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REPORT FROM THE COMMISSION TO THE COUNCIL AND THE EUROPEAN PARLIAMENT

compliant with the obligations foreseen under Article 20(3) of 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

(Text with EEA relevance)

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1. INTRODUCTION

This report considers the effects resulting from Directive 2011/24/EU[1] of the European Parliament and of `the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, for insured patients wishing to be reimbursed for healthcare received outside their country of residence and in another EU Member State. Specifically it considers the potential effects of prior authorisation systems introduced under Directive 2011/24 /EU and of the definition of the Member State responsible for reimbursing patients the costs of cross-border healthcare. The latter point particularly concerns the specific case of pensioners having transferred their residence and, for that reason, their access to healthcare to their new Member State of residence, which is different from the Member State that has recognised the pensioner's rights to social security benefits. This latter Member State remains responsible for the coverage of the costs of healthcare for these groups of pensioners. Through this report the Commission complies with the requirement in paragraph 3 of Article 20 of Directive 2011/24/EU.

As from 25 October 2013, two legal instruments apply to the situation of patients seeking healthcare outside their country of residence: Directive 2011/24/EU, hereinafter "the Directive", and Regulations (EC) No 883/2004 and (EC) No 987/2009 of the European Parliament and the Council on the coordination of social security systems, hereinafter "the Regulations". As the Directive was due to be transposed by Member States into national legislation by 25 October 2013, there is obviously no data available at this point in time on the impact of the Directive, either alone or in interaction with the Regulations. Consequently, this first report considers the possible effects resulting from the joint application of the two instruments to the situation of patients seeking healthcare in another Member State. It is intended to serve as a reference point for future reports produced according to Article 20(3) of the Directive.

This report outlines the two instruments and then goes on to assess possible impacts of their interaction in two areas: possible substitution effects between the prior authorisation systems used under the two instruments; and the adequacy of the financial compensation for costs of healthcare paid between Member States under the Regulations. On the latter part it will specifically consider those cases where Member States receive fixed amounts intended to cover the costs of healthcare benefits in kind for pensioners. It will then explain that, due to the lack of available information noted above, no clear conclusions can currently be drawn on either of these two issues but some important messages for the future administration of the two instruments can nevertheless already be discerned.

This report has been produced with the collaboration and assistance of the Member States as represented by their delegates in the Administrative Commission for the Coordination of

[1] See http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF

Social Security Systems (henceforth " Administrative Commission") and in the Implementing Committee of the Directive.

2. BACKGROUND

2.1. Directive 2011/24/EU of the European Parliament and the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare

The general objective of the Directive is to facilitate the access to safe and high-quality cross-border healthcare in another Member State and to be reimbursed for it in accordance with the principles established by the Court of Justice as well as to promote cooperation on healthcare between Member States.

The Directive requires the Member State of affiliation[2] to reimburse an insured person who receives cross-border healthcare if the healthcare in question is among the benefits to which the insured person is entitled in this Member State. The Member State of affiliation may provide for a system of prior authorisation for reimbursement of costs of cross-border healthcare limited to specific types of planned healthcare as defined in Article 8 (including care requiring an overnight stay in hospital or the use of highly specialised and cost-intensive medical infrastructure or medical equipment), if such system is justified and proportionate. This prior authorisation may not be refused when the patient is entitled to the healthcare in question and this healthcare cannot be provided on its territory within a time limit which is medically justifiable (also called " undue delay").

This decision on whether the waiting time for treatment is medically justifiable must be based on an objective medical assessment of the patient's medical condition, the history and probable course of the patient's illness, the degree of the patient's pain and/or the nature of the patient's disability at the time when the request for authorisation was made or renewed[3].

The overall use of prior authorisation is subject to the requirement that the system of prior authorisation shall be restricted to what is necessary and proportionate to the objective to be achieved.

The patient may be required to pay for care first and then claim reimbursement. Reimbursements for cross-border healthcare will be up to the level of costs that would have been assumed by the Member State of affiliation, had the healthcare been provided within its territory (without exceeding the actual costs of healthcare received).

