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**ECJ Rulings on Health Care Services and Their Effects on the
Freedom of Cross-Border Patient Mobility in the EU**

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Abstract

Patient mobility and cross-border medical care are significant issues of the discussion about the future development of the health care systems of the Member States of the European Union. New rights for patients were defined by the European Court of Justice in its sequence of judgements (e. g. *Kohll*, *Müller-Fauré*) referring to Regulation (EEC) No 1408/71 on the social security of migrant workers. The Court's rulings also provoked considerable effects in national governments, insurance institutions, care providers and medical professionals.

In its communication of April 2005 the European Commission proposed a new health and consumer protection strategy, of which the scope of facilitating utilisation of cross-border health care is a striking aspect. Discussions are based on the existence of two categories of health care systems within the EU: social insurance systems and national health systems both varying in organisation, financing and benefits.

As regards individual rights before going abroad the patients in certain cases have to be aware of the need of prior authorisation by the competent authority. In terms of the Court's reasoning the question will be how the freedom to choose one's doctor and hospital can be realised without endangering the system's financial balance and what restrictions are necessary to provide a balanced medical and hospital service accessible to all, which is indispensable for the maintenance of an essential treatment facility or medical service on national territory.

The Court's most important rulings on these issues are introduced. In the light of these rulings and the increasing mobility of patients, especially retired persons, the paper reflects financial and institutional effects on the national health care systems within the EU.

Contents

I.	Introduction	1
II.	Basic legal provisions	2
III.	Health care systems and the principle of solidarity in the EU	3
IV.	Principle of territoriality	6
V.	Patient mobility in view of ECJ-judgements	7
	1. Cases Decker and Kohll	8
	2. Cases Vanbraekel and Geraets-Smits/Peerbooms	9
	3. Case Müller-Fauré/van Riet.....	11
	4. Case Inizan.....	11
	5. Case Leichtle	12
	6. Cases concerning long-term care – Molenaar, Partridge, Jauch and Gaumain-Cerri/Barth	13
	7. Recent judgements concerning pensioners.....	18
	8. The pending Case Watts	19
VI.	The implementation of the ECJ-Judgements on national level – the German experience.....	21
VII.	Final remarks.....	22
	BIBLIOGRAPHY	27

I. Introduction

The basis of recent activities of the European Community in the field of cross-border patient mobility of the European Union is the European Social Agenda for the period 2005 to 2010.¹ There are some more documents of the European Commission that have to be taken into consideration: first of all the programme of Community action in the field of public health (2003-2008),² which forms an essential part of the European Community's health strategy, focusing on the following objectives and general measures:

- a) improving information and knowledge with a view to promoting public health and health systems,
- b) boosting the ability to respond rapidly and coherently to health threats,
- c) addressing health determinants.

Regarding patient mobility, the European Commission has no direct mandate to intervene short of a full-scale ruling by the European Court of Justice. In order to level existing national differences of opinions in these matters, a strategy of consensus finding was established. The Commission thus instigated a "high level process of exchange of opinion" and finally published a communication "Follow-up in the high-level reflection process on patient mobility and health care developments in the European Union".³ In this communication the European Commission refers to various rulings of the European Court of Justice and stresses that the court has clarified the conditions under which patients may be reimbursed for health care provided in a Member State other than the Member State of affiliation of the patient. The European Commission also draws attention to the fact that community law stipulates that health care which citizens have acquired in one Member State is to be recognised when they move to another. A recent communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on "healthier, safer, more confident citizens: a Health and Consumer protection Strategy"⁴ proposes a programme of Community action in the field of Health and consumer protection 2007-2013.

1 COM 2005, 33 final, 9.2.2005.

2 Decision 1786/2002/EC, OJ C 271 of 9.10.2002, 1.

3 COM (2004) 301 final, 20.4.2004. For cross-border health care and patients' mobility as actual issues see *Bertinato, L., Busse, R., Fahy, N., Legido-Quigley, H., McKee, M., Palm, W., Ronfini, F.* 2005 and recently *Falke* 2006. *Falke* emphasises patient mobility as a part of public welfare as well as consumer protection.

4 COM (2005) 115 final, 6.4.2005.

Before going into details, I would like to introduce the legal framework that is the basis for the current discussions about patient mobility in Europe.

II. Basic legal provisions

Mobility of persons in general constitutes one of the four cornerstones of the Interior Market, commonly called the “Four Freedoms”, namely those of Goods, Capital, Services and People.

Patient mobility is thus in theory based on the principles of the free movement of persons, the freedom to provide services and the freedom of capital within the internal market of the European Community which is valid also for the European Economic Area (EEA), i. e. the EU including Iceland and Norway. According to Article 18 EC every citizen of the Union shall have the right to move and reside freely within the territory of the Member States, subject to the limitations and conditions laid down in this Treaty and by the measures adopted to give it effect. The legal basis of the free movement of workers, the free provision of services and the freedom of establishment is to be found in D Title III of the Treaty (Articles 39 et seq. EC). The right of Union citizens and their family members to move and reside freely within the territory of the Member States has been recently designed in Directive 2004/38/EC.⁵ To protect the social security rights of persons moving within the European Union, basic Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and families moving within the Community had been adopted. This regulation is based on Regulation (EEC) No 574/72 which lays down the practical implementation (competent national authorities, administrative formalities, etc.). The regulation applies to workers (employed and self-employed) who are nationals of a Member State or third country, or stateless persons/refugees residing in the territory of a Member State, to whom the legislation of one or several Member States applies, and to the members of their families and their survivors. This regulation also applies to persons who are studying or undergoing vocational training and to the members of their families. Persons residing in the territory of a Member State to whom the regulation applies are subject to the same obligations and enjoy the same benefits under the legislation of any Member State as the nationals of that state. The regulation applies to all legislation relating to the social security branches concerning sickness and maternity benefits, invalidity benefits, old age benefits etc. It applies to general and special contributory and

⁵ OJ L 158 of 30.4.2004, 77.

non-contributory social security schemes and to schemes concerning the liability of an employer or ship-owner. It does not apply to medical or social assistance. Benefits acquired under the legislation of one or more Member States may not be subject to any reduction, modification, suspension, withdrawal or confiscation by reasoning that the recipient resides in the territory of another Member State. As regards sickness and maternity benefits, the regulation makes it possible, under certain conditions and in accordance with specific procedures, for European citizens to obtain health care while residing in a Member State other than that in which they are registered, when they are staying abroad or if they wish to receive treatment in another Member State. Corresponding to judgements of the European Court of Justice, this regulation was updated and amended. With a view to simplifying and clarifying the Community rules governing the co-ordination of the Member States' social security systems, the European Parliament and the Council have endorsed Regulation (EC) No 883/2004.⁶ This regulation is the new point of reference for the co-ordination of the Member States' social security systems. It considerably facilitates the life of European citizens by strengthening the exercise of their right to move freely within the EU; it reinforces the co-operation obligations between the administrations in the field of social security. The new regulation is an essential prerequisite for the effective exercise of the right of free movement of persons, as enshrined in the EC Treaty.

