European Integration and Health Care Systems: a Challenge for Social Policy EC Regulations 1408/71 between Status Quo and Upgrading

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I. Health Care Systems in Europe

The risk of becoming incapable of work due to ill health or an accident at work is never far away. It would appear that in many countries, illness or accidents pose a far greater threat to our daily security than old-age or unemployment.
Through the rising costs of medical services and a larger use of them, health costs have increased considerably over the last few years. This increase is reflected in the rising percentage of GDP spent on health services. In the Member States between 6.3% (Ireland) up to 10.7 % (Germany) of GDP is spent on health services.

There are, however, enormous discrepancies within the European Community between the various schemes of sickness and accident insurance[1].
Differences can be found concerning the following points:

a. the basis for the right to benefits: insurance as an employed or self-employed person or as a former employed or self-employed person on the one hand, and as a resident on the other hand and, in connection herewith, derived or individual rights of members of the family;
b. the financing of care: financing from contributions or taxes and various combinations;
c. the institution providing the care: the provision of benefits by insurance institutions, but also authorities such as municipalities, counties and the government;
d. the benefits involved: both the forms of medical care that make up the benefits and the degree to which persons entitled to benefits have to contribute to the costs themselves;
e. the way in which the benefits are provided: in kind and restitution systems.

On the basis of these criteria, the health care systems in the Member States are generally divided into two categories: social insurance systems and national health systems.

The social insurance systems -typically to be found in the 6 old founding Member States- are based on an insurance model – the Bismarckian model- where the law determines who is compulsory insured. In recent years in many of these countries the categories of people who are insured have been extended so that the whole population or large parts of the population are now covered. The system is financed through the payment of premiums- mostly income-related and calculated on the basis of total yearly expenditure. The administration is entrusted to local (semi-) public bodies such as sickness funds.
In turn, social insurance systems can be divided into two groups of systems. In the first group, the systems are based on the principle of reimbursement whereas the second group is based on the benefits-in-kind principle. The principle of reimbursement implies that patients are entitled to the payment of the cost of medical care where patients pay the medical provider and are, on the basis of a receipt, afterwards reimbursed by their sickness fund. Patients are entitled to choose their health care provider. This system can be found in Belgium, France and Luxembourg. In systems with a benefits-in-kind principle, patients are entitled to obtain medical care from health practitioners who are directly paid by the competent health insurance institutions. In these cases an agreement is concluded between the sickness insurance fund and a health care provider. As a general rule, patients do not have to pay a medical bill. This is the case if they use a care provider with whom the sickness fund has concluded a contract. This system can be found in Austria, Germany and the Netherlands.

[1] See Stiemer , N., "Sickness Insurance viewpoint of the EU-Member States", in Jorens, Y. and Schulte, B. (ed.), *Coordination of social security schemes in connection with the Accession of Central and Eastern European States*, *"The Riga Conference",* Brugge, die Keure, 1999, pp.227 -253; van der Mei, A.P., *Free Movement of Persons within the European Community, Cross-border Access to Public Benefits*, Maastricht, Doctoral Thesis, 2001, pp.259-263; AIM (Association Internationale de la Mutualité), *Implications of recent jurisprudence on the co-ordination of health care protection systems,* General report produced for the Directorate General for Employment and Social Affairs of the European Commission, May 2000, pp.16-18.

Contrary to the social insurance systems, national health services are not based on an insurance model but on a national health service model –the Beveridge model- which provides a universal right to medical care. Health is funded from tax revenues and medical care is provided to the whole population according to the benefits-in-kind principle with a uniformity of benefits, matching response to need. These systems were in the beginning mostly administered on a centralised basis although in some countries it is decentralised. Most of the time patients do not need to pay any money, apart from a few flat-rate charges.
This system can be found in the United Kingdom, Ireland, Spain, Italy, Portugal, Greece, Denmark, Finland and Sweden.

However, as is always the case, it is extremely difficult to distinguish between these three categories. As borderlines are not always clear cut, systems sometimes overlap, not least because all health care systems are confronted with the same challenges: rising costs because medical services are more widely used, new and expensive treatment and increasing pressure on the care system through the ageing of the population. Techniques from one system are used by the other thus leading to a certain amount of convergence.

II. The European Union and Health Care Policy

Health care policy is a national matter in all the Member States. Community law does not detract from the powers of the Member States to organise their own social security systems[2]. Consequently, it is therefore for the legislation of each Member State to determine, first, the conditions concerning the right or duty to be insured with a social security scheme and, second, the conditions for entitlement to benefits[3]. It is up to the Member States themselves to determine how their health care system should be organised, financed and regulated. Not a single Member State of the European Union has a health care system which is governed exclusively by market forces and each health care system operates more or less within a state health care system.
Although the Treaty of Amsterdam[4] has increased somewhat the competence of the Community in this area; it remains limited, however.
During the BSE crisis there were greater calls to increase Community action in the field of public health and a separate title was incorporated into the Treaty of Amsterdam giving the Community the power to undertake measures to improve national public health, in accordance with the principle of subsidiarity.
Title XIII, Article 152 of the Treaty provides "[…] a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention".
Although the Treaty clearly shows that the European Community will ensure a high level of human health protection, it leaves the organisation of the system to the national legislature. This is clearly set out in Article 152 (5) of the Treaty. "Community Action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and

[2] ECJ, case C-158/96, *Kohll* , *ECR,* 1998, I-1931, paragraph 17
[3] ECJ, case C-158/96, *Kohll* , *ECR*, 1998, I-1931, paragraph 18
[4] Article 129 of the Treaty of Maastricht introduced for the first time health protection as a separate policy domain that previously did not fall under the scope of the Community. The Community has to contribute towards ensuring a high level of human health protection. The adoption of this article demonstrated that the Community is moving more closely from an economic to a social Community. Although the Treaty did not set out any provisions, the European Community had already been active in the field of health care through general programmes such as the Europe against Cancer Programme or the Europe against Aids Programme. The Treaty of Amsterdam replaced this Article 129 by Article 152 with specific provisions.

delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood."
Although the direct influence of European Community law on national health policy may be limited, it by no means implies that the social security sector constitutes an island beyond the reach of Community law and that, as a consequence, all national rules relating to social security fall outside its scope[5].Whilst Community law may not affect the competence of the Member States to organise their own social security systems, it means only that Community law does not regulate this matter directly and does not even take action in this field when its application would compromise the very existence of the social security systems. Otherwise, however, Member States are bound to comply with Community law even when exercising the powers reserved to them in the field of social security[6].
This applies in particular to the rules governing free movement where fundamental freedoms have an effect on social security law unless there is a general interest justifying a limitation of such freedom, not least of course because the Court made it clear that medical products and medical treatment should be considered as goods and services within the meaning of European Community law. Moreover, not only medical providers can invoke the principles of the free movement of services and freedom of establishment to set up business in another Member State or provide services there. The freedom to provide services includes the freedom, for the recipients of services, to go to another Member State in order to receive a service there, without being obstructed by restrictions, even in relation to payments and that tourists, persons receiving medical treatment and persons travelling for the purpose of education or business are to be regarded as recipients of services[7].
Although it is true that through its objective and solidarity-based structure social security as such cannot be regarded as an enterprise within the meaning of European Community law and the provisions of competition law (Articles 81 *et seq*) do not always apply; this does not apply to the domain of fundamental freedoms, in particular the framework in which social security services are provided. The provision of benefits in health care should therefore be regarded as an economic activity, which as such is subject to fundamental freedom. In that sense social security institutions can be said to participate in the general economy[8].

III. Territoriality Principle in National Health Care Systems

A common characteristic of all the social security schemes in the Member States of the European Union, is that the right to medical care is a territorial right. This means that people are only entitled to have the cost of medical care reimbursed in national territory. The cost of medical treatment provided abroad is reimbursed only in a limited number of cases, such as urgent medical treatment during a temporary stay abroad, or after receiving prior authorisation from the sickness fund. However, as the latter is at the discretion of the sickness fund, there is no genuine right to medical care abroad. In most cases such permission is interpreted in a very narrow manner.
It is not surprising, therefore, that the ruling of the Court of Justice on such cross-border health care was eagerly anticipated. If the Court of Justice were to hold that national provisions forbidding the right to health care abroad or allowing it only under certain conditions countered the free movement of goods and services, then the Member States would no longer be able to lay down such provisions. Needless to say, this would have

[5] Conclusions Advocate General Tesauro under cases C-120/95 and C-158/96, *Decker,,ECR*, 1998, I-1831, paragraph 17.
[6] Conclusions Advocate General Tesauro under cases C-120/95 and C-158/96, *Decker, ECR*, 1998, I-1831, paragraph 22.
[7] ECJ, cases C-286/82 and 26/83 *Luisi* and *Carbone* , *ECR*, 1984, 377, paragraph 16.
[8] Application of the principle of free movement provides considerable material for discussion but it is not related to the issue at hand so it will not be discussed here (application of European competition rules on medical providers and medical insurers; are medical care providers or care institutions companies within the meaning of Community law; to what extent do requirements in terms of diploma or occupation constitute an impediment to freedom of establishment and /or the provision of services for medical care providers? Price-fixing and parallel import of medicines? Pharmacy across the Internet, etc.

enormous implications on current cross-border health care regulations. For the Member States it would constitute a doomsday scenario of medical tourism enabling patients to seek treatment anywhere in the European Union at the cost of the competent sickness fund. Patients would be allowed to consult doctors abroad or purchase medicine abroad and present the bill to their sickness fund. This might mean that a sickness fund would be obliged to repay the cost of medical treatment that does not figure on the list of officially recognised medical treatment under national legislation. It could also mean having to reimburse medical treatment that is much more expensive abroad than in one's own country and risk upsetting the financial balance of the social security systems of the Member States.[9]

There are also other arguments against cross-border health care. It has been pointed out that there would be a risk of losing control over the quality of the health care. All the Member States impose certain requirements in terms of diploma or occupational qualifications for medical practitioners or certain minimum standards for medical products. If patients were to seek treatment or products from medical care providers abroad which comply to other or less strict requirements, then there would no longer be any way of guaranteeing quality.

Furthermore, granting patients an unconditional right to seek care anywhere they choose would also pose a threat to public health planning. Member States calculate the number of facilities (hospitals, doctors, etc.) required to meet the needs of their population.. There is a genuine risk, particularly in border areas, that certain hospitals might become overburdened as a result of free movement[10]. If too many insured were go abroad, some units and hospitals might have to be closed down due to a lack of patients. It is important to remember that hospitals have high fixed-costs, regardless of the number of patients. Quantitative reductions in this regard could lead to reductions in terms of quality[11]. In turn it could very well jeopardise the principle of sound, decent care accessible to all.

On the other hand, the possibility of seeking treatment abroad also has positive consequences. Member States with waiting lists could see them reduced provided of course the problem is not transferred, i.e. the states' problems in terms of capacity and waiting lists for the recipient states. Some patients, particularly in border areas, would have easier access to health care. In border areas it happens for example that care is available within a stone's throw across the border and that a considerable distance has to be covered in one's own country.

IV. Cross-border Health Care in EC Coordination Law

A. Residing in another State than the Competent State

Not only national health care is territorially limited. The principles of other national legislation are contained in EC Regulations Nos 1408/71 and 574/72 on the social security of migrant workers.

[9] See for example Cornelissen, R., *25e anniversaire du Règlement (CEE) n° 1408/71, ses résultats et ses limites*, tekst op Europees Colloquium, *25 Années du Règlement (CEE) n° 1408/71*, Stockholm, Juni 1996, p.41; Jorens, Y., "Algemene situering en probleemstelling", in Jorens, Y. (ed.), *Grensarbeid*, Brugge, die Keure, 1997, p.14.

[10] See for example. Cornelissen, R., *25e anniversaire du Règlement (CEE) nE 1408/71, ses résultats et ses limites*, tekst op Europees Colloquium, *25 Années du Règlement (CEE) nE 1408/71*, Stockholm, Juni 1996, p.41; Mavridis, P., "Le citoyen européen peut-il se faire soigner dans l'Etat de son choix? ", *Dr.Soc.*, 1996, pp.1092-1093; Zechel, S., *Die territorial begrenzte Leistungserbringung der Krankenkassen im Lichte des EG-Vertrages*, Berlijn, Erich Schmidt Verlag, 1995, p.29 e.v.

[11] Overburdening in a certain Member State may lead some states to wonder whether they should actually keep medical infrastructure at such high levels if it attracts citizens from other Member States (see Novak, M.,*EG-Grundfreiheiten und Europäisches Sozialrecht*, EuZW, 1998, pp.367-368).