The application of the Directive does not depend on whether the healthcare provider is affiliated to a public health system: it covers all providers.

2.2. Regulations (EC) No's 883/2004 and 987/2009 of the European Parliament and of the Council on the coordination of social security systems

As regards healthcare, the Regulations focus on publically insured persons and the members of their family living or staying in a Member State different from the competent Member

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2 Generally, the Member State that is competent to grant to the insured person a prior authorisation to receive appropriate treatment in another Member State according to Regulation (EC) 883/2004 and (EC) No 987/2009. For a third country national in a cross-border situation within the EU it is according to Regulation No 859/2003 or Regulation (EU) No 1231/2010. As regards the latter, in special cases, where no Member State is competent according to those Regulations, the Member State of affiliation shall be the Member State where the person is insured or has the rights to sickness benefits according to the legislation of that Member State. It is important to notice that the concept of Member State of affiliation in the Directive was based on the concept of competent Member State, which is a concept defined by the Regulations on social security coordination.

3 See Article 8(5) of Directive 2011/24/EU

State[4]. Healthcare which becomes necessary on medical grounds during a stay ("unplanned healthcare") will be provided without prior authorisation and the costs covered by the competent Member State (e.g. through use of the European Health Insurance Card).

The Regulations also allow an insured person to seek authorisation from the competent institution when travelling to another Member State with the purpose of receiving healthcare. This authorisation should be accorded "where the treatment in question is among the benefits provided for by the legislation in the Member State where the person concerned resides and where he/she cannot be given such treatment within a time limit which is medically justifiable"[5], thus in the same circumstances as under the Directive. Prior authorisation is granted to the patient through the issuance of a so-called S2 Form (formerly E112) by the competent institution.

For this "planned" healthcare, the competent Member State is responsible for the assumption of the cost of treatments that shall be provided on the basis of the rules of the Member State of treatment and cost compensation will be managed at the level of Social Security Administrations with no upfront payment from the patient other than co-payments established in the Member State of treatment.

The Regulations do not cover all providers: some providers not affiliated to a public health system are not encompassed within the scheme**.**

The Regulations also provide for situations in which certain insured persons move their residence to a Member State, but continue to be covered by the social security system of another Member State. In these cases, the person concerned is given an S1 form, with which he/she can register for healthcare coverage in their Member State of residence. The Member State of residence reclaims the cost of healthcare from the competent Member State. The Member State of residence may choose between two types of compensation arrangements:

- reimbursement on the basis of real costs, which requires production of proof of actual expenditure; or
- (for certain categories of persons) on the basis of fixed amounts (lump-sums) for Member States "where the use of reimbursement on the basis of actual expenditure is not appropriate"[6,7]

The latter compensation arrangements may only be applied to pensioners and their family members, or family members of an insured person who reside in a different Member State

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4 The Member State where the competent institution is situated. In turn, the competent institution means:
. "(i) the institution with which the person concerned is insured at the time of the application for benefit;
or
(ii) the institution from which the person concerned is or would be entitled to benefits if he/she or a member or members of his/her family resided in the Member State in which the institution is situated;
or
(iii) the institution designated by the competent authority of the Member State concerned;
or
(iv) in the case of a scheme relating to an employer's obligations in respect of the benefits set out in Article 3(1) of Regulation (EC) No 883/2004, either the employer or the insurer involved or, in default thereof, the body or authority designated by the competent authority of the Member State concerned".

5 Article 20(2) of Regulation (EC) No 883/2004.

6 This will be the case if the actual amount of the expenses for the benefits received is not shown in the accounts of the institution that provided them

7 See Article 63, paragraph 1 of 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

from the insured person where this Member State has opted for the system of reimbursement based on fixed amounts.