Regulations aimed at the free movement of health professionals are not dealt with in this paper.

III. Health care systems and the principle of solidarity in the EU

The provision of health care as an aspect of health policy can be seen as an important part of Social Policy that contains various areas, e. g. pensions, education, employment. Health care as a main field of health policy is a matter of organisation of health services, according to various specializations and geographic coverage. For the purpose of this paper I shall restrict myself to questions of social coverage of health care: The extent to which any given person has access to the health care system of a state in the form of social benefits is conveniently called "social health care".⁷ The scope of social health care, the

6 OJ L 166 of 30.04.2004, 1; *Schulte* 2005.

7 For the following see *Hatzopoulos* 2005. See also *Igl* 1999; *Hervey* 2002 and 2003; *McKee*, *Mossialos*, *Baeten* 2002; *Mossalios & McKee* 2002; *Nickless* 2002; *Palm*

quality of services available, the generosity of remuneration, patients' choice and accessibility of care in general vary greatly from state to state. Questions of personal scope (who is covered?), the scope of treatment (what is/is not covered?) and the scope of implementation (who may provide health services covered by the social health care system?) are handled quite differently. There exist important differences between the various states for health services or patients who fall outside the scope of social health care. As a consequence, coverage may be offered by voluntary or additional health insurance schemes, e. g. private insurers. For those who are not legally covered by social health care, in some Member States the private sector offers a variety of health insurance products, e. g. for self-employed people or civil servants in Germany.

As far as social health care is concerned, the European ideal is as comprehensive a degree of compulsory coverage as possible. This principle governs social health care, which sharply distinguishes Europe from the other continents, where such forms of care are either open to choice or even an incentive offered by the respective employers. Compulsory coverage itself is a manifestation of the principle of solidarity, which is dominant in the organisation of social health care in EU Member States. The principle of solidarity may be located at three levels: in terms of the integration into the system, in terms of the funding of the system, and in terms of benefits insured by the system. Except for this essential feature the Member States' systems have very little in common. All these systems may be seen as specific emanations of the two broad models of social health care: the continental⁸ model of social insurance or the Beveridgean model of a national system of health care.

The model of the social insurance system, established in Germany during the 1880s by Chancellor Bismarck, follows a participative pattern: People are insured because of their participation in some professional group, organisation, industry or firm. Complementary schemes are put into place to cover those who do not come under any of the sector-specific schemes. The result is a multitude of funds, financed by direct contributions of both the employer and the employee. This model is followed in Austria, France, Germany, the BENELUX countries and most of the new Eastern European Member States.⁹

The starting point of the Beveridge model (see the famous "Beveridge Report" on social insurance and allied services to the British Ministry of Health in 1942) is universal coverage of legal residents and service provision within the system proper which is completely organised, administered, financed and

2002; *Tiemann* 2006. Emphasising the legal aspects: *Hervey, McHale*, 2005.

8 This model derives from Bismarck.

9 See GVG 2003.

run by the State. People are insured by virtue of their citizenship and/or physical presence on national territory. There is one single fund, which is financed directly by the state through taxes and other direct or indirect contributions. The Beveridge model of national health system is followed in the UK, Ireland, Denmark, Finland, Sweden, the “Mediterranean” countries: Spain, Portugal, Italy and Greece.

From the point of view of benefits given to patients, the European social health care systems may be classified into two broad categories of reception of benefits: namely cost reimbursement or benefits in kind. The cost reimbursement system allows patients to receive treatment by a practitioner/institution of their choice, more often than not out of a pre-defined “social category” or bound to the cost bearer by contract, and then offers reimbursement of the expenses incurred. In this system the patient enjoys a wide choice, opting for a variety of practitioners and, on a limited scale, hospitals. Such systems exist in Belgium, Luxembourg and France. Under the benefits in kind system the patients either have a comprehensive choice of practitioners organised by contracts of their sickness funds (Germany or Austria) or – in all countries with national systems – of health care obliged to accept treatment at the institutions close to their domicile (UK, Sweden, Denmark etc.). Once a choice has been made or the local offer accepted, the patient is directed to specific practitioners or hospitals, where he/she is treated “for free”. The different systems overlap sometimes: While all of the countries following the Beveridge model operate a system of benefits in kind, the same is true for some of the countries following the social insurance model as well. In some Member States with social insurance models, patients are entitled to choose their health care provider (Germany and Belgium), whereas in others the local sickness fund is obligatory (Austria, France). In systems based on benefits in kind, patients are entitled to obtain medical care from health practitioners who are paid directly by the health insurance institutions. In these cases a contract is concluded between the sickness fund and groups of health care providers or with a special institution (e. g. the Federal Association of Panel Doctors of Germany) which binds every single member to its contracts with statutory insurance funds. As a general rule, patients do not have to pay a bill, as long as they use a provider with whom the sickness fund has concluded a contract. This system exists in Austria, Germany, and until now in the Netherlands.¹⁰

10 For further details see *Dawes 2005; Hatzopoulos 2005; Jorens 2002b*. The Dutch health care system has recently been reformed, *Busse, van Ginneken, Schreyögg, Wisbaum 2005*.

IV. Principle of territoriality

In theory, national boundaries do not exist for individuals seeking health care in another Member State of the EU, insofar as people are free to move and live anywhere within the territory of the EU. This frontierless access is, however, confined to types of health services acquired on a purely private basis. In other words, everybody who is ready to pay out of his or her pocket may do so wherever he or she pleases. In practice this consumption is, however, of next to no importance since all EU Member States have the foresaid different statutory health care systems for those living under their jurisdiction. Thus, regardless of the fact that within the Community free movement of persons exists, authorities responsible for health care always confine their financial obligations in one way or another to their own country. Statutory health coverage has traditionally been limited to providers established within national boundaries. This is known as one side of the principle of territoriality; the other being the obligation to be insured with a legally defined institution or subject to care offered by national services. Both aspects, as a matter of fact, cannot work without territoriality. For patients – as long as they are subject to statutory schemes of care or insurance – this implies that they must obtain medical treatment from a provider based on the national territory and that in principle they are not entitled to be reimbursed for the costs of medical care obtained outside of the national territory. Since 1958, the EC Treaty has provided an exemption to the territoriality principle in order to encourage the free movement of people within the EU. The community mechanism for a co-ordination of social security systems, based on EEC Regulations No 1408/71 and No 574/72,¹¹ has guaranteed access to health care for migrant workers and their dependent family members moving to or residing in another EU Member State. These regulations were subsequently extended to virtually the entire EU population. Only recently, third country nationals were included in this co-ordination system.¹²

There are two reasons for eligibility to health care during a temporary stay abroad. They differ depending on whether a patient's condition requires immediate and necessary examination and treatment. Persons who may receive treatment outside their country of residence, regardless of whether their condition is critical, include: pensioners entitled to a pension and their families; employed and self-employed persons not currently in employment who go to another Member State to look for a job and their families; employed or self-

11 See Swedish National Social Insurance Board, European Commission 1997; *Jorens, Schulte* 2001.

12 Regulation (EC) No. 859/2003 OJ L 124 of 14.5.2003, 1.

employed persons exercising their professional activity in another Member State; seasonal workers and students, and those undertaking professional training and their families. Access to health care outside the Member State of residence is, therefore, essentially limited to urgent health care during a temporary stay in a Member State. Otherwise, those seeking planned health care in another Member State under Article 22.1.c of EEC Regulation No 1408/71 must obtain prior authorisation from the patient's competent social security institution.