In principle, the coordination mechanism applied in the chapter on sickness and maternity is quite simple. An insured person - and the members of his family[12].- who lives or stays within the territory of a Member State other than the competent State has the right to medical care[13] that is equivalent to what is legally available there, with the stipulation that they comply with all the conditions for the right to benefits in accordance with the legislation of the competent Member State[14].This care is provided by the institution that is active in the insured person's place of residence or stay.

We have to refer to the legislation of the place of residence to ascertain whether care is a benefit in kind which can be classified under the provisions for sickness and maternity,[15] and it is irrelevant whether the legislation of the competent sate considers it a benefit in kind for sickness and maternity. This could have great consequences for the competent institution. However, it is in keeping with the system used by the Regulation according to which the person concerned will receive benefits in accordance with the State where the benefits are provided as if he was insured there.[16].

Expenses for medical care made by this institution will be invoiced with the competent institution.

Apart from the matter of benefits, coordination has also been reached on the matter of the payment of contributions. The general valid basis is that the insured person is liable to pay contributions in accordance with the legislation of the Member State in which the institution is situated that is accountable for the benefits according to the Regulation. In this case, no contribution can be imposed according to the legislation of, for example, the place of residence, even if the legislation of the Member State is applicable and the person concerned is insured and liable to pay contributions according to national legislation.[17]

[12] Members of family have this right insofar as they have no right to benefits based on the legislation of their country of residence. In cases of Member States where the right to benefits is based on residence, the cost of medical care of these members of the family is also at the charge of the institution which insures the employed or self-employed person, as long as the wife(husband) is not employed in the country of residence. This is a solution of equity: the state that obtains the contributions, has also to bear the costs of medical care. The definition of a member of the family can be found in Article 1(f) of the Regulation, although it makes for difficult reading. For the application of the definitions concerning sickness and maternity, it has always been assumed that the legislation in the country of residence determines who should be considered to be a member of the family. However, in ECJ, (case C-451/93, *Delavant, ECR*, 1995, 1545) the Court of Justice ruled that "member of the family" can also be determined by the legislation of the competent Member State, when a person cannot be considered to be a member of the family according to the legislation of the country of residence.

[13] Benefits refer to benefits in kind, even when they take the form of an allowance for the costs of medical care, as is the case with restitution systems (ECJ, case C-61/65 *Vaassen-Göbbel, ECR*, 1996, 257). Apparently, it has to involve the reimbursement of a well-defined treatment. In *Molenaar* (ECJ, case C-160/96 *ECR*, 1998, 843), the Court of Justice determined that German *Pflegegeld* was not a benefit in the sense of the Regulation, but an allowance. The argument for this stance was that *Pflegegeld* was not intended to reimburse the cost of a definite treatment. It involved a regular monthly payment for spending on the costs of nursing according to one's own discretion. Premium contributions for sickness insurance do not constitute benefits in kind within the meaning of the Regulation. Benefits in kind means benefits to be granted on the occurrence of an actual case of sickness or maternity. They do not include supplementary pension contributions which are intended as a contribution towards the financing of the beneficiary's sickness insurance (ECJ, case C-33/65 *Dekker*, *ECR*, 1965, 1135).

[14] Article 19 EC Regulation 1408/71.

[15] In point 1 of its Decision No 175, the Administrative Commission determined that, with a view to the mutual reimbursement between institutions, benefits can be considered to be benefits for sickness and maternity insurance purposes, if they can be considered to be such based on the legislative regulation used by the institution that is providing them, insofar as the benefits can be obtained based on the provisions of the chapter on sickness and maternity.

[16] Jorens, Y., *Wegwijs in het Europees socialezekerheidsrecht*, Brugge, die Keure, p.86.

[17] Stiemer, N., "Sickness Insurance viewpoint of the EU-Member States", in Jorens, Y. and Schulte, B. (ed.), *Coordination of social security schemes in connection with the Accession of Central and Eastern European States, "The Riga Conference"*, Brugge, die Keure, 1999, p.228.

B. Temporary Stay in another State or Permission to seek Treatment in another State

The principles contained in national law –on whether or not someone is entitled to go abroad to seek treatment there - are mirrored in EC Regulation No. 1408/71 on the social security of migrant workers. Article 22 of EC Regulation No. 1408/7 sets out two cases where persons who do not reside in another Member State are entitled to cross-border health care.
Contrary to the other articles of the Regulation that only apply to employed or self-employed people, these provisions also apply to persons who are nationals of a Member State and are insured under the legislation of a Member State and to the members of their families residing with them.
The relevant factor here is the place where the illness occurs, i.e. the Member State where a person resides temporarily or the Member State where s/he is insured. In the case of the former, i.e. during a temporary stay in another Member State, such as a holiday for example, a person is entitled to medical care if they become ill and their condition requires immediate treatment.[18] This right is conferred by means of form E 111 "provided the person's condition necessitates immediate benefits"[19]. This implies care that cannot be postponed until one has returned to the competent Member State, i.e. the place of residence without the insured person risking his life or health.[20] Although it is not really clear who should rule on the condition necessitating immediate benefits –the state of residence or the state of insurance – it seems reasonable to assume that the state providing the benefits –the state of residence – will also rule on their immediate necessity.[21] In practice it is noticed that many Member States find the concepts "necessitates immediate care" and "urgent care" unclear. Although these concepts should be interpreted under national law, there seems to be a need for a uniform interpretation. It is not always possible to find out how the borderline is drawn between necessary health care and other health care. [22]
However, if the illness occurs in the state of insurance, a person can receive treatment in another Member State after receiving prior authorisation from the sickness fund by means of a form E 112. According to Article 22(2), 2nd paragraph this authorisation may not be refused if the treatment in question is among the benefits provided for by the legislation of the Member State on whose territory the person concerned resides and where he cannot be given such treatment within the time normally necessary for obtaining the treatment in question in the Member State of residence taking account of his current state of health and the probable course of the disease.

[18] The question arises whether this provision only applies if the necessity of medical care could not be foreseen before the person's departure or does it also apply to existing disorders which require medical treatment even during a temporary stay abroad? In this respect the Administrative Commission in its Decision n° 163 pointed out that regard must be had to preventing the improper use of the provisions of Article 22 (1) (a) by persons who move temporarily to the territory of another Member State to obtain benefits in kind under this subparagraph without complying with the procedure laid down in subparagraph (c) of the same Article, which makes the granting of such benefits subject to prior authorisation by the competent institution. On the other hand, an over-restrictive interpretation of Article 22(1)(a) would cause a significant obstacle to freedom of movement for persons whose condition necessitates continuous and regular medical treatment such that they will be likely to require immediate benefits in the event of a stay in the territory of another Member State. For this reason kidney dialysis or oxygen therapy provided in a Member State other than the competent Member State for a person entitled to invoke the provisions of Article 22(1)(a) of Regulation (EEC) No. 1408/71 or for a member of his or her family shall be regarded as being an immediate benefit within the meaning of the aforementioned provision if it is part of existing and ongoing dialysis or oxygen therapy, and in as far as the stay is for reasons other than medical reasons. The provisions of the previous paragraph shall apply without prejudice to the practical obligation on the person concerned to make a prior arrangement with a view to ensuring the effective availability of the treatment in question during a temporary stay in the Member State.

[19] Except for some employed or self-employed persons, such as posted workers, who according to Article 22b, benefit from these provisions for any condition requiring benefits.

[20] Stiemer, , N., "Sickness Insurance viewpoint of the EU-Member States", in Jorens, Y. and Schulte, B. (ed.), *Coordination of social security schemes in connection with the Accession of Central and Eastern European States, "The Riga Conference"*, Brugge, die Keure, 1999, pp.231-232.

[21] Jorens, Y., *Wegwijs in het Europees sociale zekerheidsrecht*, Brugge, die Keure, 1992, pp.96-97.

[22] See also Jorens, Y. and Schulte, B, *European Report 2000*, European Observatory on Social Security for Migrant Workers, DG Employment and Social Affairs, European Commission, 2000, 44.

Permission therefore has to be provided when the treatment cannot be given within the usual time period, for example due to problems with capacity and long waiting lists. Barring such circumstances it is in principle up to the Member States to grant permission for cross-border health care. The Member States therefore have considerable discretionary powers in this regard.[23] It seems to be that this authorisation causes many problems due to the diversity in practice between Member States in given authorisations- some states are very restrictive while others are quite generous or that even medical practitioners and patients are not well informed.[24]

In this respect it is important to look at the history of Article 22. Initially, Article 22(2) §2 provided that the authorisation could not be refused where the treatment in question could not be provided for the person concerned in the territory of the Member State in which he resides. In the Pierik case , the Court pointed out, firstly that the words "who satisfies the conditions of the legislation of the competent state for entitlement to benefits" were exclusively intended to determine the persons, who, in principle, are eligible for benefits. It did not mean that a patient who stays in another Member State could be denied the opportunity of receiving benefits in kind provided by the legislation of that state to persons staying there if it was also granted in his state of residence.[25]

Thus a worker insured in a certain state was entitled to the full range of benefits in kind provided for by the law of the place of stay. His treatment was not limited to benefits in kind provided for within his competent Member State.[26]

The Court of Justice was also of the opinion that the benefits in kind for which the worker is authorised in accordance with this provision to go to another Member State, cover all treatment calculated to be effective for the sickness or disease from which the person concerned suffers. In those circumstances it is of little importance whether the benefit in kind which the worker requires can be provided on the territory of the Member State where he resides since the mere fact that that benefit corresponds to treatment more appropriate to the state of health of the person concerned is decisive for the purpose of issuing the authorisation. The words benefits in kind provided on behalf of the competent institution by the institution of the place of stay or residence do not refer solely to benefits in kind provided in the Member State of residence but also to benefits which the competent institution is empowered to provide.[27] Furthermore, the duty laid down in Article 22(2) to grant authorisation required under Article 22(1)c) covered both cases where the treatment provided in another Member State was more effective than that which the person concerned could receive in the Member State where he resides and those in which the treatment in question could not be provided on the territory of the latter State.[28]

This was also so the case in situations were the treatment in question is deliberately not included in the scheme of benefits in kind under the sickness and maternity legislation administered by the competent institution , for example on medical, medical-ethical or financial grounds or because the value of the treatment in question in the Member State in which the competent institution has its seat is in general not regarded as positive or because the treatment is not regarded as falling within the field of health treatment and furthermore is deliberately not provided by virtue of any other legislation of that Member State to which the regulation is applicable. When the competent institution acknowledges that the treatment in question constitutes a necessary and effective treatment of the sickness or disease from which the person concerned suffers, the conditions for the application of the second

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[23] Since the costs relating to the treatment in question are chargeable to the competent institution which granted the authorisation, the institution of the Member State to which the person goes to receive the treatment is obliged to provide it upon presentation of such an authorization even if, under the legislation which it administers, it does not have a duty but only a power to grant it (see Jorens, Y., *Wegwijs in het European sociale zekerheidsrecht*, Brugge, die Keure, 1992, p.100).

[24] See also Jorens, Y. and Schulte, B, *European Report 2000*, European Observatory on Social Security for Migrant Workers, DG Employment and Social Affairs, European Commission, 2000, 45.

[25] ECJ, case C-117/77 *Pierik, ECR, 197*8, 825, r.c. 13.

[26] Jorens, Y., *Wegwijs in het Europees socialezekerheidsrecht*, Brugge, die Keure, 1992, p.98.

[27] ECJ, case C-117/77 *Pierik*, *ECR* , 1978, 825, r.c. 15-16 and 21.

[28] ECJ, case C-117/77 *Pierik*, *ECR,* 1978*,* 825, r.c. 22.

subparagraph of Article 22(2) of Regulation No 1408/71 are fulfilled and the competent institution may not in that case refuse the authorisation referred to by that provision and required under Article 22(1)(c).[29]
The cost relating to benefits in kind provided on behalf of the competent institution by the institution of the place of stay or residence would be fully refunded. The decisive factor was that the worker in question received the treatment his condition required.
Thus persons covered by Regulation 1408/71 were entitled to the best medical treatment they could get within the European Community. When the treatment in question would be more effective than that available in the competent state the competent institution had to authorise the worker to seek treatment abroad.[30]
In order to block the consequences of the Judgment of the Court of Justice, the Council decided to change the wording of the Regulation and to grant greater power of discretion to the Member States.
In a certain way one could argue here that what could be considered as the first appearance of a free movement of patients was blocked by the Council. The Member States made it patently clear that the decision whether a patient can go abroad for medical care at the expense of the sickness fund, is made by them and not by the patients themselves.[31]
It is clear that under EC Regulation No. 1408/71 there is no real right to free movement of patients.