The Audit Board, which is the body created under Article 74 of Regulation (EC) No 883/2004, is responsible for establishing the methods for determining the elements in order to calculate the fixed amounts. These elements are listed in Regulation (EC) No 987/2009 and the Administrative Commission, which is a body under Regulation (EC) No 883/2004, "consisting of a government representative from each Member State, charged in particular with dealing with all administrative questions or questions of interpretation arising from the provisions of this Regulation, and with promoting further cooperation between the Member States", shall present in 2015 a specific report on its application and in particular on the reductions applicable to ensure that the calculation of fixed amounts comes as close as possible to the actual expenditure incurred and the reductions do not result in unbalanced payments or double payments for the Member States.

Member States claiming the reimbursement on the basis of fixed amounts are Norway, Ireland, Spain, Cyprus, The Netherlands, Portugal, Finland, Sweden and United Kingdom[8].

2.3. On the relationship between Directive and Regulations

The following points highlight the main similarities and differences between the instruments:

Regarding the **personal scope**, the Directive applies to persons covered by Regulation (EC) No 883/2004 as well as to the third country nationals and their family members who are legally resident in the territory of a Member State[9].

As a general principle, when the terms of the Regulations are met, treatment should be delivered under the Regulations, unless a patient, fully informed about his/her rights, requests otherwise. Where the patient requests a prior authorisation for cross-border healthcare and the application of the Regulations is more advantageous to the patient, the prior authorisation should be granted under the conditions of the Regulations, unless the patient, fully informed about his/her rights, requests otherwise.

The **procedures and level of reimbursement** under the Regulations and the Directive are different, as noted above. Regarding procedural guarantees, the requirements on provision of information are broadly similar and Member States are advised to apply under the Regulations the general procedure and administrative guarantees made explicit in Article 9 of the Directive to the benefit of the patient.

In the case of insured persons residing outside the competent Member State: the Directive does not apply with regards to access to healthcare benefits in the Member State of residence.

3. MAIN FINDINGS

This report considers the two specific points as requested by the legislators. It looks at:

- The use of prior authorisation by Member States under the Directive, in particular the implications of the requirement to justify any authorisation system as proportionate, along with any substitution effects between the two legal instruments caused by the existence of two systems of prior authorisation

[8] Article 63(1) of the 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, and listed in its Annex 3.

[9] Or, in the case of Denmark, who satisfy the conditions of the legislation of the Member State of affiliation for entitlement to benefits and are in a situation which is not confined in all respects within a single Member State.

- Financial consequences, in Member States which have opted for reimbursement on the basis of fixed amounts under the Regulations, of the definition used in the Directive of the term "Member State of affiliation" (the Member State responsible for reimbursing the cost of cross-border healthcare)[10].

3.1. The use of prior authorisation systems

As set out above there are two legal instruments which deal with cross-border healthcare which both feature systems of prior authorisation. Depending on the choices made by Member States, this may result in two systems of prior authorisation co-existing side by side.

There are similarities between the two systems (for example in both cases a request for authorisation may be turned down where treatment may be provided without "undue delay"). However, there are also significant differences between them which should be noted.

The use of prior authorisation is the rule under the Regulations, whereas it is an option that Member States may – but are not obliged to – use under the Directive. There will therefore be a large number of treatments subject to authorisation under the Regulations but not under the Directive. As set out in section 2 above, prior authorisation may be required for all treatments under the Regulations, whereas it may only be used for some treatments under the Directive. The authorisation scheme under the Directive covers all providers, whereas the Regulations scheme does not cover some providers which are not affiliated to a public health system. And, as noted above, it is important to remember that the level of coverage of costs may vary considerably between the two instruments.

It is important to note that this will mean that the scope of the prior authorisation system under the Directive will vary from Member State to Member State (indeed, it may not be an option that every Member State uses).