In the health care and health insurance sectors it was generally assumed that cross-border access to medical care was exclusively governed by the provisions of EEC Regulations No 1408/71 and No 574/72, which thwart the territoriality principle only to a limited extent. This legal position continued until April 28, 1998, when the European Court of Justice concluded in *Decker* and *Kohll* that national rules which make the reimbursement of the costs of medical care obtained in another Member State conditional upon the prior authorisation of sickness funds unlawfully hamper the free movement of goods and services within the European Community.¹³ There has been a sequence of ECJ rulings which can be seen as the breaking point for the nationally orientated principle of territoriality in the field of health care systems. On the basis of these and selected following judgements of the European Court of Justice I will show to what extent EU legislation has increased the possibility of a citizen to receive treatment abroad, i.e. in another EEA country, and obliged the national bodies who pay or provide the service to alter their practices accordingly.

V. Patient mobility in view of ECJ judgements¹⁴

The first occasion in which the court proceeded on a remarkably extensive interpretation of the provisions of Regulation (EEC) No 1408/71 concerning health was in the *Pierik* cases.¹⁵ These cases concerned a pensioner entitled to benefits in accordance with Dutch legislation, who asked for reimbursement of costs incurred in the course of hydrotherapy dispensed in Germany. This case could not be aligned with the terms of Article 31 of Regulation (EEC) No 1408/71, which applies specifically to pensioners who need urgent treatment while staying in another Member State. However, Mr. *Pierik* was not staying

13 Case C-120/95 *Decker* (1998) ECR I-1831, 39, and case C-158/96 *Kohll* (1998) ECR I-1931,41. See *Van der Mei* (1998).

14 The following parts of my paper refer basically to *Hatzopoulos* 2005 and *Dawes* 2005.

15 Case 117/77, *Pierik* I (1978) ECR 825, and case 182/78, *Pierik* II (1979) ECR 1977.

in Germany when hydrotherapy became necessary, but moved there for the specific purpose of receiving it. In both cases the ECJ ruled under the prevailing conditions that authorisation for the cross-border treatment must not be refused. Reacting to the rulings, the Council amended the relevant provisions of Regulation (EEC) No 1408/71 twice. The conditions under which the competent institutions may not refuse patients the authorisation to go to other Member States were made much stricter.

1. *Cases Decker and Kohll*

The judgements in *Kohll* and *Decker* were delivered on the same day of 28 April 1998. In *Decker*, the court affirmed that national security and health care schemes should also respect Article 28 EC on free movement of goods. *Decker* was refused reimbursement by his Luxembourg health insurance for a pair of spectacles that he had bought in Belgium on a prescription from a Luxembourg ophthalmologist. According to the existing health insurance code in Luxembourg he should have obtained authorisation by the Luxembourg health insurance organisation. *Kohll*, a national of Luxembourg, was seeking reimbursement for a dental treatment received (by his daughter) in Germany without prior authorisation from his home institution. The court concluded that the requirement of prior authorisation constituted a violation of Article 49 of the Treaty. Such a violation could be justified by the public health exception contained in Article 46 of the Treaty to the extent that national measures served “the objective of maintaining a balanced medical and hospital service open to all”.¹⁶ The national measure could also be upheld if it were deemed necessary to ensure the financial balance of the social security scheme, and for overriding reasons in the general interest. However, none of the above justifications applied in the case under scrutiny since refund at the valid rate of the home state (Luxembourg) could in no way endanger the financial balance of the affected scheme or the quality of medical service in the same state.

Kohll and *Decker* triggered extensive and, at the beginning, quite frantic debates about their precise meaning and implications.¹⁷ Almost all Member States were against the opening of additional doors for patients. From the point of view of any one of those Member States whose health care systems were marred by lengthy waiting lists for next to everything except e. g. simple primary care at GP level, this seemed and still seems logical. Waiting lists have

16 Case C-158/96 *Kohll* (1998) ECR I-1931,41, para. 50.

17 On both cases see e. g. *Van der Mei* 1998; *Eichenhofer* 1999; *Hatzopoulos* 2000 and 2002; *Moore* 2002; *Fuchs* 2002.

always been more than a regrettable condition, namely a “bottle-neck” for patients reducing access and thus public expenditure. Yet, at the very beginning even other types of systems were reluctant to accept the new chances implied. Generally speaking, these debates involved concrete questions concerning the applicability of the common market rules to, for example, hospital care, so-called benefits in kind systems and as an instrument strengthening patients’ rights, above all against waiting lists. Another aspect is the more general question as to how the economic objectives of free movement provisions must be reconciled with the Member States’ social objectives in the fields of health care and health insurance. In the cases *Geraets-Smits/Peerbooms* and *Vanbraekel* the Court was asked to clarify the scope and precise meaning of the *Decker* and *Kohll* rulings.

2. Cases *Vanbraekel* and *Geraets-Smits/Peerbooms*

The *Vanbraekel* case¹⁸ concerned a Belgian national trying to obtain reimbursement from her social security fund for treatment received in a French hospital. According to Article 22 of Regulation (EEC) No 1408/71, any person who has obtained prior authorisation by his institution to receive treatment in another Member State is entitled to do so “as though he were insured with the competent institution of his state”. In practise this means that whenever treatment is not provided for free (benefit in kind) and the patient has to incur medical expenses, he may recover them in accordance with the tariffs applicable in the state where treatment took place. In the case under consideration benefits provided for by the French (host) legislation were lower than those offered by the Belgian fund for the same treatment administered within Belgium. Therefore, the question arose as to whether the rule of Regulation (EEC) No 1408/71 entitled beneficiaries to recover the higher benefits stipulated by the legislation of their home state, or whether the refund was limited to the level stipulated by the host state legislation.

