionals including notification of limitations of their practice or conditions of their licenses

-Medical professionals' history of education and practices

### **7.7 Reimbursement**

Cross-border healthcare needs the clarity of national tariff. In the United Kingdom, there is a good example for monitoring cost accountability and of setting up the national tariff every year, in which there normally are consultations among healthcare sectors. However, the national tariff can just be used as guidance but not a compulsory amount that patients will get reimbursed. The exact amount of payment is required to present to the government authority before going to get healthcare abroad.

### **7.8 Continuity of care**

There is a need of cooperation between the sending country and the receiving country, otherwise healthcare service will be short of continuity and diagnosis for side-effect. The National Contact Points will do the function of elaborating; however, the healthcare providers are also required to contact with one another with willingness for participation and regards for the interests of patients.

### **7.9 Translation of information**

In the United Kingdom, despite the National Contact Points having translated the information, the question still remains whether they have the duty of care for precision of that translation, or it is just to escort but not raising the duty of care.

### **7.10 Transfer of medical record information**

In the EU, there is the arrangement of transferring information including healthcare information through

another directive. And it makes sure that the medical record or e-prescription can be well-understood in another Member State by using encoding process. However, the code may not cover all cases; that's why we need a communication with good relationship on the international level.

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