The Directive also sets out certain procedural guarantees that should apply to authorisation schemes: for example the right to appeal and the requirement for Member States to set time limits for dealing with requests for authorisation. The Directive also requires that decisions on authorisation be "properly reasoned" – which means that, where authorisation is refused on grounds of no "undue delay", the patient is informed what would have constituted "undue delay" in their particular case. These differences, in reality, make explicit principles of good governance that should be applied equally to authorisations under the Regulations – and therefore these differences in the texts should not be apparent in practice.

Given the overlap between the two systems there is the clear potential for substitution effects to occur. By way of examples to illustrate this:

- there could be a reduction in the use of the Regulations for healthcare not subject to prior authorisation under the Directive by patients who do not wish to go through the authorisation procedure and who therefore choose to use the Directive;
- there could be a reduction in the use of the Regulations by patients who wish to be treated by a private provider which is not covered by the Regulations scheme;
- conversely there could be an increase in the use of the Regulations by patients who apply for authorisation under the Directive and who are judged to face "undue delay" – and who then request an authorisation under the Regulations (which must be

[10] According to Article 20(3) of the Directive, these financial consequences should be addressed in cases covered by Articles 20(4) and 27(5) of the Regulation. For the sake of clarity, and considering the methodological nature of the report, the report will be focused on pensioners as presented to Member States in the Administrative Commission on 17 April 2013 and in the Cross-border Healthcare Committee on 3 June 2013.

granted according to the "undue delay criterion") since the coverage under the Regulations can be financially more beneficial.

Monitoring and assessing these effects would require a level of detail that does not currently exist. The only available data at present is that used under the Regulations (see Annex 1). This suggests (with some exceptions) relatively low numbers of prior authorisation requests and high rates of granting of requests. It also suggests that Member States, in general, do not currently track the type of treatments for which authorisation is sought.

It is also important to note that any authorisation scheme under the Directive is subject to the requirement that it is necessary and proportionate to the objective to be achieved, and may not constitute an unjustified obstacle to the free movement of patients. This implies that Member States will need to provide data to justify their use of prior authorisation. The current data suggests that extensive systems of prior authorisation under the Directive will be difficult to justify in the absence of robust evidence demonstrating why the situation under the Directive is so different from that under the Regulations.

3.2. Financial consequences for "lump sum" payment arrangements under the Regulations

Section 2 above has described the situation where some groups of people reside in a Member State different from the one which has recognised their rights to social security benefits (the 'competent Member State') and the Member State of residence opts for reimbursement on the basis of fixed amounts, or "lump sums". The calculation method used for these lump sums is defined in Article 64 of Regulation (EC) No 987/2009 and shall be as close as possible to actual expenditure. The amounts involved are therefore adjusted regularly to take into account possible disproportionalities or cases of double payment.

Of these groups of people this report considers lump sum payments for pensioners and does not consider lump sum payments for other groups (such as Erasmus bursary students). This is for reasons of scale: both in terms of the numbers involved and the amount of healthcare used, pensioners will be by some way the most significant group.

The Directive may have an impact on the calculations used to set these amounts, for two reasons.

Firstly, due to different rules on the treatment of pensioners and their family members in their competent Member State, under the Regulations, all Member States paying lump sums receive a 15 per cent reduction on the amount to compensate for the cost of unplanned healthcare received by pensioners and their family members in a Member State other than the Member State of residence. This is because, under the Regulations, it is the competent Member State who will eventually bear this cost (for example via the European Health Insurance Card system). With regard to healthcare in the competent Member State, pensioners and their families usually have only limited rights of access – essentially to care which becomes medically necessary during their stay in that Member State.

Certain Member States choose to give pensioners and their families additional rights of access to healthcare. These Member States are entitled to a 20 per cent reduction in the lump sums by way of compensation for this, and are listed in Annex IV to Regulation 883/2004.