In the *Geraets-Smits/Peerbooms* case¹⁹ the requirement of prior authorisation was challenged under the Treaty rules on services. Under the Dutch social security scheme patients are treated “for free” by care providers, who have made an agreement with the social security fund. Authorisation for the treatment by a care provider without an agreement with the social security fund is only given by the fund if two conditions are met: a) the treatment for which authorisation is required should be considered as normal, “normal in the profes-

18 Case C-368/98, *Vanbraekel* (2001) ECR I-5363.

19 Case C-157/99, *Geraets-Smits/Peerbooms* (2001), ECR I-5473.

sional circles concerned”, and b) it should be necessary – both in terms of time and quality – for the particular patient.

Against contrary positions of the intervening Member States, the court ruled identically in both cases. The court affirmed that “it is settled case law that medical activities fall within the scope of article 60 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.”²⁰ The court reiterated the statement already made in Kohll 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 49 and 50) of the Treaty”.²¹ In the *Vanbraekel* case the court found 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”. Hence, “additional reimbursement covering that difference must be granted to the insured person by the competent institution”.²² Regarding requirements of prior authorisation the court found that the national regulation may “deter, or even prevent, insured persons from applying to providers of medical services established in another Member State and constitute, both for insured persons and service providers, a barrier to freedom to provide services”.²³ Such a restriction may be justified by “overriding considerations” relating to the control of costs and to the maintenance of high quality hospital treatments within a Member State and the measure be upheld. The court continues: “Authorisation to receive treatment in another Member State may be refused only if treatment which is the same or equally effective for the patient can be obtained without undue delay from an establishment with which the insured person’s insurance has an agreement”.²⁴

20 *Vanbraekel*, para. 41, *Geraets-Smits/Peerbooms*, para. 53.

21 *Vanbraekel*, para. 42, *Geraets-Smits/Peerbooms*, para. 54. On both cases see reflections by *Van der Mei* 2002.

22 *Vanbraekel*, para. 51.

23 *Geraets-Smits/Peerbooms*, para. 69.

24 *Geraets-Smits/Peerbooms*, para. 103.

3. *Case Müller-Fauré/van Riet*

The judgements described above were confirmed and refined in the judgement *Müller-Fauré* and *van Riet*.²⁵ The case concerned two Dutch patients asking their respective funds for a reimbursement. *Müller-Fauré* received dental treatment by a private practitioner in Germany without having obtained prior authorisation, while *van Riet* received both hospital and non-hospital treatment in Belgium despite being refused authorisation by her home fund. The court confirmed that prior authorisation may not be required for reimbursement of medical expenses incurred in another Member State for outpatient treatment and that it is restricted to hospital treatment. The court does not distinguish between systems operating a refund system (like in *Kohll*) and systems based on a benefits in kind scheme (like in *Müller-Fauré/van Riet*). Regarding the criteria by which the existence of “undue delay” is to be assessed and the question whether the delay caused by waiting lists is “undue”, the court found that account should be taken “not only of the patient’s medical condition ... and, where appropriate, of the degree of pain or the nature of the patient’s disability which, for example, might make it impossible or extremely difficult for him to carry out a professional activity, but also of his medical history”.²⁶

4. *Case Inizan*

*Inizan*²⁷ concerned a French national who received multidisciplinary pain treatment in Germany without having received the authorisation provided for under French law. The court made it clear that such an authorisation may only be required where the patient seeks to receive in the host state benefits in kind or refund according to the tariffs and conditions applicable in that state. If the patient only claims a refund according to the legislation of his state of affiliation, then the requirement of the prior authorisation violates Article 49 EC. On the other hand such a requirement may be justified in relation to hospital treatment. Authorisation may be refused “only if treatment which is the same or equally effective for the patient can be obtained without undue delay within the territory of the Member State in which the insured person’s sickness fund is established”.²⁸ Completing *Müller-Fauré/van Riet*, the *Inizan* judgement states that authorisation is necessary for hospital treatment abroad, even if the health care system to which the patient is affiliated does not operate in benefits

25 Case C-385/99 - *Müller-Fauré/van Riet* (2003) ECR I - 4509. See *Van der Mei* 2004.

26 *Müller-Fauré/van Riet*, para. 90.

27 Case C-56/2001 - *Inizan* (2003) ECR I-12423.

28 *Inizan*, para. 59.

in kind, but on a refund basis. This ought to be stressed since from the beginning, national systems trying to evade the consequences of the ECJ rulings upheld the opinion that legal constructions of so subsidiary a nature as the arrangement of remunerations and payment may be employed to overrule EC legislation.

5. *Case Leichtle*

The *Leichtle* case²⁹ refers to the question of reimbursement for a thermal cure despite the fact that the authorisation required under German law was refused. Mr. *Leichtle* is an official of the Bundesanstalt für Arbeit (Federal Labour Office; ‘the Bundesanstalt’). He requested the Bundesanstalt to confirm that the expenditure associated with a health cure which he proposed to take at Ischia (Italy) was eligible for assistance under the General Administrative Provisions on Assistance in the event of Sickness, Treatment, Birth and Death, known as ‘the Beihilfevorschriften’ (Assistance Provisions, BhV). That request was rejected by the Bundesanstalt, on the ground that the condition laid down in Paragraph 13(3) (1) of the BhV had not been met. According to the opinion of the Bundesanstalt’s medical officer, the medical information available did not permit the conclusion that the cure provided at Ischia offered much greater prospects of success than the health cures available in Germany.

The patient received a refund of the expenses strictly linked to the cure itself. Other expenses such as transport, hotel, subsistence, tax etc. were qualified for refund only if a medical expert testified that treatment abroad offered “greatly increased prospects of success”. According to the German government this requirement was justified by the need to maintain the financial equilibrium of treatment institutions and competence within the national territory. The court misses an analysis concerning the appropriateness and professionalism of the restrictive measure.³⁰ It states, however, that nothing precludes the state (as the co-paying body in this case) from fixing a maximum “ceiling” of reimbursement for expenses abroad at a level equal to the cost of the same treatment within the national territory. The court feels that a patient who has appealed against the refusal of the competent institution to grant authorisation to receive treatment abroad, need not wait for the outcome of the appeal procedure: Most patients’ state of health does not allow for long waiting periods. And such a requirement would impair the direct effect of the Treaty provisions.

29 Case C-8/2002 – *Leichtle* (2004) ECR I-2659.

30 *Leichtle*, para. 45.

6. *Cases concerning long-term care – Molenaar, Partridge, Jauch and Gaumain-Cerri/Barth*

Reference has to be made to several Court rulings on long-term care. Social security provisions to cover the risk of dependency on care have since the end of the 1960s been introduced by many, but not all EU Member States.³¹ While South European countries do not provide public care services, Scandinavian countries, particularly Denmark, offer tax-financed care benefits on the communal and regional level. The Netherlands have had a care insurance scheme since 1968; since 1980 this has included home care and since 1989 also domestic services, financed through special taxation based on the Special Health Insurance Law (AWBZ) which will exist even in the Dutch system of the future with privatised paying institutions. Other European countries did not introduce care regulations until the 1990s, e. g. the Austrian Federal Care Benefit Law of 1993, the German Care Insurance Law and the Luxembourg Care Insurance Law of 1998. In France there have been regulations for ‘specific’ care benefits as part of means-tested social aid benefits since 1997. Comparable with the health sector, the current models of dependent care within the EU differ as far as organisational structure, financing and forms of benefit are concerned.³² The guiding thought behind the institutionalisation of this new form of social security had been the growing ratio of old people to the total population and the realisation that the provisions for people dependent on care were insufficient.