In this connection we could point out that Article 22 has not really been affected by the Commission's proposal to simply Regulation No. 1408/71.[32] The proposed new Article 16 (temporary stay in another state) and Article 18 (permission to seek treatment in a state other than the competent State) leave intact the basic principles of Article 22. The only change is an expansion of the personal scope of application further to the general proposal of the Commission to expand the Regulation's scope to everyone –not only EU nationals insured under the social security legislation of a Member State.

V. Cross Border Health Care under the Common Market Rules[33]

A. Health Care and the Common Market principles: the issue

The Kohll and Decker cases raise the fundamental issue of whether patients should have a say in deciding whether to seek cross-border health care. We are already well aware of the prejudicial questions brought before the European Court of Justice. Do the provisions of the free movement of goods and services as set out in the EC Treaty preclude national rules under which reimbursement, in accordance with the scale of the State of insurance, of the cost of dental treatment provided by an orthodontist established in another Member State is subject to authorisation by the insured person's social security institution?

[29] ECJ, case C-182/78 *Pierik* II ,*ECR* , 1979, 1977, r.c. 12-13.
[30] Jorens, Y., *Wegwijs in het Europees socialezekerheidsrecht*, Brugge, die Keure, 1992, p.99.
[31] van der Mei, A.P., *Free Movement of Persons within the European Community, Cross-border Access to Public Benefits*, Maastricht, Doctoral Thesis, 2001, p.300.
[32] COM (1998) 779 def. from 21.12.1998
[33] A lot has been written on the case law of the Court of Justice . In this respect we refer to the contributions/bibliography in the following seminars or books: *Grensoverschijdende gezondheidszorg in de Euregios: uidaging of bedreiging/ Soins de Santé transfrontaliers dans les Eurégios: un Défi ou une Menace,* Europees Seminarie/ Séminaire Européen, Verslagboek/ Procès-Verbal, Alden Biesen, 1999, 63 pages; *Health Care without Frontiers within the European Union*, Ministry of Social Security of the Grand Duchy of Luxembourg, Association Internationale de la Mutualité, European Institute of Social Security, International Symposium, Luxembourg, 1999, 76 pages; Jorens, Y. and Schulte, B. *Grensoverschrijdende gezondheidszorg in Europa/ Grenzüberschreitende Gesundheitsversorgung in Europa*, Belgian-German-Dutch Seminar November 1998, Antwerp, Die Keure, Nomos, 2001, fortcoming or the bibliography mentioned in AIM (Association Internationale de la Mutualité), *Implications of recent jurisprudence on the co-ordination of health care protection systems,* General report produced for the Directorate General for Employment and Social Affairs of the European Commission, May 2000, pp.163-168.

These cases became the focus of considerable attention. Some called it “the Bosman case of sickness insurance” whereas others depicted it as “the denture menace” or “dentures under palms trees”. Some welcomed the rulings because they introduced competition law to the health care sector and a subsequent reduction in costs; others believed they would inevitably lead to higher costs and some dreamed of reimbursed massages under palm trees.

One matter was striking: mainly practitioners of social law were examining these cases with Argus' eyes. Not surprisingly, perhaps, as the Court had been threatening to overturn a well known principle in national legislation for many years. Doomsday scenarios of medical tourism appeared threateningly on the horizon.

The Kohll, Decker and Bosman cases have the following in common: specialists in European law had been expecting these rulings for a long time because they were in line with earlier European Court of Justice case law. Not only were experts not unduly shocked by these rulings, they dismissed them quite quickly because they did not introduce anything fundamentally new. Indeed, we could even go so far as to ask why the rules of cross-border health care were kept from the Court of Justice. In this respect the cases are not revolutionary but a logical consequence of the dynamic development of European Community law and in particular fundamental freedoms whereby national law, aided not least by the Court of Justice – is interpreted in an increasingly narrow manner.

Although the facts of both cases are well known, I shall nevertheless recall them briefly. The Decker case concerns the purchase of spectacles prescribed in Luxembourg and purchased in Belgium. The Luxembourg sickness institution refused to reimburse the cost of the spectacles because they had been purchased abroad without prior authorisation from the sickness fund in accordance with Luxembourg legislation. The European Court of Juctice was asked whether this refusal was in breach of the free movement of goods, pursuant to Article 30 (now Article 28) of the EC Treaty. In the second case, Mr Kohl had requested the Luxembourg sickness fund to seek orthodontic treatment for his minor daughter in Germany. This permission – which is required for reimbursement – was refused, however, on the grounds that the proposed treatment was not urgent and that it could be given in Luxembourg. Did this refusal counter the free movement of services as provided for in Articles 59 and 60 (now Articles 49 and 50) of the EC Treaty?

B. Does prior authorisation rules hinder Free Movement?

In these cases the Court merely applied the well-known “Dassonville rule”[34]. Can national social security provisions actually be said to hinder, directly or indirectly, actually or potentially intra-community trade? This certainly appears to be the case. However, although it must be said that national provisions in principle do not deter patients from purchasing medical products abroad or seeking medical treatment, they will be less inclined to do so in the knowledge that their cost will not be reimbursed by the sickness funds[35].

Moreover, Advocate General Tesauro pointed out that this rule also has a negative effect on the service providers established in another Member State. With the exception of a small number of rare cases where authorisation is granted, they will only offer non-reimbursable services[36]. This can also be said to constitute an obstacle to free movement[37].

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[34] ECJ, case C-8/74 *Dassonville*, *ECR*, 1974, 837.

[35] In ECJ, case C-18/84, *Commission v. France* , *ECR,* 1985, 1339) the Court had already ruled that by depriving newspaper publishers of certain tax advantages in respect of publications which they print in other Member States, the French Republic failed to fulfil its obligations under Article 30 of the EEC Treaty; the tax provision at issue may be regarded as an obstacle to intra-community trade. See also ECJ, case C-204/90 *Bachmann, ECR* , 1992, 249.

[36] Conclusions Advocate General Tesauro under ECJ cases C-120/95 and C-158/96, *Decker*, *ECR*, 1998, 1831, paragraph 43

[37] See Montagnie, Y. “De arresten Decker en Kohll in het licht van de rechtspraak van het Hof van Justitie van de EG” in Jorens, Y. en Schulte, B., *Grensoverschrijdende gezondheidszorg in Europa/ Grenzüberschreitende Gesundheitsversorgung in Europa*, Die Keure, Nomos, 2001, forthcoming

C. *Justifications of limitations to Free Movement*

1. *Grounds of Justification*

Measures which limit free movement are not prohibited as such. The question at issue is whether they are justified. The grounds for justifying such a limit may be in the public interest as set out in Articles 30 and 46) of the EC Treaty (for example health protection) or on the grounds of the "rule of reason" of the European Court of Justice. According to the Court, a rule can only be justified where such requirement is in the public interest or objectively justified by the need to ensure observance of professional rules of conduct[38]. In addition, such rules may not be discriminatory[39].
Although the Court recognised in principle that the three objectives cited in these cases, i.e. guaranteeing the financial equilibrium of the social security system, ensuring a balanced medical service accessible to everyone and finally the protection of health may be used as grounds for justification, they were refuted in the actual cases.

a. PROTECTION OF HEALTH

The first ground of justification raised is the protection of health.
Can foreign doctors on the basis of prevailing national quality standards be barred from treating Belgian patients? The desire to protect public health as grounds for justification does not raise any problems. It is explicitly referred to in Articles 30 and 46 of the EC Treaty. Recourse to these articles or to the rule of reason ceases to be justified, however, if Community directives provide for the complete harmonisation of national law[40].
The Court pointed out that the pursuit of the medical professions is the subject of mutual recognition between the Member States. Mutual standards have been introduced and the conditions for taking up and pursuing the profession of doctor, ophthalmologist , and apothecary have been the subject of several coordinating and harmonising directives. As a result, the quality of health care afforded by such medical service providers is the same as that provided by doctors, ophthalmologists and apothecaries established on national territory. According to the Court "these rules such as those applicable in the main proceedings cannot be justified on grounds of public health in order to protect the quality of medical services provided in other Member States."
At first sight this consideration would appear to be correct. If freedom of establishment precludes a Member State from imposing in the interest of public health stricter requirements on the formal training of doctors as those provided in these directives (who can therefore be granted permission to practice medicine in our country on the basis of a medical diploma obtained in another Member State), it seems logical to apply this reasoning to the provision of passive services, all the more so since the Court of Justice seems more inclined to allow limitations to freedom of establishment than obstacles in terms of the free provision of services. Refusal to recognise the service provided by non-national health care providers cannot be justified on the grounds that they do not possess the requisite scientific knowledge or expertise. It is possible to ask here whether the requirements imposed by national health care providers is based on a desire to protect the insured or intended to ward off competition. In contrast, it could be argued that the Court actually starts from a hypothetical notion whereby the fact that the requirements for practising and access to a medical profession is the subject of mutual recognition in Europe, automatically implies that the quality of care provided in Europe is also uniform. The Court therefore seems to hold that fundamentally,

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[38] See for example ECJ, case C-33/74 *Van BinsBergen, ECR* , 1974, 1299, paragraph 14; ECJ, cases C-110 and 111/78, *van Wesemael*, *ECR* , 1979, 35, paragraph 29.

[39] In contrast to legal exception provided for by treaties, rule of reason exceptions can only be invoked for national measures which are not discriminatory and therefore apply without distinction to goods and services from national or Member States.

[40] See ECJ, case C- 5/77 *Tedeschi* , *ECR* , 1977, 1555, paragraph 35 and ECJ, case C-39/90 *Denkavit, ECR* , 1991, 3069, paragraph 19.

medical quality standards are the same all over Europe so that there are no reasons for making medical treatment in another Member State subject to prior authorisation on the grounds of protecting patient health. Still, it cannot be denied that the EC guidelines to which the Court refers, tend to regard access to the profession rather than its actual practice.[41].

It could, however, be argued that the treatment provided by foreign doctors does not meet the quality standards required in the national state. After all, the European Court of Justice already recognised that the existence of a Community regulation does not preclude a Member State from appealing to Article 36 to justify additional measures at national level if it is essential for the public health and even the survival of the population[42].

All states impose certain requirements for taking up and pursuing a medical profession. After all, a doctor has to meet the rules for pursuing his/her profession necessary to guarantee the quality of medical services regardless where he has obtained his/her diploma. It could be argued, therefore, that treatment given in another state by someone who does not meet such requirements cannot be reimbursed without more and that prior authorisation is needed. However, an important consideration has to be borne in mind. Pursuant to the case law of the European Court of Justice, restriction of the free movement of services cannot be justified on the basis of the common interest (because objectively it is not absolutely necessary) if this objective has already been achieved on the basis of comparative rules in the state where the service provider is established. Member States therefore have to take quality control rules applicable in other States into account. In accordance with directives concerning the mutual recognition of diplomas, a doctor established in another Member State is exempted from license fees or registration with professional associations in the receiving state provided that he observes professional rules. If s/he were to practise activities under the national health insurance of the receiving state it is reasonable to assume that the standard provisions laid down by the legislation applicable to him, will apply. In this case, however, the treatment is not provided at the charge of the receiving state.

Given the fact that the quality standards required for practising a medical profession are largely similar in the different States of the European Community, it is unlikely that a lack of quality could be used to justify the refusal to reimburse treatment provided in another State. Although quality standards exist for medical professionals, this is not the case for hospitals. To date there have been no harmonisation directives for hospitals.

b. FINANCIAL BALANCE OF SOCIAL SECURITY SYSTEM

Another ground for justification which was used was the risk of upsetting the financial balance of the social security scheme. This could be the case if the cost of treatment provided in another state and reimbursed by sickness institutions were to be paid in accordance with the tariffs of the country where the medical services were bought or supplied and in view of the considerable differences that currently exist in terms of the cost of health care and the financing mechanisms of sickness funds. Although aims of a purely economic nature cannot justify a barrier to the fundamental principle of the free movement of goods, it cannot be excluded that the risk of seriously undermining the financial balance of the social security system[43] may constitute an overriding reason capable of justifying a

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[41] This is the case particularly in *Decker* where the Court refers to Directive 92/151 on a general system for the recognition of professional education and training.

[42] See ECJ, case C-72/83, *Campus Oil , ECR,* 1984, 2727. See also Montagnie, Y. "De arresten Decker en Kohll in het licht van de rechtspraak van het Hof van Justitie van de EG", in Jorens, Y. en Schulte, B. , *Grensoverschrijdende gezondheidszorg in Europa/ Grenzüberschreitende Gesundheitsversorgung in Europa*, Die Keure, Nomos, 2001, forthcoming.