The rules under the Directive are different. Pensioners and their families resident in a lump-sum Member State which is not their competent Member State may seek healthcare in their competent Member State under the terms of the Directive. If the competent Member State is listed in Annex IV then the same terms and conditions apply as for the Regulations. If the competent Member State is not listed in Annex IV then the rules vary depending on whether the treatment in question is subject to prior authorisation in the Member State of residence. If

so, then the usual reimbursement rule in the Directive applies: it is the Member State of residence which, as the Member State of affiliation, is responsible for reimbursement. If the treatment is not subject to prior authorisation in the Member State of residence then it is the competent Member State which is responsible for bearing the costs.

This can be summarised thus: under the Directive Member States not listed in Annex IV are nevertheless required to provide healthcare which they are not required to provide under the Regulations. They may therefore consider that they are responsible for a greater proportion of total healthcare costs for the insured persons concerned than they previously were, and that this should be taken into account when adjusting the lump sum amounts.

The second way in which the Directive may have an impact on lump-sum amounts is with regard to unplanned healthcare in a third Member State received by pensioners and their family members resident in a lump-sum Member State which is not their competent Member State. Under the Regulations it is the competent Member State which is responsible for the costs of this healthcare, as noted above, and for which they receive a 15% reduction on the amount of the lump sum. Under the Directive the patient may choose to claim reimbursement directly from the Member State of residence, as this is his or her Member State of affiliation. Therefore the Member State of residence might consider that it is now bearing costs for which it is not being reimbursed via the lump sum, and that this should be taken into account when adjusting the lump sum amounts.

Whether or not these impacts come to pass depends on the decisions made by Member States and individual patients on the use of prior authorisation, the choice of country for planned healthcare, the preferred system of reimbursement and so on. Robust data will therefore be needed to monitor any effects and to assess what this might entail for the lump sum amounts.

Currently, there is no information available to assess the financial consequences of the application of this Directive on 'lump sum' Member States. According to a preliminary appraisal from Member States that answered a March 2013 survey on 'Reporting obligations under Article 20(3) of Directive 2011/24/EU' regarding the potential impact of the Directive on the adequacy of the lump sums, Member State expectations vary. Some thought that the lump sum amounts would increase; others thought that Annex IV would no longer be relevant; others thought that there would be no significant impact; others thought that there would be an impact only for care not subject to prior authorisation but that this was unquantifiable at present.

Given the lack of data, no assessment of disproportionalities is currently feasible. Any disagreement between Member States on disproportionalities in the payment and receipt of lump sums related to the actual cost of healthcare received will need to be addressed at a later date.

Article 64(5) of Regulation (EC) No 987/2009 requires the Administrative Commission to presents a report no later than 1 May 2015 on the application of Article 64 of Regulation (EC) No 987/2009, in particular on the reductions under Article 64(3). The aim of the analysis is to ensure that the calculation of fixed amounts comes as close as possible to the actual expenditure incurred and that the reductions referred to in Article 64(3) do not result in any disproportionality or double payments for Member States. The report may contain a proposal for any amendments which may prove necessary in the light of experience of the application of the above provision. In short, each Member State is asked to provide a note with an analysis of whether or not the basic reduction applied to average costs is realistic. To the extent possible, the analysis should be supported by quantitative evidence and data. Member States are to present the data and accompanying notes to the Audit Board no later than 30 June 2014.

4. DATA FOR FUTURE REPORTS

To be able to assess the impact of the Directive on the number of patients using the Regulations, a "baseline" zero-measurement needs to be established to capture patient mobility under the Regulations prior to the implementation of the Directive. Next, this zero-measurement needs to be compared with another measurement that will be made after transposition of Directive 2011/24/EU.

It will therefore be necessary to improve the current situation, where there is a dearth of statistical data on cross-border healthcare.

Considerably improved data will, in the majority of cases, also be needed in order for those Member States introducing a prior authorisation system under the Directive to demonstrate that such systems meet the overall requirements of proportionality.

4.1. Zero-measurement

For future analysis within the scope of this report, a zero-measurement baseline is needed against which future impacts could be measured. The Commission has seen that this cannot be established through means of historically collected data. In Annex 1 available statistical data on patient mobility under the Regulations for planned healthcare are presented and discussed. It is found that available data are incomplete across Member States and do not distinguish whether related healthcare is among the basket of publicly covered benefits in the competent Member State. Further, no data on the type of healthcare are available.