Several Commission communications³³ contain explicit references to the growing financial burden on health resources as a consequence of the ageing of society and on necessary measures to uphold the so called “European model of solidarity” or at least equilibrium at national level. In the Commission communication of mid July 1999 on “A concerted strategy for modernising social protection”³⁴ the subject of dependent care is addressed under the general objective: “It is important to provide health care that meets high quality standards and can be financed in the long term”. It reads: “More support must be given to long-term care for the infirm, e. g. by ensuring that the social protection systems provide suitable care offers and reconsider the coverage of care benefits and providers of care.”

31 See *Igl* 1995; *Sieveking* 1998; *Sieveking* 2000.

32 See also: MISSOC; Social protection in the Member States of the European Union, Brussels – Luxembourg 2004.

33 E. g. COM(99) 221 final of 21.05.1999.

34 COM (99) 347 final of 14.07.1999.

The problem of unimpeded transborder utilisation of dependent care benefits arises because Union citizens are market-conscious and want to utilise the form of benefit which is most convenient for them. This, however, puts them into conflict with the traditional, but increasingly redundant principles of social law coordination: the principle of the export of benefits according to Community Law (in the area of health insurance advance of costs for later reimbursement) runs contrary to the national principle of the prohibition of the export of benefits (in the case of a stay abroad, in principle the claim to health and care benefits is suspended).

A number of ECJ decisions are concerned with the conditions of transborder health care as benefits in kind, cash benefits or services. So far none has dealt with the direct transborder provision of dependent care insurance benefits, but there have been decisions on the export of benefits in case of dependency on care.

The question of the exportability of legal claims under German care insurance law is at the centre of the decision in the *Fath-Molenaar/Molenaar* case, which pinpoints the current structural deficiencies of the coordination system of the regulation on social protection of migrant workers and their family members.

The plaintiff is a Dutch citizen with residence in France who is employed in Germany and is voluntarily insured with the defendant statutory health insurance fund. After the defendant had stated that the plaintiff's entitlement to care insurance would be suspended as long as he was living abroad (§ 34 German Code of Social Law XI), the plaintiff filed suit at the social court against the defendant's decision that insurance under and contributions to the German dependent care insurance are compulsory. The plaintiff's wife, who also lives in France and is employed in Germany and who is likewise voluntarily insured against sickness, filed suit for the same reason.

In its ruling³⁵ the ECJ decided that care benefits are to be exported, and the reasons given were as follows: The introduction of a social statutory insurance scheme such as care insurance is unobjectionable as far as Community law is concerned. However, § 34 No. 1 German Code of Social Law XI is in violation of Articles 19 para 1, 23, para 1 and 28, para 1 of Regulation (EEC) No 1408/71. Although both parties agreed that the care insurance scheme is covered by Regulation (EEC) No 1408/71, they differed as to whether care benefits fall within Art. 4 of this regulation. The ECJ considered them to be sick-

35 Case C-160/96 – *Molenaar*, ECR 1998, I-843. From a German perspective see the comments by *Lafrenz* 2002.

ness benefits, “even if they have their own characteristics”. Regarding the differentiation between benefits in kind and cash benefits, the Court stated that benefits covering care in the home or in specialised centres, the purchase of equipment and work carried out indisputably fall within the definition of “benefits in kind” according to Articles 19 para 1, 25 para 1 and 28 para 1 Regulation (EEC) No 1408/71. For the definition of “cash benefits”, the Court developed three criteria distinguishing them from benefits in kind:

- payment of the allowance is periodical,
- the amount of the allowance is fixed and independent of the costs actually incurred, and
- the use of this allowance is largely at the recipient’s discretion.

Thus, according to the Court, a benefit such as care allowance must be regarded as a health insurance cash benefit, as referred to in the relevant Articles of Regulation (EEC) No 1408/71. § 34 German Code of Social Law XI with its provision that entitlement to care benefits is suspended in case of a stay abroad is therefore in violation of Community law.

The ECJ commented again on the export of care benefits in the *Partridge* case, concerned with the export of disability care benefits under British law.³⁶ The 83-year-old plaintiff (a British citizen) who was receiving a state pension and a civil service pension in the United Kingdom, had been granted disability care benefit in 1992. In 1993 she left the United Kingdom to live in France with her son. Payment of the benefit was suspended on the grounds that her stay in France was not intended to be temporary. The ECJ emphasised that the benefit in question was mentioned in Appendix IIa to Regulation (EEC) No 1408/71 and therefore represented a non-contributory special benefit, as per Art. 4 para 2a Regulation (EEC) No 1408/71, which falls under the coordination rules of Art. 10a. Consequently, the plaintiff was entitled to disability care benefit, payable in cash, only in the Member State of her residence according to that state’s regulations.

The classification of care benefits under national law that is apparent in the *Partridge* decision sheds new light on a specific coordination problem. The legal and social consequences of the *Molenaar* decision are that the German legislator has to change Vol. XI of the Code of Social Law. For non-German citizens of the Union the decision means that after their return to their native country they are only entitled to care benefits under German care insurance

36 Case C-297/96 – *Partridge*, ECR I998, I-3467.

law if they have retained their insurance cover. So far it has not been investigated how many people make use of the possibility of continuing their insurance membership from abroad. In case they have not done so (or could not do so), they are subject to their respective country's social security system and would not be entitled to German care benefits. Thus, it can be argued that the decision has been basically beneficial for German old-age pensioners on Mallorca, but not for migrant workers returning to their native country.

Two further ECJ decisions should be mentioned: In the *Jauch* case³⁷ the Court ruled that the Austrian care allowance, which is to be regarded as a sickness benefit in cash, must be provided irrespective of the Member State in which a person reliant on care, who satisfies the other conditions for receipt of the benefit, is resident. In consequence Article 19 (1) of Regulation (EEC) No 1408/71 precludes entitlement to Pflegegeld (care allowance) under the Bundespflegegeldgesetz (Austrian Federal Law on care allowance) from being subject to the condition that the person reliant on care must be habitually resident in Austria.