[43] In this respect we want to refer to the new article 137, § 4 of the Treaty of Nice. According to this Article , the provisions of the EC Treaty shall not affect the right of the Member States to define he fundamental principles of their social security systems and must not *significantly* affect the financial equilibrium thereof. It has to be seen if this Article would influence the Case Law of the Court of Justice . However it could be said that these terms seem to be less strict than the wordings of the Court of Justice.

barrier of that kind[44]. In *Duphar,* the Court recognised that "Community law does not detract from the powers of the Member States to organize their social security systems and to adopt, in particular, provisions intended to govern the consumption of pharmaceutical preparations in order to promote the financial stability of their health-care insurance schemes […] that it is not in principle incompatible with Community law for the Member State concerned, in a scheme which -like that in force in the Netherlands- is based on the principle of reimbursement in respect of all medicinal preparations which may be prescribed, with a view to achieving its aim of limiting costs, to prepare limitative lists excluding certain products from the reimbursement scheme". However, the Court later goes on "to be in conformity with the Treaty the choice of the medicinal preparations to be excluded must be free of any discrimination to the detriment of imported medicinal preparations. To that end the exclusionary lists must be drawn up in accordance with objective criteria, without reference to the origin of the products and must be verifiable by any importer". Reimbursement according to foreign tariffs could be detrimental to Member States whose treatment costs are significantly lower than those of the national State. In such cases prior authorisation is a sound instrument. In this case, however, such justification grounds do not apply because the costs are reimbursed in accordance with the tariffs of the country where the concerned is insured and subsequently responsible for repayment, not pursuant to the tariffs of the country where the treatment was provided. It is not relevant whether the treatment or medical services were administered in the national state or another State

Hence, Article 22 of Regulation No. 1408/71 (that provides for reimbursement in accordance with the rates of the State where the benefits are administered provided prior authorisation is given) does not counter the free movement of goods and services[45]. Some parties submitted that the applicability of Article 22 of Regulation No. 1408/71 should be questioned if national provisions are incompatible with free movement. The Court replied clearly that the fact that a national measure may be consistent with a provision of secondary legislation, in this case Article 22 of Regulation No 1408/71, does not have the effect of removing that measure from the scope of the provisions of the Treaty.

Article 22 therefore does not prevent the reimbursement by Member States, at the tariffs in force in the competent State, of the cost of medical products purchased in another Member State without prior authorisation. This is logical because the Regulation may not restrict the rights of Community citizens granted on the basis of the Treaty[46]. This article by no means requires that the cost of medical treatment has to be borne by the person concerned if permission was refused, or that they are not entitled to any form of compensation whatsoever.

It is not really clear why the Court refers to Article 22. After all, it may just as well have pointed out that national legal provisions were in breach of the general principles of free movement. Unless of course the Court intended to show that if it is allowed under EC law, it should be allowed under national law as well.

Following these rulings and the direct applicability of the principles of the free movement of goods and services, Article 22 of Regulation No. 1408/71 has been awarded a totally different role.

Indeed, in the wake of this case law a person who goes abroad to seek treatment or purchase a medical product now has two options, as opposed to only pursuant to Article 22 of Regulation No. 1408/71:

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44 See ECJ, case C-120/95, Dec*ker, ECR*, 1998, 1831, paragraph 39; see also ECJ, case C-328/91*, Secretary of State for Social security v. Thomas*, *ECR* , 1993, 1247, unequal treatment of men and women in matters of social security and financial balance of pension system / and ECJ, case C-137/94 *Richardson, ECR*, 1995, 3407 on exempting certain categories of persons from prescription charges and financial balance of pension systems. For a famous example on fiscal measures see ECJ, case C-204/90 *Bachmann*, *ECR*, 1992, 249 on cohesion between fiscal system and the deduction of insurance premiums.

45 See Article 22 of EU Regulation No. 1408/71.

46 See Conclusions Advocate General Tesauro under ECJ, cases C-120/95 and C-158/96, *Decker, ECR*, 1998, 1831, paragraph 32

- It may sometimes be more advantageous for the person concerned to request prior permission. An insured person who goes abroad to seek medical treatment after prior authorisation from the competent physician will be entitled to reimbursement of the cost pursuant to Article 22 of Regulation No. 1408/71, in accordance with the tariffs in the country where the treatment was given.
- Now s/he will be able to seek treatment abroad without prior authorisation. In such circumstances Article 22 does not prohibit the Member State concerned from reimbursing the treatment or product , in accordance with the scale of the State of insurance.

We shall come back to this point later.

c. MEDICAL AND HOSPITAL SERVICE TO ALL

The risk of upsetting the financial balance of the system and the desire to guarantee good quality medical and hospital service available to all its ensured is the third ground for justification. Granting everyone an unconditional right to health care anywhere in Europe could also pose a threat to public health planning. Member States calculate the number of facilities (hospitals, doctors, etc.) required to meet the needs of their population.. There is a genuine risk, particularly in border areas, that certain hospitals might become overburdened as a result of free movement.[47]. If too many insured were to go abroad, some units and hospitals might have to be closed down due to a lack of patients. It is important to remember that hospitals have high fixed-costs, regardless of the number of patients. Quantitative reductions in this regard could lead to reductions in terms of quality.
That is why the Court points out that the objective of maintaining a balanced medical and hospital service to all, that objective, although intrinsically linked to the method of financing the social security system, may also fall within the derogations on grounds of public health under Article 56 (now Article 46) of the Treaty in so far as it contributes to the attainment of a high level of health protection. Article 56 (now Article 46) also permits the Member States to restrict the freedom to provide medical and hospital services in so far as the maintenance of a treatment facility or medical service on national territory is essential for the public health and even the survival of the population. This was not the case as no-one had shown that that the rules at issue were necessary to provide a balanced medical and hospital service accessible to all.

D. Reactions from Member States: restricted applicability only to restitution schemes?

Although the Kohll and Decker judgments were not revolutionary and lay in the line of the case law of the Court of Justice on free movement, they provoked considerably reaction particularly in political circles.
This was perhaps due to the perceived threat that masses of patients would go abroad to seek treatment there and the subsequent effect this would have on the social security systems. However, it should be observed that it is not unreasonable to expect that people will seek out the best medical care available and that national legislators will usually be inclined to consider their own system as the very best.
Moreover, it is highly unlikely that hordes of people will go to foreign countries and consult foreign doctors (who may not even speak their language) or hospitals.

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[47] See for example Cornelissen, R., « 25e anniversaire du Règlement (CEE) n° 1408/71, ses résultats et ses limites » in *25 Années du Règlement (CEE) n° 1408/71 sur la sécurité sociale des travailleurs migrants,*, Stockholm, Office National de la Sécurité sociale de Suède et Commission Européenne, 1997, p.57; Mavridis, P., *Le citoyen européen peut-il se faire soigner dans l'Etat de son choix?* , Dr.Soc., 1996, pp.1092-1093; Zechel, S., *Die territorial begrenzte Leistungserbringung der Krankenkassen im Lichte des EG-Vertrages*, Berlijn, Erich Schmidt Verlag, 1995, p.29 et seq.

Studies show that patients do not go immediately abroad to obtain medical services. Most of the time this is limited to the three following cases[48]:

- In border areas in cases where proximity of foreign medical services, its cost, reputation, language, accessibility (waiting lists) administrative procedures, and how much is known about those services encourage this kind of medical integration
- for high tech services in cases where accessibility (waiting lists), the seriousness of the treatment and the quality of the service-provider are the decisive factors in the patients´ choice
- and in cases were persons have at their disposal all the necessary information for making a rational choice.

At the present time frontier workers who are able to choose between treatment in their country of employment or residence rarely use this option to seek treatment in the country of employment[49]. In addition, studies have revealed that cross-border health care eats up only a marginal percentage, i.e. between 0.3 and 0.5 of the total health budget.[50].

In this connection I believe it would be useful to carry out a study on the number of people entitled to medical care in another state. I have no doubt that it will be much lower than expected.

Still, political reactions focused on other matters[51]. Many Member States believed that *Decker* and *Kohll* apply only to health care systems such as Luxembourg and Belgium, i.e. restitution schemes where patients pay for health care costs and are reimbursed by their sickness fund. Consequently, the reasoning of the Court would not apply without more to other schemes such as benefits-in-kind systems (as in Germany and the Netherlands) or national health care systems (such as the United Kingdom). In such schemes the person concerned is not entitled to reimbursement of costs but to actual care itself. An agreement is drawn up between the care providers and the insurance institutions and costs are repaid directly by the insurance institutions on the basis of prior agreements, tariffs and conditions. They fear that this regulation on the free movement of goods and services will be used to reform their national social security systems and that the Court will effectively encourage the Member States, with a view to optimising the free movement of services, to replace benefits-in-kind systems by restitution schemes.

The question of whether or not these rulings apply only to restitution schemes is remarkable. It would lead to a situation where an EU citizen, insured in a country with a restitution scheme, would be able to seek treatment abroad without permission whereas an EU citizen insured in a benefits-in-kind system, would not have this possibility without prior authorisation from his/her insurance institution pursuant to Article 22 c of Regulation No. 1408/71or in accordance with national law.

In addition, in certain Member States who have a benefits- in -kind system, it is already provided that certain categories of persons have a right to reimbursement of benefits, which would lead to the strange conclusion that within the same system different rights to cross

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[48] AIM (Association Internationale de la Mutualité), *Implications of recent jurisprudence on the co-ordination of health care protection systems,* General report produced for the Directorate General for Employment and Social Affairs of the European Commission, May 2000, p.41.

[49] See De Buyser, J., "Grensoverschrijdende gezondheidszorg" in Jorens, Y. (ed.), *Grensarbeid*, Brugge, die Keure, 1997, p.155.

[50] AIM (Association Internationale de la Mutualité), *Implications of recent jurisprudence on the co-ordination of health care protection systems,* General report produced for the Directorate General for Employment and Social Affairs of the European Commission, May 2000, pp.37-40. Luxembourg tops the list with 9%. This is due to the fact that this country only has limited medical infrastructure and authorisation to seek medical treatment abroad is much more frequently given. In addition, it would seem that practically all cross-border medical care is given within the 6 founding countries of the European Union, France being the most popular. In contrast, Italy is the greatest debtor in this respect.

[51] See e.g. the following contributions Becker, U., "De gevolgen van de arresten Decker en Kohll van het Europees Hof van Justitie voor de wettelijke ziektekostenverzekering in Duitsland", and Lugtenberg, A., "De arresten Decker en Kohll vanuit het Nederlandse standpunt", in Jorens, Y. en Schulte, B., *Grensoverschrijdende gezondheidszorg in Europa/ Grenzüberschreitende Gesundheitsversorgung in Europa*, Die Keure, Nomos, 2001, fortcoming.

border medical benefits would exist[52]. Certain persons within the benefits-in-kind system would be able to seek treatment abroad without prior permission from their sickness fund and be reimbursed on the basis of national law, in other words those persons who are also entitled to the reimbursement of costs within the national system.

E. Restitution-Schemes, Benefits-in-kind systems and National Health Services

This problem was solved in the Geraets-Smits and Peerbooms case where the Court had to deal with the question if the principles of freedom of services or goods apply to benefits-in-kind systems. The question was if medical activities such as the Dutch ones, where the hospital establishment is paid by the fund with which the person concerned is insured, fall within the scope of freedom to provide services. Are these benefits foreseen in benefits-in-kind systems services? Different Member States and the Advocate General had their doubts about this[53]. These services could be not seen as economical activities particularly when they are provided in kind and free of charge under the relevant sickness insurance scheme.
An economic activity requires remuneration which could not be said to be the case in the Dutch system. Indeed general practitioners are not paid for the individual treatments of the patients. Doctors' charges are calculated in a particular way and on a fixed-amount basis regardless whether or not patients do indeed make use of the practitioners' services. The tariffs paid by the sickness funds to the hospitals do not really reflect the real costs but have to be seen as means of fixing the yearly hospital budget. Therefore we cannot speak of remuneration and Articles 49 and 50 (now Articles 40 and 41) are not applicable.
The Court clearly rejects these arguments.
Medical activities fall within the scope of Article 60 (now Article 50) of the Treaty, there being no need to distinguish in that regard between care provided in a hospital environment and care provided outside such an environment[54]. It is also settled case law that the special nature of certain services does not remove them from the ambit of the fundamental principle of freedom of movement so that the fact that the national rules at issue in the main proceedings are social security rules cannot exclude application of Articles 59 and 60 (now Articles 49 and 50)of the Treaty[55].
With regard more particularly to the argument that hospital services provided in the context of a sickness insurance scheme providing benefits in kind should not be classified as services within the meaning of Article 60 (now Article 50) of the Treaty, it should be noted that, far from falling under such a scheme, the medical treatment at issue in the main proceedings, which was provided in Member States other than those in which the persons concerned were insured, did lead to the establishment providing the treatment being paid directly by the patients. It must be accepted that a medical service provided in one Member State and paid for by the patient should not cease to fall within the scope of the freedom to provide services guaranteed by the Treaty merely because reimbursement of the costs of the treatment involved is applied for under another Member State's sickness insurance legislation which is essentially of the type which provides for benefits in kind.