For future reports on patient mobility under the system of prior authorisation as required under the Directive, further data collection is needed, for 2012 and 2013, with a greater level of detail. For that purpose, a new round of data collection has been launched within the Administrative Commission. However, certain Member States have communicated that they will not provide data for 2012 or 2013. Moreover, for Member States willing to provide data for 2012 and or 2013, there is no guarantee that they will do so with the level of detail requested, such as the distinction of whether episodes of treatment fell inside or outside of the basket of benefits.

Consequently, to constitute the most likely zero-measurement baseline for all Member States the extrapolation and interpolation of the limited available data will probably be required.

4.2. Measurement after transposition of the Directive

Data for 2014 will be collected for the assessment of the general operation of this Directive within the Implementing Committee of the Directive.

For the purpose of the analyses, data on prior authorisation should:

- be collected by year of request,
- be collected by the Member State of affiliation to which the request was addressed,
- concern requests for healthcare that is covered by the basket of publicly covered goods/services of the Member State of affiliation,
- indicate the number or percentage of requests that have been granted,
- ideally, indicate the number or percentage of granted requests where undue delay was found to apply,
- indicate the percentage of refused requests and the main reasons for refusal,
- ideally, distinguish by type of patient indication (e.g. rare disease patients).

4.3. Impact Measurement

Only if and when the zero-measurement and post-transposition of the Directive measurement have been established, will it be possible for the Commission to analyse:

- Substitution effects (directly compared to zero-measurement): e.g. a drop in authorisations under the Regulations that can be explained by an increase in authorisation under the Directive: Is this a conscious choice of patients (e.g. use of the Directive for free choice of provider)?
- Dynamic impacts: e.g. analysing whether more patients will receive prior authorisation under the Regulations as a result of additional information on undue delay becoming available to patients under the Directive, or as a result of increased awareness about patients' rights.

5. CONCLUSIONS

At this point in time – close after the end of transposition deadline of the Directive - it is clearly not possible for the Commission to consider the use that Member States have made of the possibility to introduce prior authorisation systems under the Directive, and the possible substitution effects with the Regulations.

For similar reasons, it is not possible for the Commission to conclude that there are or are not any disproportionality resulting from the implementation of the Directive.

It is, however, possible at this point to draw some conclusions with a view to addressing both of these points fully in the report on the general operation of the Directive, which the Commission is required to present by 25 October 2015. This will be the first in a series of triennial reports.

With regard to prior authorisation systems the concept of a medically-justifiable time limit should be the same under both instruments. Similarly, the procedural guarantees established under the Directive should be applied to any authorisation system under the Regulations.

Member States wishing to introduce a prior authorisation system under the Directive would need to review their current systems of data collection as the current data would, in most cases, not seen sufficient to justify an extensive system of prior authorisation.

In order to be able to properly examine the effects of the Directive on the use of the Regulations and on the adequacy of the lump sums, it would be useful to develop the way in which data is collected as set out in 4.2, above.

The development by Member States of a monitoring system under the Directive will pose a challenge of coordination with that established under the Regulations. Methodological issues need to be discussed to adjust these systems to the statistical international standards. Member States should unify – as far as possible - the collection of information, for the sake of efficiency.

Annex 1: Historical data on patient flows

A 2008 note of Directorate General Employment, Social Affairs and Inclusion reporting on a questionnaire related to the E112 form sent to delegates in the Administrative Commission pointed to some interesting observations: Small numbers of prior authorisation requests and high rates of authorisations granted upon requests are reported for most Member States[11]. With some notable exceptions, according to the information provided by Member States, requests for prior authorisation were refused mainly for absence of undue delay, with a very low rate of contested refusals[12]; the mobility of patients mainly concerns neighbouring Member States or those using the same language; and the parallel existence of other procedures (such as specific bilateral agreements between Member States) covering cross-border healthcare was noted by six Member States (DK, EE, CY, LT, MT and NL).