Recently the Court judged on the meaning of the exportability of the German Pflegegeld, which must “be regarded as a sickness insurance “cash benefit”, as referred to in [Article] 19(1) (b) ... of Regulation (EEC) No 1408/71.”³⁸ Ms *Gaumain-Cerri*, of German nationality, and her spouse, who is French, reside in France and practise their profession on a part-time basis as frontier workers in an undertaking established in Germany. By virtue of that employment, both are covered by German care insurance. Their son, who lives with them, is handicapped and, as a dependant of his parents, receives care insurance benefits, namely the care allowance. The parents themselves, at home and on a voluntary basis, are in the role of carers providing assistance to a reliant person. However, the KKH care fund, the body providing insurance against the risk of reliance on care in this case, refuses to pay the old age insurance contributions of Ms *Gaumain-Cerri* and of her husband in respect of their activity as carers for a reliant person on the ground that they are not resident within Germany. For her part, Ms *Barth*, who is of German nationality, is resident in Belgium, near the German border, and looks after a retired civil servant in Germany. She receives from the latter EUR 400 per month. The assistance provided by Ms *Barth* is regarded, in the light of the relevant provisions of the SGB, as non-professional. The reliant person whom she assists is in receipt of care insurance benefits from two bodies, the Landesamt für Be-

37 Case C-215/99 – *Jauch*, ECR 2001, I-1901.

38 Joint cases C-502/01 – *Gaumain-Cerri* – and C-31/02 – *Barth*, ruling of 8 July 2004, ECR 2004, I-6483, para. 36.

soldung und Versorgung Nordrhein-Westfalen, as the basic social insurance provider for retired civil servants, and the PAX Familienfürsorge Krankenversicherung ('the PAX'), as an additional insurer under a compulsory private care insurance policy the conditions of which are required by law to be identical to those applicable to the basic social insurance.

For reasons similar to those put forward in respect of Ms Guamain-Cerri, regarding the fact that she is resident outside Germany, the Landesversicherungsanstalt Rheinprovinz discontinued payment of the contributions enabling Ms *Barth* to acquire pension rights which until then the PAX and the Landesamt had made.

Referring to the *Molenaar* case the court stated that "the term 'benefits in kind' does not exclude the possibility that such benefits may comprise payments made by the debtor institution, in particular in the form of direct payments or the reimbursement of expenses, and that 'cash benefits' are essentially those designed to compensate for a worker's loss of earnings through illness".³⁹ In addition the court referred to the finding in the *Molenaar* case that "care insurance benefits consist, first, in the direct payment or reimbursement of expenses incurred as a result of the insured person's reliance on care, in particular medical expenses entailed by that condition. Such benefits, which are designed to cover care received by the person concerned, both in the home and in specialised centres, purchases of equipment and work carried out, indisputably fall within the definition of 'cash benefits' referred to in [Article] 19(1) (a) ... of Regulation (EEC) No 1408/71"⁴⁰. However, although the care allowance is also designed to cover certain costs entailed by reliance on care, in particular those relating to aid provided by a third person, rather than to compensate for loss of earnings on the part of the recipient, it nevertheless displays features distinguishing it from sickness insurance benefits in kind.

The Court ruled: "However, in cases such as those constituting the subject-matter of the main proceedings, refusal to pay the old age insurance contributions on behalf of a third party assisting a reliant person on the ground that he is not resident in the competent State, the legislation of which is applicable, leads to different treatment of persons finding themselves in the same situation, that is to say of providing assistance on a non-professional basis, within the meaning of the legislation of the competent State, to persons covered by the care insurance provided for under that same legislation. In that context, in view of the purpose of the activity carried on by third parties assisting reliant persons, the condition as to residency of such third parties appears to afford dif-

39 Id., para. 31.

40 *Molenaar*, para. 30 seq.

ferent treatment to comparable situations, rather than to constitute a factor objectively establishing a difference in their situations and thus justifying such different treatment, and therefore constitutes discrimination prohibited by Community law.”⁴¹

7. *Recent judgements concerning pensioners – Ioannidis and Van Der Deuin*

Only recently the Court had to rule on cases concerning health care rights of pensioners. The *Pierik* cases mentioned above concerned a pensioner who could not claim the more favourable status provided for pensioners by Article 31 of Regulation (EEC) No 1408/71. The case *Ioannidis*⁴² refers to the relationship between Articles 22 and 31 of Regulation (EEC) No 1408/71. Article 22 concerns workers in general, while Lead Article 31 specifically targets pensioners. The difference of these provisions is fundamental: On the one hand Article 22 allows only for benefits which become immediately necessary during a stay in the territory of another Member State and, secondly, after prior authorisation delivered by the competent home institution. On the other hand, article 31 recognises rights to pensioners “staying in the territory of a Member State other than the one in which they reside”, contains no reference to any urgency requirement and makes no mention of any authorisation procedure.

Ioannidis affiliated to the Greek social security fund is a retired worker. He received hospital treatment while visiting his son and wife in Germany. He then asked the German fund to pay for his treatment. The German fund refused payment and asked the Greek social security fund to issue another Form for his patient which documented authorisation of hospital treatment delivered abroad. According to Greek law an ex-post authorisation of hospital treatment could only be delivered exceptionally where an illness manifested itself suddenly while the patient was staying in another country or had to be transferred urgently in order to avoid a real risk to his life. Considering the fact that the patient’s illness was chronic and the deterioration was not sudden, the Greek fund refused the Form. The court ruled that Articles 31 and 36 of Regulation (EEC) No 1408/71 must be interpreted as meaning that enjoyment of the benefits in kind guaranteed by the provision to pensioners staying in a Member State other than their state of residence is not subject to the condition that the illness which necessitated the treatment in question manifested itself suddenly during such a stay, making that treatment immediately necessary. That provi-

41 *Gaumain-Cerri/Barth*, Para. 35.

42 Case C-326/00, *Ioannidis* (2003) ECR I-1703.

sion, therefore, precludes a Member State from subjecting that entitlement to such a condition.

In the *Van Der Deuin* judgement the court confirmed that authorisation was indeed required by pensioners who moved to another Member State for the purpose of receiving treatment.⁴³ According to Article 28 of Regulation (EEC) No 1408/71 two Dutch pensioners had taken residence in other Member States and had “moved” their health care rights to the institutions of the place of their residence. This provision allows pensioners to receive benefits in kind by the institution of the state of their residence, and at its own expense as if they were pensioners in this latter state. In consequence, during their long-term residence in another Member State, the institution of this state is required to act as the “home institution”. In the course of this period, if the pensioner decides to go to another Member State in order to receive treatment, he has to receive prior authorisation by the institution of the place of his residence even if he is moving to his country of origin.

8. *The pending case Watts*

The case *Watts* is pending at the Court. The basic facts are the following: In September 2002 Yvonne *Watts* was told she had osteoarthritis in both hips and would need a total hip replacement on each side. Mrs. Watt’s daughter requested authorisation for Mrs. *Watts* to receive treatment abroad. In the context of this application the examining consultant stated that Mrs. *Watts* was in as much need of a hip replacement as any of the other patients on his waiting list, that her case was “routine” and that she would have to wait approximately one year for treatment. The request for treatment abroad was refused by Bedford Primary Care Trust (PCT) as the treatment could be provided within NHS targets and therefore without “undue delay”.