Furthermore, the fact that hospital medical treatment is financed directly by the sickness insurance funds on the basis of agreements and pre-set scales of fees is not in any event such as to remove such treatment from the sphere of services within the meaning of Article 60 (now Article 50) of the Treaty. First, it should be borne in mind that Article 60 (now Article

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[52] For example in Germany for the voluntary insured.

[53] See Advocate General Colomer under ECJ, case C-157/99, *Geraets-Smits and Peerbooms* 2001, not yet reported paragraph 41-45

[54] See ECJ, Joined cases C-286/82 and 26/83 *Luisi* and *Carbone, ECR* , 1984, 377, paragraph 16; ECJ, case C-159/90, *Society for the Protection of Unborn Children Ireland*, *ECR*, 1991, 4685, paragraph 18, concerning advertising for clinics involved in the deliberate termination of pregnancies; and ECJ, case C-158/96, *Kohll* , *ECR* , 1998, 1931, paragraphs 29 and 51

[55] ECJ, case C-279/80 *Webb* , *ECR* , 1981, 3305, paragraph 10, and ECJ, case C-158/96, *Kohll* ,*ECR* , 1998, 1931, paragraph 20,

50) of the Treaty does not require that the service be paid for by those for whom it is performed[56].Second, Article 60 (now Article 50) of the Treaty states that it applies to services normally provided for remuneration and it has been held that, for the purposes of that provision, the essential characteristic of remuneration lies in the fact that it constitutes consideration for the service in question[57]. In the present cases, the payments made by the sickness insurance funds under the contractual arrangements provided for by the ZFW, albeit set at a flat rate, are indeed the consideration for the hospital services and unquestionably represent remuneration for the hospital which receives them and which is engaged in an activity of an economic character.
The Court herewith clearly determines that from the moment a patient has to pay for medical care abroad- which is normally always the case- the rules on free movement of services and goods apply even if benefits are provided for free in the national system to which the person concerned belongs[58]. This applies both to benefits-in-kind systems and national health systems, which are financed out of tax revenues [59]. No distinction can therefore be made either between reimbursement systems and benefits-in-kind systems, nor between benefits-in-kind systems and national health services. In addition, services provided for in National Health Services have to be considered as services within the meaning of European Community law. Consequently, we may conclude that European Community law is binding within the entire Community and the way in which the different national states organise relations between care providers and the insured may not erode the application of fundamental freedoms. Otherwise Member States would be in a position to define unilaterally that Community law is applicable or not.

The fact, however, that all health systems fall under the principles of free movement does not imply that there are no justifications for restricting the free movement.

F. Intra-mural and extra-mural care

After the Kohll and Decker cases, it was discussed if the reasoning of the Court of Justice only applied to extramural care or if also intramural-hospital care was envisaged. There is no doubt whatsoever that the arguments used by the Member States as justification for restricting free movement, seem to play a more important role with regard to intramural care. Where in the case of extramural care the sickness providers are in a certain way subject to the rules of supply and demand and as such are in competition with each other, this is less the case for hospitals. Hospitals are confronted with higher fixed costs. In addition, hospitals are heavily subsidised in many Member States, most of the time also by a special contribution of the insured. The consequence could be that foreigners, who by no means have participated in this solidarity, could now benefit from these subsidised hospital tariffs.
Already in the Kohll case -the Court did not have to answer this question- Advocate General Tesauro had a closer look at this question and believed that restrictions to free movement are allowed in the case of intramural care[60].

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56 ECJ, case C-352/85, *Bond van Adverteerders and Others*, *ECR* , 1998, 2085, paragraph 16, and ECJ, Joined cases C-51/96 and C-191/97 *Deliège, ECR* , 2000, I-2549, paragraph 56

57 ECJ, case C-263/86 *Humbel , ECR,* 1998, 5365, 17.

58 The argument used in the Geraets-Smits and Peerbooms case that we could not speak about services, is all the more surprising as exactly these persons concerned had to pay for their benefits.

59 In a certain way under the application of Regulation No. 1408/71 medical care provided under National Health Services was already considered as services which have to be paid for. The United Kingdom is indeed reimbursed for medical care provided on the basis of Article 22 of EC Regulation No. 1408/71 to a national of another Member State who needed immediate medical treatment.

60 Also Advocate General Saggio in the *Vanbraekel* Case (ECJ, case C-368/98, 2001, not yet reported) accepts restrictions to intramural care. The reasons, however, differ from these used by Advocate General Tesauro. According to Advocate General Saggio the rules on free movement do not apply to benefits which constitute, on the one hand, an integral part of public health systems in so far these are established and organised by the state and on the other hand are financed out of the public purse. Hospital care is therefore excluded from free movement. However, as already pointed out, the Court of Justice rejected this view in both the *Vanbraekel* case (r.o. 41) and in *the Geraets-Smits and Peerbooms* case (r.o. 53) by pointing out that medical activities

In his conclusions in the Decker and Kohll cases, Advocate General Tesauro accepted the restrictions in relation to all benefits which must be provided to insured persons in hospitals. Unlike the benefits provided by individual practitioners, the reality in the case of hospitals is, first, that their location and number is determined by forward-planning and, secondly, that the cost of one person's stay in a hospital cannot be separated from that of the hospital as a whole. Clearly, if a large number of insured persons chose to avail themselves of hospital facilities located in another Member State, their domestic hospitals would be under-utilised but would have the same staff and equipment overheads as if they were being used to full capacity. In other words, reimbursement, by the competent social security institution, of medical benefits received by insured persons in hospitals of other Member States, even on the basis of a flat-rate equivalent to the `Luxembourg' cost of the benefits in question, would none the less result in an additional financial burden for the system concerned. In the hospital sector, therefore, it remains essential, in order not to disrupt the financial balance of the system and to ensure the maintenance of a service which is accessible, both financially and logistically, to everyone, including therefore those who do not intend to travel but wish to receive the health-care they require in the place nearest to them, to seek and obtain prior authorisation[61].
Doubts could be expressed, however, concerning such a unlimited restriction. Is it really true that the complete health care plannification is endangered if one has the right to seek medical treatment in a foreign hospital and is permission in this case a real necessity? If freedom to choose one's doctor and hospital were given, would there be an uncontrolled and uncontrollable flow of patients from one Member State to another? The fact remains that travelling to a State other than the State of residence entails significant inconvenience, often including language difficulties, and additional costs, if only for those persons accompanying the patient[62]. Moreover, in countries confronted with waiting lists, would not the fact that patients go abroad help these countries as it would decrease shortages? Is there still a danger that hospitals will have to close given the increased reliance upon outpatient care that has taken place over the last few years? Does competition between private and semi-private hospitals not play a greater role?

In its judgment in Kohll the Court made clear that the Member States have the possibility to prove that restrictions are necessary in order to provide a balanced medical and hospital service open to all insured persons. However, concluding that automatically every restriction is acceptable and lawful in our opinion seems to be going too far[63]. It is much more likely that the Court will judge on a case-by-case basis whether the restrictions can be justified. The Court speaks about medical and hospital care -which can also imply extramural care- whereas the Advocate General only speaks about intramural care-. As such the Court makes no difference between treatment, whether it is intramural or extramural or even basic medical care or specialised expertise[64]. According to the Court, Member States will have to prove that the restrictions are “necessary” to provide a balanced medical and hospital service accessible to all and “indispensable” for the maintenance of an essential treatment facility or medical service on national territory. Strong arguments were therefore necessary to prove

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fall within the scope of free movement, there being no need to distinguish between care provided in a hospital environment and care provided outside such an environment.

[61] Paragraph 59-60

[62] See also Conclusions Advocate General Tesauro under ECJ, Cases C-120/95 and C-158/96, *Decker, ECR*, 1998, 1831, paragraph 60, footnote 91.

[63] Jorens, Y., “De betekenis van de arresten Decker en Kohll in een Sociaal Europa/ L'importance des Arrêts Decker et Kohll dans une Europe Sociale”, in *Grensoverschijdende gezondheidszorg in de Euregios: uidaging of bedreiging/ Soins de Santé transfrontaliers dans les Eurégios: un Défi ou une Menace,* Europees Seminarie/ Séminaire Européen, Verslagboek/ Procès-Verbal, Alden Biesen, 1999, p.21 and, van der Mei, A.P., *Free Movement of Persons within the European Community, Cross-border Access to Public Benefits*, Maastricht, Doctoral Thesis, 2001, p.355

[64] Jorens, Y., “De betekenis van de arresten Decker en Kohll in een Sociaal Europa/ L'importance des Arrêts Decker et Kohll dans une Europe Sociale”, in *Grensoverschijdende gezondheidszorg in de Euregios: uidaging of bedreiging/ Soins de Santé transfrontaliers dans les Eurégios: un Défi ou une Menace,* Europees Seminarie/ Séminaire Européen, Verslagboek/ Procès-Verbal, Alden Biesen,1999, p.21.

that this restriction is necessary and indispensable. The arguments used by the Member States in the Geraets-Smits and Peerbooms case, were according to the Court strong enough. Explicitly referring to the observations all governments have submitted, the Court argues that, by comparison with medical services provided by practitioners in their surgeries or at the patient's home, medical services provided in a hospital take place within an infrastructure with, undoubtedly, certain very distinct characteristics. The number of hospitals, their geographical distribution, the mode of their organisation and the equipment with which they are provided, and even the nature of the medical services which they are able to offer, are all matters for which planning must be possible. As may be seen, in particular, from the contracting system involved in the main proceedings, this kind of planning therefore broadly meets a variety of concerns. For one thing, it seeks to achieve the aim of ensuring that there is sufficient and permanent access to a balanced range of high-quality hospital treatment in the State concerned. For another thing, it assists in meeting a desire to control costs and to prevent, as far as possible, any wastage of financial, technical and human resources. Such wastage is all the more damaging because it is generally recognised that the hospital care sector generates considerable costs and must satisfy increasing needs, while the financial resources which may be made available for health care are not unlimited, whatever the mode of funding applied. From both those perspectives, a requirement that the assumption of costs, under a national social security system, of hospital treatment provided in another Member State must be subject to prior authorisation appears to be a measure which is both necessary and reasonable[65].
If insured persons were at liberty, regardless of the circumstances, to use the services of hospitals with which their sickness insurance fund had no contractual arrangements, whether they were situated in
the competent state or in another Member State, all the planning which goes into the contractual system in an effort to guarantee a rationalised, stable, balanced and accessible supply of hospital services would be jeopardised at a stroke. The Court accepts that there are reasons which justify restrictions on the free movement in case of hospitals. However we may not conclude that just because the Court accepts justification grounds that immediately and automatically every restriction is lawful. Justifications are not enough. As the Court points out – but this is a task for the national courts to find out-, the conditions attached to the grant of such authorisation must nonetheless be justified with regard to the overriding considerations examined and must satisfy the requirement of proportionality.
It would be too easy to say that intramural care is all together excluded. On a case by case basis one has to see whether the criterion of proportionality is fulfilled. The fact that only a few patients would go abroad, does not seem to be enough for allowing an unlimited restriction of free movement.
In addition, it is also unclear if this reasoning applies only to hospital treatment as such, or if it is also applicable to every clinical institution where medical care is provided. It is questionable if restrictions are also allowed concerning nursing homes, rehabilitation institutions ... as arguments as the high financial cost are less applicable to these institutions. In addition the question of "What is hospital treatment?" could arise. Does it cover all treatment given in a hospital or is out-patient care excluded? One could perhaps argue that restrictions are only allowed with respect to medical care which normally cannot be provided for outside an hospital.

G. Benefits not covered by Insurance Packages?

As medical benefits are reimbursed according to the tariffs in force in the competent State, one could expect that benefits not covered by the sickness insurance system in that state, did not need to be reimbursed. On the other hand, one immediately understands that this limits to a great extent the principle of cross-border medical care. People would hardly see any reason to cross the border for obtaining medical care.