Furthermore, the note raises two relevant data issues:

- Data on clinical indication (diagnosis and/or specific procedure) would not fall within the traditional competence of the Administrative Commission.
- Distinguishing the number of applications from the actual number of patients who have applied for authorisation is not straightforward, as often more than one authorisation refers to the same patient case.

An overview of available data of E112 forms requested by Member State for the year 2006, 2007 and 2008 is presented below. Data are only available for 24 Member States. There is a great variability between countries in the number and evolution of prior authorisations issued. The highest rates (per head of population) are observed in LU, AT, SI, CY (above average in 2008) as shown in Annex 1. The average rate without LU (that presents 36,046 issued authorisations per million inhabitants) is 55 authorisations per million inhabitants. Member States above this average are AT, SI, CY, SK, BE, IE, EL and LV.

It is important to underline, therefore, that historical data collection exercises within the Administrative Commission do not distinguish whether the healthcare for which prior authorisation was requested was within the basket of entitlements in the Member State of residence and offer no insight into the mix of clinical indications involved.

In addition, they do not provide a complete picture as these figures do not include mobility of patients under parallel schemes (e.g. bilateral agreement between Member States or regions planning and organising transfers of patients).

[11] Only one Member State (LU) reported over 17,000 and two Member States (BE and AT) over thousands; the majority of them reported few hundred (CZ, DK, IE, EL, CY, HU, PT, RO, SI, SK, SE, UK,); and the rest (BG, EE, LT and PL) reported fewer than 100.

[12] At less than 1% for most Member States.

Number of E112 requests forms by year of receipt of request

Member State	2006			2007			2008
	Requested	Issued	% Issued / Requested	Requested	Issued	% Issued / Requested	Issued
AT	3,643	3,566	98	2,946	2,835	96	2,935
BE	1,222	1,066	87	1,322	1,094	83	1,165
BG	NA	NA		81	4	5	10
CY	NA	NA		156	156	100	146
CZ	NA	NA		425	411	97	328
DK	396	65	16	733	64	9	84
EE	8	8	100	1	1	100	5
IE	656	630	96	690	648	94	372
EL	813	768	94	795	770	97	816
ES	NA	722		NA	722		800
FR	1,169	695	59	NA	NA	NA	NA
HU	209	193	92	185	215	116	232
LT	7	6	86	19	14	74	12
LU	17,825	17,290	97	17,280	16,800	97	17,439
LV	46	29	63	132	110	83	127
MT	NA	NA	NA	0	0		0
NL	3,482	2,912	84	NA	NA	NA	NA
PL	12	10	83	25	13	52	NA
PT	218	200	92	207	178	86	166
RO	NA	NA		213	124	58	562
SE	163	81	50	330	115	35	NA
SI	493	340	69	504	262	52	442
SK	679	640	94	792	743	94	685
UK	560	366	65	634	552	87	NA

Source: ADMINISTRATIVE COMMISSION FOR THE COORDINATION OF SOCIAL SECURITY SYSTEMS

Number of E112 issued forms per million inhabitants by year of receipt of request

Member State	2006	2007	2008
AVERAGE	**110**	**112**	**163**
AT	432	342	353
BE	101	103	109
BG		1	1
CY		200	185
CZ		40	32
DK	12	12	15
EE	6	1	4
IE	150	150	85
EL	69	69	73
ES	16	16	18
FR	11		
HU	19	21	23
LT	2	4	4
LU	36,859	35,280	36,046
LV	13	48	56
MT		0	0
NL	178		
PL	0	0	
PT	19	17	16
RO		6	26
SE	9	13	
SI	170	130	220
SK	119	138	127
UK	6	9	

Source: own calculations on the basis of ADMINISTRATIVE COMMISSION FOR THE COORDINATION OF SOCIAL SECURITY SYSTEMS