The case *Watts* concerns for the first time a country with a National Health Service, namely the United Kingdom. The illuminating question of this case will be whether in the light of the above mentioned ECJ jurisprudence United Kingdom nationals are entitled to receive hospital treatment in other EU Member States. In his Opinion of 15 December 2005⁴⁴ Advocate General Geelhoed suggests that the current NHS system for granting authorisation for treatment abroad is incompatible with Community law. The sole use of NHS targets to determine whether a person can receive treatment without undue delay does not take sufficient account of the individual needs of each patient. Under

43 Case C-156/01, *Van Der Deuin* (2003) ECR I-7045.

44 Press release No. 112/05, Advocate General’s Opinion in Case C-372/04 – *Watts*.

Community law a person is entitled to receive services throughout the EU. These include certain medical services. The E-112 scheme allows people to apply for authorisation to travel abroad for treatment. Authorisation may not be refused if the treatment is one which is normally provided and cannot be granted without undue delay in the home Member State. The sickness insurance fund is then obliged to reimburse the person for the costs incurred.

The Advocate General considers that the absence of a clearly defined procedure within the NHS for considering applications for treatment abroad restricts the possibilities for patients to seek treatment outside the system. It therefore constitutes a restriction of their freedom to receive services and is contrary to the EC Treaty. He also states that the authorisation procedure in its present form is incompatible with the EC Treaty. The sole criteria of whether the treatment can be provided with the NHS Plan targets does not take the individual needs of patients sufficiently into account. In order to be compatible with Community law, the Advocate General suggests that waiting lists must be managed in a dynamic and flexible way, with regular reassessment and maximum waiting times set so as to balance the needs of the patient with the need to allocate limited resources. Furthermore, Advocate General Geelhoed considers that the concept of “undue delay” must be determined with regard to the specific circumstances of each case, taking into account not only the patient’s medical condition but also his medical history, with the prime consideration being whether the condition of the patient would make any postponement of treatment unacceptable. Waiting times and clinical priorities may be taken into account where they are determined on the basis of individual needs. Targets for providing treatment do not, in view of their abstract character, comply with this criterion. The management of hospital care in a situation of limited resources and the fact that health care is provided free at the point of delivery, both of which relate to the economic organisation of the NHS, cannot be taken into account.

Where a Member State, after having refused prior authorisation, is required to reimburse an individual for treatment which he/she received abroad, the Advocate General states that this must be at the level which would have been reimbursed had the treatment being carried out in the home Member State. If such tariffs do not exist in the home Member State, for example because treatment is provided free at the point of delivery, reimbursement must be made at the level of the actual cost of the treatment, that being the only remaining point of reference. On this point the Advocate General notes that such tariffs should exist in the UK so as to determine the costs that must be paid by foreign visitors receiving treatment from the NHS. As to the travel and accommodation costs incurred by the patient, these must be refunded where national law provides for the reimbursement of such expenses when treatment is provided

within the country concerned.

The judgement will be given at a later date in 2006. In the light of the preceding rulings one can expect that the Court will follow the Advocate General's Opinion which is not binding on the Court.

VI. The implementation of the ECJ Judgements on the national level – the German experience

Looking at the sequence of the ECJ judgements following the *Kohll* and *Decker* cases, the measure of patient mobility within the EU becomes more evident. There remain questions and uncertainties regarding the procedures of authorisation. Looking at the implementation of the Court's jurisprudence by the Member States,⁴⁵ the German example indeed stands out. The German health care system is mainly characterised by financing through contributions dependent on income level, the principle of solidarity, a high variety of health insurance funds and patients' choice as well as benefits predominantly delivered in kind.⁴⁶ The judgement *Müller-Fauré/van Riet* of May 2003 initiated a process of altering the German compulsory health insurance legislation.⁴⁷ This law modified the fifth social security code by amending § 13. Against the previous territorial restriction of the demand of benefits, the new law determines that insured persons can as a matter of principle make use of care providers in other Member States of the EU and EEA, and make use of cash benefits instead of benefits in kind. The law confines the use of cash benefits to ambulant treatment care and makes the use of hospital benefits abroad dependent on a prior authorisation procedure of the competent insurance fund. Authorisation may only be refused if equal or equally effective treatment from a contract partner of the insurance fund can be acquired in due time. In addition, a new paragraph 140e of the fifth social security code now determines the extension of the benefit in kind principle to cross-border issues. According to § 140e in-

45 See already: Commission Staff Working Paper: Report on the application of internal market rules to health services. Implementation by the Member States of the Court's jurisprudence, SEC (2003) 900 of 28.7.2003; for the German perspective: e. g. *Danner* 2004; *Kücking* u.a. 2005.

46 See *Palm, Nickless* et al. (2000), pp. 44 seq.

47 Entwurf eines Gesetzes zur Modernisierung der gesetzlichen Krankenversicherung (GKV-Modernisierungsgesetz – GMG) that became effective on January 1, 2004. For further details see *Schreiber* 2004; *Altenstetter, Busse* 2005.

insurance funds can provide the insured persons with benefits abroad by means of contracts with foreign benefit providers.

In Germany there are now three different legal foundations opening a way to receive health care in another country of the EEA: First Article 22 Regulation (EEC) No 1408/71 for migrant workers, second reimbursement according to § 13 para. 4 SGB V for any person insured in the social insurance system, and third, the contracts of insurance funds with health care providers in EEA countries based on § 140e SGB V: This may be interesting for people living in special European regions. As to cross-border contracts, this is still a rather limited field of professional endeavours. Apart from lucrative cross-border treatments such as dental protheses (high German prices and co-payments make it attractive if not risk free to go abroad) and spa treatment in Eastern Member States contracting is quite difficult. This is due to the fact that there are no contracts in the foreign country upon which to build. Many German sickness funds feel that contracting individual doctors for need of locally existing umbrella organisations such as the German Associations of Panel Doctors, may be clumsy, difficult and – for lack of sufficient quantities of patients – not even attractive to the foreign partner. There are, however, a number of co-operations with hospitals abroad, above all with those which are close to the border.⁴⁸

VII. Final remarks

Since the first rulings of the European Court of Justice concerning outpatient care in April 1998, many questions have been asked about the possible consequences for hospitals once patients would gain a right to choose care abroad