[65] ECJ, case C-157/99 , *Geraets-Smits and Peerbooms* 2001, not yet reported paragraph 76-80.

On the other hand, if also medical benefits not covered could be reimbursed, patients would obtain the possibility to look for the best treatment in the European Union.
The Court, following its Advocate General, is quite clear in this respect. The Court refers to former case law where the Court decided that it is not incompatible with Community law for a Member State to establish, with a view to achieving its aim of limiting costs, limitative lists excluding certain products from reimbursement under its social security scheme[66].The same principle must apply to medical and hospital treatment when it is a matter of determining which treatments will be paid for by the social security system of the Member State concerned. It follows that Community law cannot in principle have the effect of requiring a Member State to extend the list of medical services paid for by its social insurance system: the fact that a particular type of medical treatment is covered or not covered by the sickness insurance schemes of other Member States is irrelevant in this regard[67].Nonetheless, in exercising that power the Member State must not disregard Community law. Thus it follows from the Court's case law that the list of medicinal preparations excluded from reimbursement must be drawn up in accordance with Article 28 of the EC Treaty and that this will be so only where the list is drawn up in accordance with objective criteria, without reference to the origin of the products.
Member States are therefore not obliged to reimburse benefits not provided for in their national legislation, because they are free to define their own sickness insurance packages.
On the one hand, it is clear that this argument of the Court considerably limits the right of free movement of patients. On the other hand, the reasoning of the Court is also very terse.
Is it a sufficient justification to postulate that the national Member States decided not to include this benefit in their insurance package? Is the justification that Member States have the power to define insurance packages because it is up to the Member States to organise their social security systems or do we not have to look for further grounds[68]? In the Duphar case - which the Court refers to- the Court indeed accepted that Member States could prepare limitative lists, not just because they have the power to do so, but because this was necessary in order to promote the financial stability of their national health insurance system[69]. Member States can exclude certain medical products or services for different reasons, as there are financial reasons, but also because of medical or medical-ethical reasons. There could be sound financial reasons not to reimburse very expensive drugs.
However, should it not be possible that a medical product bought or service rendered abroad which is not on the list of the competent state , but which is cheaper than a similar product or service at home, be reimbursed? In particular, similar medical products are introduced under different names on the market of different Member-States. Imagine the case that someone buys a medical product abroad and asks for reimbursement which is not possible, however, as it is not on the list of the competent State, only because it is named differently. It seem strange that in these cases reimbursement would not be possible.

When Member States are structuring their national sickness insurance scheme they have to respect European Community law, which implies in particular when drawing up the list of reimbursable benefits, that they have to do so on the basis of objective criteria, without reference to the origin of products.
In this respect a scheme of prior authorisation cannot legitimise discretionary decisions taken by the national authorities which are liable to negate the effectiveness of provisions of Community law, in particular those relating to a fundamental freedom[70].

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[66] ECJ, case C-238/82, *Duphar and Others, ECR*, 1984, 523, paragraph 17.
[67] ECJ, case C-157/99 *Geraets-Smits and Peerbooms* 2001, not yet reported, paragraph 86-87
[68] see also van der Mei, A.P., *Free Movement of Persons within the European Community, Cross-border Access to Public Benefits*, Maastricht, Doctoral Thesis, 2001, pp.364- 368
[69] van der Mei, A.P., *Free Movement of Persons within the European Community, Cross-border Access to Public Benefits*, Maastricht, Doctoral Thesis, 2001, p.365
[70] ECJ, Joined cases C-358/93 and C-416/93 *Bordessa and Others, ECR* , 1995, I-361, paragraph 25; ECJ, Joined cases C-163/94, C-165/94 and C-250/94 *Sanz de Lera and Others* , *ECR,* 1995, I-4821, paragraphs 23 to 28, and ECJ, case C-205/99 *Analir and Others* , not yet reported, paragraph 37.

Therefore, in order for a prior-administrative-authorisation scheme to be justified even though it derogates from such a fundamental freedom, it must, in any event, be based on objective, non-discriminatory criteria which are known in advance, in such a way as to circumscribe the exercise of the national authorities' discretion, so that it is not used arbitrarily.
Such a prior-administrative-authorisation scheme must likewise be based on a procedural system which is easily accessible and capable of ensuring that a request for authorisation will be dealt with objectively and impartially within a reasonable time and refusals to grant authorisation must also be capable of being challenged in judicial or quasi-judicial proceedings.
The actual Dutch system of sickness insurance is not based on a pre-established list of types of treatment issued by the national authorities for which payment will be guaranteed. The Netherlands legislature has enacted a general rule under which the costs of medical treatment will be assumed provided that the treatment is `normal in the professional circles concerned'. It has therefore left it to the sickness insurance funds, acting where necessary under the supervision of the *Ziekenfondsraad* and the courts, to determine the types of treatment which actually satisfy that condition. In the present two cases, it is clear from the arguments submitted to the national court and from the observations submitted to the Court that the expression `normal in the professional circles concerned' is open to a number of interpretations, depending, in particular, on whether it is considered that regard should be had to what is considered normal only in Netherlands medical circles, which, to judge by the order for reference, seems to be the interpretation favoured by the national court or, on the other hand, to what is considered normal according to the state of international medical science and medical standards generally accepted at international level. The point of view of the Netherlands Government that when a specific treatment constitutes professionally appropriate treatment having a valid scientific basis, it is regarded as a qualifying benefit for the purposes of the ZFW, so that the application of the `normal' criterion must not have the consequence that only treatment normally available in the Netherlands can qualify for reimbursement, is considered by the Court as based on objective criteria. Only an interpretation on the basis of what is sufficiently tried and tested by international medical science can be regarded as satisfying the requirements of objective criteria. To allow only treatment habitually carried out on national territory and scientific views prevailing in national medical circles to determine what is or is not normal will not offer those guarantees and will make it likely that Netherlands providers of treatment will always be preferred in practice.
If, on the other hand, the condition that treatment must be regarded as `normal' is extended in such a way that, where treatment is sufficiently tried and tested by international medical science, the authorisation sought under the ZFW cannot be refused on that ground, such a condition, which is objective and applies without distinction to treatment provided in the Netherlands and to treatment provided abroad, is justifiable in view of the need to maintain an adequate, balanced and permanent supply of hospital care on national territory and to ensure the financial stability of the sickness insurance system, so that the restriction of the freedom to provide services of hospitals situated in other Member States which might result from the application of that condition does not infringe Article 59 of the Treaty. Further, where, as in the present case, a Member State decides that medical or hospital treatment must be sufficiently tried and tested before its cost will be assumed under its social security system, the national authorities called on to decide, for authorisation purposes, whether hospital treatment provided in another Member State satisfies that criterion must take into consideration all the relevant available information, including, in particular, existing scientific literature and studies, the authorised opinions of specialists and the fact that the proposed treatment is covered or not covered by the sickness insurance system of the Member State in which the treatment is provided[71].
The condition that the proposed treatment be normal therefore has to be understood in this way that this treatment is sufficiently tried and tested on a international level. Although it is up to the Member States to decide by themselves what services they want to reimburse, the

[71] ECJ, case C-157/99 , *Geraets-Smits and Peerbooms*, 2001, not yet reported, 89-98.

new element in the Court's case law is that to determine which benefits have to be taken into account, this cannot only be judged on a national level, but also from an international point of view: if this treatment is sufficiently tried and tested on a international level. If a Member State recognises the reimbursement of a certain treatment for a particular disease, this state, when confronted with the question of whether or not other methods of treatment for that disease have to be reimbursed, has to take into account whether this other method is internationally tested and recognised.
As such the Court introduces an international standard in order to determine what can be considered as medically normal. This is a first step towards taking the path to European Standards on Health Care and an invitation to the method of open coordination in the field of health care. In addition it should not be forgotten that this criterion of being internationally recognised is a dynamic concept. What today could not be accepted as method could become it tomorrow. It is clear that a constant exchange of information would be advisable in this respect.

H. Waiting lists

It is clear that in principle the application of prior-authorisation rules to benefits abroad for which at home waiting lists exist, could infringe free movement. Restriction to this principle should for this reason only be allowed if it is justified. Therefore it is up to the Member States to prove that restrictions are necessary in order to protect the financial stability of the system or the maintenance of a balanced medial and hospital service.
In *Geraets-Smits and Peerbooms*, the Court argued that the condition concerning the necessity of the treatment, can be justified under Article 59 (now Article 49) of the Treaty, provided that the condition is construed to the effect that authorisation to receive treatment in another Member State may be refused on that ground only if the same or equally effective treatment can be obtained without undue delay from an establishment with which the insured person's sickness insurance fund has contractual arrangements.
Furthermore, in order to determine whether equally effective treatment can be obtained without undue delay from an establishment having contractual arrangements with the insured person's fund, the national authorities are required to have regard to all the circumstances of each specific case and to take due account not only of the patient's medical condition at the time when authorisation is sought but also of his past record. Such a condition can allow an adequate, balanced and permanent supply of high-quality hospital treatment to be maintained on the national territory and the financial stability of the sickness insurance system to be assured.
Were large numbers of insured persons to decide to be treated in other Member States even when the hospitals having contractual arrangements with their sickness insurance funds offer adequate identical or equivalent treatment, the consequent outflow of patients would be liable to put at risk the very principle of having contractual arrangements with hospitals and, consequently, undermine all the planning and rationalisation carried out in this vital sector in an effort to avoid the phenomena of hospital over-capacity, imbalance in the supply of hospital medical care and logistical and financial wastage.
However, once it is clear that treatment covered by the national insurance system cannot be provided by a contracted establishment, it is not acceptable that national hospitals not having any contractual arrangements with the insured person's sickness insurance fund be given priority over hospitals in other Member States. Once such treatment is *ex hypothesis* provided outside the planning framework established by the ZFW, such priority would exceed what is necessary for meeting the overriding requirements[72].
Restrictions are therefore allowed because otherwise financial problems or imbalances in the medical and hospital service would exist. Waiting lists could be possible but again the proportionality clause has to be taken into account.

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[72] ECJ, case C-157/99 *Geraets-Smits and Peerbooms* 2001, not yet reported, 103-107

As such the Court uses a quantitative argument, referring to an "outflow of patients" and "logistical and financial wastage". It is clear that this criterion asks for further clarification but strong arguments will have to be used. Until now, no massive outflow has taken place. Is it not true that in principle just the fact that patients go abroad circumventing waiting lists will decrease waiting lists at home so that accessibility of medical care will improve? This could be different if many people were to go abroad so that under-capacity would turn into over-capacity with all results. The Court argued in the Kohll case that it has to be the maintenance of an essential medical facility. Therefore it seems to be that only limited minimum care could be made dependent on permission clauses. Remarkable in this respect is that in the Kohll case the orthodontist was the only one in Luxembourg, a state with 350.000 inhabitants which of course will be more confronted with cross-border care than other and larger Member States. Although our orthodontist lost a patient, if overworked, there would no longer be any orthodontists in Luxembourg. Restrictions could therefore lead to counterproductive effects and are certainly no longer proportional. In this respect there seems to be a limit under which protection makes no sense[73].
Unclear is also what should be understood under "undue delay". This has to be judged by the competent institution and the Court will only have a limited judicial review. According to the Court the decision has to be taken while taking into account the patient's medical condition as well as his past record. Therefore decisions have to be taken on a case-by-case basis and no general rulings seem to be possible.
The fundamental right to health care demands that this period has to be strictly interpreted and that the situation of the patient is central. Without undue delay means not only to treat and cure the patient in time- so before his health situation gets worse- but also to avoid pain and make bearable the symptoms of the disease. In this respect it is very difficult to define what is to be considered as acceptable waiting time for treatments. This will as a matter of fact not only differ from the national situation, but also from the disease concerned. Life-endangering disease will ask for shorter waiting periods as e.g. the replacement of a new hip.