48 Recently, for the first time the German sickness fund AOK-Brandenburg and Medpol-ska, a Polish provider, agreed upon a contract concerning dental protheses: under authorisation by the German insurance company a German patient insured by the respective social fund may get dental treatment by a Polish dentist in Slubice, see *Weser-Kurier* of 3 December 2005, p. 3. For similar developments see agreements between Hungarian and German dentists, “Gesundheitsversorgung ist selten grenzenlos”, *Frankfurter Allgemeine Zeitung*, 28 February 2006, p. 19. In this context see also the activities of the European Consumer Centre France and the European Consumer Centre Germany which are both hosted by Euro-Info-Consumers. It is a French-German association providing European consumers with legal advice and information, informing consumers about their rights and obligations within the Internal Market, about means of redress in case of cross-border consumer complaints and about existing organisations and authorities providing assistance and help throughout Europe. Euro-Info-Consumers is located in the Kehl/Strasbourg agglomeration, in the French-German border region. Euro-Info-Verbraucher, <http://www.euoinfo-kehl.com/>>.

instead of at home. Even though the famous cases *Kohll* and *Decker* did not touch inpatient care, it became clear to many that in one way or another a European market of health care was in the offing. With a quick glance at growing waiting lists in as many as ten EU Member States it was clear to almost everybody that this was going to be next on the agenda of the ECJ.⁴⁹ In the cases *Smits-Geraets* and *Peerbooms* Dutch patients had decided to get treatment not in their home country but in Germany and Austria respectively. The local courts decided to let the ECJ answer a few key questions as to the definitions of EU basic freedoms of goods and services and national prerogatives to confine the insured to care offered and available at home. Although the lines of argumentation were much like those put forth during the hearings of the previous cases dealing with outpatient care, the prospect of potentially huge waves of migration dominated the discussion. This fear was not based on real facts and has never been justified: The ongoing development shows that waves of cross-border migration did not come true.

In the end the Court decided that although prior consent of the nationally responsible paying institution – health insurer or state-run system – to inpatient care abroad would be upheld, the latter would have to be given if adequate care was not available at home “within due course”. This has by now lead to quite striking results: Many national systems of health care had to accept that “cross-border care” is no longer unthinkable. It still will be of great interest how far the Court’s jurisprudence will be implemented all over Europe as it was done in Germany (or France).

There remains a lot of research work. The social rights of the European patients have been strengthened. There will be, of course, a manifest desire to undergo an operation as close to one’s home as possible. Going abroad, often to a country where one cannot speak the language and might only know very little about medical standards and patients’ rights, is just a difficult choice to make. Patients need better information as to how inpatient health care will be consented by the local authorities. There might be a considerable increase on short term basis in the border regions between old and new Member States. It is supposed that contracts of cross-border treatment by the respective partners of the insurance funds will guarantee patients’ rights most effectively.

In April 2005 the Commission presented a communication to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions entitled “Healthier, safer, more confident citizens: a Health and Consumer protection Strategy. Proposal for a decision of

49 For considerations about future developments see SEC (2003) 900 mentioned in footnote 45.

the European Parliament and Council establishing a Programme of Community action in the field of Health and Consumer protection 2007-2013”.⁵⁰ In accordance with its communication on the financial perspectives for 2007-13,⁵¹ the Commission would like to bring together public health and consumer protection policies under one framework. Its proposal for a decision will replace the current programme of Community action in the field of public health (2003-08)⁵² and the general framework for financing Community actions in support of consumer policy for the years 2004 to 2007. The Commission also makes proposals for joint actions and for measures concerning health and consumer protection, and proposes the extension of the current executive agency of the public health programme to include a new department – the Consumer Institute. The Commission also sets out in its communication the means by which the European Union intends to improve health and boost consumer confidence using the powers conferred on it by the Treaty, and stresses the positive synergies which will be achieved by combining the two policies: greater coherence, economies of scale, increased visibility and rationalisation of administrative and budgetary procedures.

The Commission proposes the following objectives: protecting citizens from risks and threats which are beyond the control of individuals and cannot be effectively tackled by individual Member States alone; increasing the capacity of citizens to take better decisions about their health and interests as consumers; incorporating objectives relating to health and consumer protection into all Community policies. In this context the Commission aims at achieving synergies between national health systems facilitating cooperation through the meetings of the High Level Group on Health Services and Medical care and the open method of coordination.⁵³ Community support would include facilitating cross-border health care provision, information exchange, promoting patient safety, support to set up an EU system for centres of reference and providing information on health service.

In its “Report on patient mobility and healthcare developments in the European Union”⁵⁴ the European Parliament, Committee on the Environment, Public Health and Food Safety, presented a number of measures to be implemented in the future, e. g. adopting guidelines on core patient mobility issues

50 COM (2005) 115 final, 6.4.2005. The European health insurance card recently introduced by Decision No 189 of 18 June 2003, OJ L 276 of 27.10.2003, p. 1, is part of the Commission’s strategy to facilitate patient mobility.

51 COM (2004) 487 final, 14.7.2004.

52 See *supra* fn 3.

53 See *Jorens* 2002a; GVG 2004.

54 PE 353.303v02-00, Document of 29.4.2005 (Rapporteur: *John Bowis*), A6-0129/2005.

by 1 January 2007. The Committee encourages the Commission to set deadlines for the collection and evaluation of data on existing cross-border movement of patients and calls on the Commission to make the findings of such studies known as soon as possible. It also strongly endorses efforts to improve knowledge and legislation on the movement of health and social care professionals. A clear and transparent framework for cross-border health care purchasing should be announced very soon as part of the 'High-Level Group on Health Services and Medical Care'.

There will be demands for more precise improvements for patients who desire cross-border health care as well as, e. g., cross-border agreements between financing agencies and service providers⁵⁵ respecting the principle of subsidiarity. There might also be more – and more precise – cooperation at the European level, too. The extended options for health care created by virtue of the Court's jurisprudence must be determined more precisely and implemented through targeted political measures, above all at the national level. Still most countries with waiting lists do not even have an official flyer to inform patients on such lists about their basic EU rights. This may not be altered by Brussels, since with shrinking common ground and crumbling visionary projects galore, these health care aspects are not only quite low on the real agenda but also tend to enrage at least some of the Member States leading to even greater difficulties for future compromising. A positive effect is the recognition of free movement of patients as a component of the right to freedom to which all Union citizens are entitled, on the understanding that there will be limitations justified by general interests. In the end domestic medical care will remain dominant but services will be used in other Member States regardless of limited resources and capacities in some countries or in the face of an existing service and cost gap between (the old and most of the new) Member States.

Regarding the ongoing activities on community and national level my final conclusion will be: The judgements of the Court of Justice concerning the patients' rights to cross-border health and long-term care caused not only an increase of personal rights but even more a fundamental change in understanding what European health policy reciprocal to the European and national level in the future really could mean. There are many proposals concretising the process of implementing the Court's jurisprudence. I am sure: We will witness the emergence of a new European area of health. Systems, more often than not only judged according to their limited expenditure of public funds, will have to understand that civic participation in a new and enlarged health care market will turn patients to consumers and force paying bodies at national level to act

55 For the respective agreements e. g. by *Jorens, Schulte* 2003.

accordingly. Reaching out instead of fencing up might thus become a new and clearly enriched variant of subsidiary systems of health care.

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