VI. Relation between EC Regulation 1408/71 and Common Market Principles

A. Two methods of cross-border medical care

1. Hierarchical order?

As we already pointed out, the Kohll and Decker case led to a second method for cross-border medical care. The Court made clear that Coordination Regulation 1408/71 does not intend to provide an exhaustive list of the means by which someone may obtain medical goods and services in another Member State. According to the spirit and intentions of the Regulation it can be interpreted as simply providing one suggestion on how cross-border social care could be provided. It is just because the national rules had been interpreted by the national courts as precluding all other methods of obtaining social health care goods and services , that one had to act.
The fact that there are now two methods of cross-border medical care, raises the question if one method prevails over the other[74]. The problem is, however, that you can hardly establish a hierarchy between the two cross-border procedures. The Court confirmed that Article 22 is not contrary to the Treaty where it poses that Article 22 is only one way of cross-border care

[73] Jorens, Y., "De betekenis van de arresten Decker en Kohll in een Sociaal Europa/ L'importance des Arrêts Decker et Kohll dans une Europe Sociale", in *Grensoverschijdende gezondheidszorg in de Euregios: uidaging of bedreiging/ Soins de Santé transfrontaliers dans les Eurégios: un Défi ou une Menace,* Europees Seminarie/ Séminaire Européen, Verslagboek/ Procès-Verbal, Alden Biesen,1999, p.21; du Pre, *Het EG-Verdrag door een ziekenfondsbrilletje*, SMA, 1998, p.370.

[74] See e.g. AIM (Association Internationale de la Mutualité), *Implications of recent jurisprudence on the co-ordination of health care protection systems,* General report produced for the Directorate General for Employment and Social Affairs of the European Commission, May 2000, pp.137-140.

and as such there is no conflict between both rules. As this article does not prevent partial reimbursement in cases where no prior authorisation is given, there is also no need to amend Article 22 and to state that in case of prior authorisation, reimbursement should be given in accordance with the tariffs of the Member State of insurance.
As *Kohll* and *Decker* is based directly on the EC Treaty, it will always apply whatever is provided for under the Regulation, unless States were to decide to change the Treaty and to exclude health care from the provisions of free movement. Even when the Regulations would have been changed, a patient could always base himself on the principles of freedom of goods and services before the Court and the Court could even in future cases award bigger rights under these principles. Modification of the Regulation can never lead to the disappearance of the procedure based on the Treaty.
Therefore it is very difficult to establish a hierarchical order between both methods.
As there is also no conflict between these two procedures, one cannot argue that the Regulation has priority on the basis of the *lex specialis*.

2 Advantages and disadvantages

We are therefore confronted with two different ways of cross border medical care which can, however, exist next to each other and where every system has its advantages and disadvantages[75].
As the Court pointed out under Article 22, no extra costs are incurred[76]. Under Article 22 one has the same rights as if someone were insured with it. This implies that a person will be subject to the same access conditions (contracted doctor, referral by a general practitioner), same form of payment (reimbursement care of benefits in kind, payment at their expense – own contribution). There is application where necessary of the charge and rate of reimbursement of the country in which treatment is provided. When this treatment is given for free, this is also the case for someone who has the right to treatment under Regulation 1408/71. The patient has the guarantee of having a social security reimbursement in relation to the cost of care.

The procedure under *Kohll* and *Decker* is different if one considers the private services of the provider and does not take account of the system of social protection of the state of establishment of this service-provider. A patient is not bound by the obligations and conditions of this system. It is just as if the treatment had been performed in the country of the competent State. Consequently, there are no disadvantages- e.g. it is not necessary to contact a general practitioner first in order to obtain a referral to the specialist, this procedure may be more advantageous when the cover of the country of insurance is higher or when the services of the foreign provider are not covered by the social protection of that country. In this respect this procedure can be used to obtain care which is not covered under Article 22 of EC Regulation No 1408/71, as there is non-urgent and non-authorised care, and care not covered by the social protection scheme in the state of stay as e.g. care provided by private providers or provisions not covered in that state. On the other hand, one can not profit form the advantages of the EC Regulation.
Under *Kohll* and *Decker* one always has to advance payment of treatment. It is important to take this into account. The difference between level of reimbursement and actual price to be paid could even result in significant additional expenditure for the patient concerned which

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[75] see e.g. AIM (Association Internationale de la Mutualité), *Implications of recent jurisprudence on the co-ordination of health care protection systems,* General report produced for the Directorate General for Employment and Social Affairs of the European Commission, May 2000, 137-138; Langer, R., *Grenzüberschreitende Behandlungsleistungen- Reformbedraf für die Verordnung 1408/71*, NZS*,* 1999, pp.537-542.

[76] By holding that a duty to full reimbursement only exists when prior authorisation is given, the Court could circumvent the problem of Article 36 according to which full reimbursement is provided for costs incurred by a state on behalf of another state. In cases where prior authorisation rules are not applied, partial reimbursement is permissible and precisely because partial reimbursement is possible there is also no need for making payment dependent on the prior authorisation.

could lead to the situation that some people will not be in a position to advance the costs. Could the right of choice therefore be economically limited? Would this lead to a two-track Europe where the right to health care will be different according to the financial situation of the person concerned?
One of the guarantees under Article 22 of the Regulation, is that the person concerned has the same rights and will have to pay the same cost as if someone were insured with it. There is no such guarantee under the Kohll and Decker procedure. Does this imply that medical providers who treat foreigners who use of the Kohll and Decker procedure can now charge what they want?
The answer is negative. In Ferlini, the Court of Justice pointed out that Article 12 forbids that private organisations , but since the case law of the Court in Angonese,[77] it may be expected that this applies also to private persons, may not discriminate against nationals of other Member States and are therefor not allowed to apply to foreigners scales of fees for medical and hospital care which are higher than those applicable to residents affiliated to the national social security scheme[78]. The criterion of affiliation to the national social security scheme on which the differentiation of fees for medical and hospital care are based, constitutes indirect discrimination on the ground of nationality. Such differentiation could be justified only if it were based on objective considerations which were independent of the nationality of the persons concerned and proportionate to the objective legitimately pursued. A medical provider therefore has to apply the same tariffs to a person who is not affiliated to the national social security scheme as he is allowed by national law to ask from persons affiliated to the scheme. However, it may be very difficult for the person concerned to prove that he is discriminated against.

Although both systems exist next to each other , one has to accept that this can cause administrative as well as judicial problems[79].
The Kohll and Decker procedure would be more difficult as one has to check the services provided abroad, identify them according to their own nomenclature and apply tariffs on the basis of the applicable legislation. It will be necessary to put services abroad into the same category as a service contained in the national lists and then to apply an analogous charge which will lead to administrative uncertainties.
People argue that this opens the way to abuse as one can know in advance that two systems will be mixed. If no permission is granted under Article 22 or if the urgent need is rejected, one knows that one can always fall back on the Kohll and Decker procedure. Some people wonder why one should therefore still ask for an E 112 form. On the other hand, however, we all know that abuse can never be avoided and that also under Regulation No. 1408/71 the procedure of Article 22 was not always used for the purpose for which it was intended.
As the two methods have a different tariff of reimbursement, the choice of the patient of which procedure should be applied could be based on where he will receive the cheapest treatment, i.e. the best tariffs of reimbursement. If a person knows in advance which procedure is even better, he could apply directly the Vanbraekel procedure.
This was made clear in the Vanbraekel case, were the relation between Article 22 of EC Regulation 1408/71 and the Treaty Provision of Article 59 (now Article 49) was examined.

The first question was whether, when a person who has requested authorisation on the basis of Article 22(1)(c) of Regulation No 1408/71 has been refused by the competent institution and it is subsequently established that that refusal was unfounded, the reimbursement by the competent institution of the costs of the treatment should be made according to the relevant rules in force in the Member State in which the person concerned is insured or according to those laid down in the legislation of the Member State on whose territory the treatment was

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[77] ECJ, case C-281/98 *Angonese*, 2000, not yet reported, see further
[78] ECJ, case C-411/98, *Ferlini,* 2000, not yet reported.
[79] See Eichenhofer, E., *Der Europäische koordinierende Krankenversicherungsrecht nach den EuGH-Urteilen Kohll und Deckerr* VSSR, 1999, pp.117-122; Langer, R., *Grenzüberschreitende Behandlungsleistungen-Reformbedraf für die Verordnung 1408/71*, NZS, 1999, pp.537-542.

provided? According to Article 22 someone has a right to medical care according to the legislation of the Member State in which the treatment is given, while the competent institution remains responsible for subsequently reimbursing the institution of the place of stay, as provided for in Article 36 (now Article 30) of Regulation No. 1408/71. Both the practical effect and the spirit of those provisions require, moreover, that when the request of an insured person for authorisation on the basis of Article 22(1)(c) of Regulation No. 1408/71 has been refused by the competent institution and it is subsequently established, either by the competent institution itself or by a court decision, that that refusal was unfounded, that person is entitled to be reimbursed directly by the competent institution by an amount equivalent to that which it would ordinarily have borne if authorisation had been properly granted in the first place. As, however, the amount reimbursable under the competent system is higher than the amount payable under the system where the benefits have been provided, the question arises whether the plaintiffs can also claim extra reimbursement to cover the difference between these two systems. As Article 22 of that regulation is not intended to regulate any reimbursement at the tariffs in force in the Member State of registration, it does not have the effect of preventing or prescribing payment by that State of additional reimbursement covering the difference between the system of cover laid down by the legislation of that State and the system applied by the Member State of treatment, where the former is more advantageous than the latter and such reimbursement is provided for by the legislation of the Member State of registration.[80]

There is no doubt that the fact that a person has a lower level of cover when he receives hospital treatment in another Member State than when he undergoes the same treatment in the Member State in which he is insured may deter, or even prevent, that person from applying to providers of medical services established in other Member States and constitutes, both for insured persons and for service providers, a barrier to freedom to provide services.

Is there any justification for this restriction? As the person concerned was in fact entitled to obtain the authorisation, it cannot be claimed that payment of additional reimbursement, would be liable to jeopardise the maintenance, in the Member State of registration, of a balanced medical and hospital service open to all or the maintenance of treatment capacity or medical competence on national territory. Furthermore, since such additional reimbursement does not in theory impose any additional financial burden on the sickness insurance scheme of that State by comparison with the reimbursement to be made if hospital treatment had been provided in that latter State, it cannot be argued that making that sickness insurance fund bear such additional reimbursement would be liable to have a significant effect on the financing of the social security system. Article 59 (now Article 49) of the EC Treaty is to be interpreted as meaning that, if the reimbursement of costs incurred on hospital services provided in a Member State of stay, calculated under the rules in force in that State, is less than the amount which application of the legislation in force in the Member State of registration would afford to a person receiving hospital treatment in that State, additional reimbursement covering that difference must be granted to the insured person by the competent institution.[81] Article 36 of Regulation No. 1408/71 cannot be interpreted as meaning that it follows from that provision that a covered person who has requested authorisation on the basis of Article 22(1)(c) of that regulation and been refused by the competent institution is entitled to reimbursement of all the medical costs which he incurred in the Member State in which he received treatment once it is established that the rejection of his request for authorisation was unfounded.

In case the amount reimbursable under the competent state is higher than the amount payable under the system where the benefits have been provided, the person concerned can claim extra reimbursement. On the other hand, the person concerned is not allowed to enrich himself by asking reimbursement according to the tariffs in the competent state of a product

[80] ECJ, case C- 368/98, *Vanbraekel* 2001, not yet reported, paragraph 31-37
[81] ECJ, case C-368/98, *Vanbraekel* 2001, not yet reported, paragraph , 45-53

or treatment which is cheaper abroad. In our opinion, it seems that the competent institution is not obliged to apply its tariffs in an unlimited way. Reimbursement will be limited to the actual cost paid abroad. The wording of the Court of Justice justifies the conclusion that this reasoning of the differential amount applies to all health-care systems and that it is not limited to restitution schemes.

The application of the *Kohll* and *Decker* procedure as a method of cross-border medical care, has another advantage with regard to the Regulations. It is well known that until now, third country nationals are excluded from the personal field of application of EC Regulation 1408/71.
However, for the principle of free movement of goods as well as for the principle of free movement of services, the nationality of the recipient is irrelevant. In this respect, third country nationals who are insured in a Member State can in principle benefit from the Court's rulings. From the moment third country nationals are allowed to travel to and to enter the national territory of another State, on the basis of national or international law, they have to be treated in the same way as EU nationals, and enjoy the same rights. Of course they cannot benefit from the advantages of EC Regulation No. 1408/71 and of course have to accept the limits and disadvantages of the Kohll and Decker procedure. They cannot use *Kohll* and *Decker* to circumvent the non-applicability of EC Regulation No. 1408/71 from which they are now excluded. They will, however, obtain greater protection in case of cross-border medical care.

B. Modifications of EC Regulation No 1408/71?

Some proposals were made to change radically the Regulation. The most radical one was proposed by
Professor Eichenhofer who combines the best options under the two systems: reimbursement according to the tariffs of the country where treatment was provided and the right to get abroad all the medical services one can obtain in the competent State[82]. His idea is therefore to change Article 22 of EC Regulation No 1408/71 in such a way that everybody has the right to the medical care one can apply for in the competent state in every country where he goes and that he will reimbursed according to the tariffs of the country where treatment has been given.
In a certain way, however, this solution disregards political reality. As the Court pointed out, Member States can determine how to structure their national social security system and financial concerns could limit the reimbursement of benefits obtained abroad. If states have to refund all that is given abroad and according to the tariffs of the state were treatment was given, they risk having financial problems and be overburdened. This would be very problematic, particularly for the new candidate states.

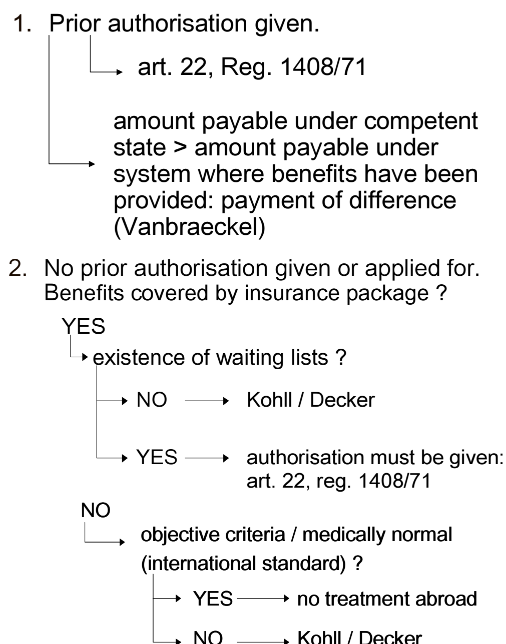
As the two methods exist next to each other and there is no possibility to order them in a hierarchical way, we believe that there is no need to change in a constitutive way the EC Regulation[83.] As we already pointed out earlier, the case law of the Court of Justice is directly

[82] Eichenhofer, E., *Der Europäische koordinierende Krankenversicherungsrecht nach den EuGH-Urteilen Kohll und Decker*, VSSR, 1999, pp.117-122.

[83] An exception has to be made with respect to Article 19 of regulation No. 574/72 which foresees that in the case of frontier workers or members of their families, medicinal products, bandages, spectacles and small appliances may be issued, and laboratory analyses and tests carried out, only in the territory of the Member State in which they were prescribed, in accordance with the provisions of the legislation of that Member State, except where the legislation administered by the competent institution or an agreement concluded between the Member States concerned or the competent authorities of those Member States is more favourable. This article cannot be applied anymore after the case-law of the Court. Frontier workers can now choose on which side of the border they wish to obtain medical products. On the basis of Regulation No. 1408/71 (article 20) alone, they had already that right. Article 19 of Regulation No. 574/72 limited this to a certain extent for medical products. It is clear after the Case Law of the Court that measures which should limit this right for frontier workers would be hardly acceptable.

based on the principles of free movement and the internal market. Consequently, criteria for cross-border medical care should be explained further and set out in, for example, a communication and later in a directive. We want to emphasize again what we have already said before. Even when reference is made to the case-law of the Court of Justice in newly adapted provisions of the EC Regulation 1408/71, it cannot be excluded that in further cases of the Court, new and bigger rights will be guaranteed to the citizen and as such the provisions of the Regulation are not a closed book. Let us not forget that the Court made clear that EC Regulation No. 1408/71 is not the only exclusive way of cross-border medical care and that each system has its own advantages. It would be a good idea to clarify and stress this.
However, due to the fact that confusion can arise and people have to be informed about their rights, a declaratory modification could be made by pointing out for example that the Regulations will apply, notwithstanding the rights obtained under the free movement of goods and services[84]. Certain clarification is needed. This is different from modification. It could e.g. be pointed out that the authorization by the competent institution has to be made on the basis of – as it is up to the national Member States themselves to define the criteria, precise criteria cannot be inserted in the Regulation – objective, non-discriminatory criteria which are known in advance. Abolishing the authorization procedure altogether however, goes too far as it could still be advantageous for the person concerned, to obtain prior permission.

C. Schematic overview



[84] See also Langer, R., *Grenzüberschreitende Behandlungsleistungen- Reformbedarf für die Verordnung 1408/71*, NZS, 1999, pp.537-542.

VII. Organisation of health care systems after the Case-Law of the Court of Justice

As European Community Law is compulsory applicable within the European Community, the different national ways the relation between service providers and the insured are arranged, cannot erode the application of the fundamental freedoms. Although it is up to the Member States to organise their own social security system, not only states that apply a reimbursement system, but also states that apply benefits in kind systems or national health services will increasingly have to take into account the case law of the Court of Justice and the influence of the fundamental freedoms. In the first place systems will have to adapt themselves to the principle of passive free movement of services for patients and insured people, as guaranteed by European Community law.
Sickness funds in systems which have no reimbursement principle will have to understand that they also have to finance medical services provided for abroad and that when these services are erroneously refused they have to finance these services and that the beneficiary has the right to be reimbursed. This by no means implies that countries with a benefits-in-kind system or national health system will now have to turn their system in a restitution system. This is not requested by the European Community. However, it is entirely different to say that if there is no reimbursement foreseen within the state, there should be no reimbursement outside the borders of that state. This argument is wrong. We tend to favour a combination where a restitution system is foreseen for benefits provided abroad. This should not pose any problems for systems which already apply in some cases the reimbursement principle and one only has to extend this system to benefits abroad[85].
According to the Court of Justice, the practical problems or difficulties this could give rise to, are no ground for not applying European Community law. The argument that the providers of medical services in the competent country are subject to legal rules guaranteeing the quality of these services as well as their financiability , is as pointed out by the Court no ground to limit the reimbursement of benefits to medical providers in the competent state.

Although there is no need to change the national health system it cannot be neglected that there is pressure on the national health care systems. The cases of the Court of Justice have shown us that a patient is entitled to choose a doctor when he goes abroad, but that he will have not this right when he stays in his country. It is true that Community law is not applicable to purely internal matters, but national restrictions will come under increasing pressure. In the beginning we already referred to the similarities with the Bosman Case. Although European Community law would not limit restrictions on transfers between two countries in one country – as this a pure internal matter- we all know that also within one Country restrictions are no longer applied.

Member States have to adapt their system to Community law to take into account the passive right to free movement of services, but also to open their system for foreign medical providers. The Court made clear that although Member States keep their competence in building their health system and may make the cover of medical services or goods dependent on certain conditions, the criteria they use have to be objective and non-discriminatory, without reference to the place of establishment of the service provider. This has also consequences for the scope of providers of services and medical goods included in the social protection scheme. Also benefits-in-kind systems or national health service systems therefore have to accept foreign medical providers.

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[85] Jorens, Y., "De betekenis van de arresten Decker en Kohll in een Sociaal Europa/ L'importance des Arrêts Decker et Kohll dans une Europe Sociale", in *Grensoverschijdende gezondheidszorg in de Euregios: uidaging of bedreiging/ Soins de Santé transfrontaliers dans les Eurégios: un Défi ou une Menace,* Europees Seminarie/ Séminaire Européen, Verslagboek/ Procès-Verbal, Alden Biesen, 1999, p.25.

European Community law requires that there may not be any discrimination , of a direct or indirect nature against service providers on the basis of nationality or place of establishment, except where this is legitimately justified[86].
This implies that a Member State when deciding with whom to sign contracts, may not discriminate against providers from other Member States and the criteria for evaluating applicants for contracts with the social protection institution must be objective and must not discriminate against foreign providers. It must therefore be as easy for a foreign medical provider to be contracted as it is for practitioners from the State concerned. As such there is a further need for those states to sign agreements with foreign providers. Nationality or place of establishment may not prevent a foreign provider from signing a contract with the sickness institutions of another state. This can only be prevented if legitimate, objective and proportional criteria would be applicable.[87]
It may be expected that this would certainly happen in the border regions. Exactly in border regions we see now different models where agreements are concluded between sickness funds in one state and medical providers in another state. Certainly foreign medical providers will now be affected by quality standards in another state. In this respect EC law forbids that other quality standards will apply to these foreign providers than those applicable to their own providers.
If more cross-border medical care is applied on the basis of the Community Freedoms, it could be recommended to speak at a European level about building standards on quality, price setting,[88] control on the delivered services ...to make these more transparent and align them[89]. The existing models in the border regions and the examples in these EUREGIOs therefore play an important role in this respect. This would definitively fit into the Convergence strategy and the open coordination method of the European Union that aims to maintain and, where necessary, develop a high-quality health-care system geared to the evolving needs of the population.

VIII. Private health-care insurance contracts.

The question could also arise if the case law of the Court also has consequences for private health-care insurance contracts. Are limitations foreseen in these contracts for reimbursement of medical care abroad -i.e. within the European Union- still allowed after this case law?
Although these insurance contracts are private agreements between an insured person and an insurance company, the case law of the Court also has to be accepted and applied in these contracts.
It is now established case law that that the fundamental freedoms have horizontal effect and that also private persons may not infringe these fundamental freedoms. The prohibition of

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[86] AIM (Association Internationale de la Mutualité), *Implications of recent jurisprudence on the co-ordination of health care protection systems,* General report produced for the Directorate General for Employment and Social Affairs of the European Commission, May 2000, pp.121-130.

[87] AIM (Association Internationale de la Mutualité), *Implications of recent jurisprudence on the co-ordination of health care protection systems,* General report produced for the Directorate General for Employment and Social Affairs of the European Commission, May 2000, pp.125-127

[88] In Germany e.g. , contrary to some other Member States, the investment costs of hospitals are paid from taxes and are not reflected in the daily in-patient accommodation charge. Patients insured in another Member State who take up benefits in German hospitals will not - as they only pay the daily in-patient accommodation charge - have to participate in the investment costs of German hospitals. In cases where German insured people were to go a country where the investment costs are reflected in the daily in-patient accommodation charge, German sickness insurance funds which have to reimburse costs of medical treatment in hospitals abroad, would indirectly contribute to the investment costs in this country.

[89] For an overview of these cross-border activities and problems: see Pitchas, R., “Grensoverschrijdende gezondheidszorg in Europa: De verbinding van zorgberoepen en de sociale verzekering in het Europese Gemeenschapsrecht ter veiligstelling van de kwaliteit” and Schirmer, H., “Juridische mogelijkheden inzake de verstrekking van grensoverschrijdende medische diensten”, in Jorens, Y. en Schulte, B. *Grensoverschrijdende gezondheidszorg in Europa/ Grenzüberschreitende Gesundheitsversorgung in Europa*, Die Keure, Nomos, 2001, fortcoming.

discrimination as formulated in the four fundamental freedoms must be regarded as applying to private persons as well[90]. Private measures which impede economic activities are forbidden. This also applies to forms of direct and indirect discrimination. However, individuals, like states, can rely on possible grounds of justification for restricting free movement[91]. Nevertheless, it is likely that private persons will find it difficult to prove that there are grounds for justifying restrictions . Every private organisation or private person therefore has to respect Article 49.

IX. Conclusions

Health care has always been considered as belonging to the national competence of the Member States and has always been looked at from the supply-oriented approach[92] where responsibility is taken for budgetary balance. A patient was never allowed to decide by himself whether he could seek the best medical treatment abroad. Almost 25 years ago, the Court of Justice made clear in the Pierik case that under Regulation No. 1408/71 insured people would have the right to look for better treatment across the borders. The Member States did not accept this approach by the Court and changed the Regulation accordingly. These days the Court has made it clear that cross-border medical care is required by the fundamental freedoms of the Common Market. Patients now have the possibility to decide by themselves if they want to move abroad for medical care. The buying of medical care across the borders will increase, and in this respect these judgments can be considered as a milestone in the case law of the Court of Justice. However, they are definitively not the stone that will cause an avalanche to destroy the entire social security system. They have to be seen as a contribution to further European cooperation in the health care sector. Further cooperation and alignment of regulations in the sense of further development of a European Health Market is therefore also an enormous opportunity which will benefit not only the providers themselves but also the insured people, i.e. the citizens of Europe.

[90] ECJ, case C-281/98, *Angonese* , 2000, not yet reported, paragraph 36, see also ECJ, case C-36/74, *Walrave and Koch, ECR*, 1974, I-1405 and ECJ, case -415/93, *Bosman , ECR,* 1995, 4921.

[91] ECJ, case C-415/93 Bosman , ECR, 1995, 4921, paragraph 86.

[92] Berghman, J., "Concluding Observations", in *Health Care without Frontiers within the European Union*, Ministry of Social Security of the Grand Duchy of Luxemburg, Association Internationale de la Mutualité, European Institute of Social Security, International Symposium, Luxembourg, 1999, p.69