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**REPORT ON THE APPLICATION OF INTERNAL MARKET RULES TO HEALTH
SERVICES**

**IMPLEMENTATION BY THE MEMBER STATES OF THE COURT'S
JURISPRUDENCE**

REPORT ON THE APPLICATION OF INTERNAL MARKET RULES IN THE FIELD OF HEALTH-CARE SERVICES

IMPLEMENTATION BY THE MEMBER STATES OF THE COURT'S JURISPRUDENCE

In July 2002 the Commission services launched a consultation process on the follow-up by the Member States to the Court's jurisprudence relating to reimbursement of medical expenses incurred in another Member State (*Kohll and Decker* Judgments (1998), *Smits and Peerbooms* and *Vanbraekel* Judgments (2001)).

This report is based on the information provided by the Member States in response to this consultation and takes stock of the situation with a view to facilitating exchanges of views with the Member States. The aim is to approach the implementation of this jurisprudence in a spirit of co-operation so that patients may benefit from the assumption by the social security systems of the costs for health care received in another Member State, subject to the conditions and limits laid down by the Court.

The Commission services recall that the Court has confirmed that health services are services within the meaning of Article 49 of the Treaty and that, as recipients of these services, patients should be able to benefit from the freedom to provide services as laid down in that Article. The Court makes this fundamental freedom subject to certain conditions aimed at taking account of the specific characteristics of the sector and particularly that medical expenses are assumed by the social security systems in the Member States and that a high level of public healthcare must be ensured.

The *Kohll and Decker* Judgments (1998), and later the *Smits and Peerbooms* and *Vanbraekel* Judgments (2001), have resulted in questioning and reflection in all the Member States but have led to changes in national legislation or practice in only a small number of them. In the *Müller-Fauré/van Riet* Judgment of 13 May 2003, the Court confirmed this jurisprudence and once more explicitly stated the conditions that Member States must fulfil in order to ensure that their healthcare systems are compatible with Community law and Article 49 of the Treaty in particular. The Commission services considered it useful, therefore, to put the responses by the Member States into the context of the guidelines provided by the entire jurisprudence.

Indeed, the Member States do not share a common interpretation of the jurisprudence and do not draw the same conclusions with regard to the right of patients to seek reimbursement for treatment undergone in another Member State, or even the possibility of doing so. Consequently, the situation faced by patients varies depending on their Member State of affiliation. Thus, only a few Member States have recognised the right to reimbursement for certain non-hospital services, even in the absence of prior authorisation as laid down by the Court. In all the other Member States, the reimbursement of the costs of healthcare (whether hospital or non-hospital) provided in another Member State is covered by a system of administrative authorisation. The conditions for granting such authorisation, the procedure and the time taken, mean that a fundamental freedom guaranteed by the Treaty might well be rendered ineffective.

Judging from the figures provided by the Member States, patient mobility is currently negligible. The majority of medical treatments undergone in another Member State are covered by the authorisation forms provided for by Regulation 1408/71 and, in the case of treatment voluntarily undergone in another Member State, the E-112 form. The largest number of patients from other EU Member States treated in a single Member State under the E-112 form was 14,061, in 2000 and cost €25,907,697. There are generally few requests for authorisation for treatment in another Member State, with only two countries receiving more than 10,000. The amounts mentioned were insignificant in the Member States that apply the *Kohll and Decker* Judgments and collect relevant data: the country with the highest number of insured persons to benefit from non-hospital treatment abroad - in a future Member State - (58,030 persons per year, or 1.0517% of the total number of persons insured) spent €3,445,470 - or 0.03% of its social security budget - on such care.

STRUCTURE OF THE REPORT

This report follows the order of the questions set out in the annex of the letter from the Commission services to the Member States of 12 July 2002.

INTRODUCTION

1. Follow-up to this case-law at national level:

- a) are discussions in progress?
- b) are any specific measures envisaged or have any already been adopted?
- c) how are the national authorities, institutions and courts applying this case-law?

The Kohll and Decker Judgements

The Smits and Peerbooms Judgement

The Vanbraekel Judgement

Disputes

2. The system of prior administrative authorisation:

- a) is there a system of prior administrative authorisation for domestic access to health care services and/or for access to such services in another Member State?
- b) what is the scope of such a system? Does it cover only medical treatment provided in a hospital or does it also include medical treatment provided by medical practitioners in their practices or in patients' homes?
- c) what are the conditions for the granting of such authorisation?
- d) what is the procedure to be followed in order to obtain it?
- e) what means of redress are available if it is refused?

A system of prior administrative authorisation applicable exclusively for access to health care services in another Member State.

Conditions for granting authorisations.

Procedure for granting authorisation and possibility of redress in the event of refusal

3. The economic and social aspect :

- a) are any data available on:
 - the number of patients who are nationals of other Member States who have received treatment in your Member State,
 - the number of individuals in your Member State who have applied for authorisation for treatment in another Member State,
 - the percentage of authorisations granted and the number of patients who have claimed, without having had prior authorisation, for reimbursement of expenses incurred in another Member State?
- b) what is the number of cases covered by forms issued on the basis of the provisions of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72?
- c) what are the amounts reimbursed and/or defrayed on the basis of the relevant provisions of these regulations and on the basis of cases outside the scope of the regulations?

Number of patients who are nationals of other Member States treated in your Member State.

Number of individuals in your Member State who have applied for authorisation for treatment in another Member State.

Percentage of authorisations granted and the number of patients who have, without prior authorisation, claimed for reimbursement of expenses incurred in another Member State.

4. Public health and the possible impact of patient mobility on the health care system of your Member State :

- a) are there any agreements between health authorities concerning the treatment of patients coming from another Member State, particularly for border regions?
- b) do you intend to put in place quality assurance procedures in this context ?

CONCLUSIONS

ANNEXES

ANNEX 1: Letter from the Commission services to the Member States of 12 July 2002.

ANNEX 2: Data on patient mobility.

Table 1: Number of patients who are nationals of other Member States treated in your Member State

Table 2: Number of individuals who have applied for authorisation for treatment abroad

*Table 3: a) Percentage of authorisations granted
b) Number of individuals who have claimed reimbursement without having had prior authorisation*

INTRODUCTION

1. In its judgments of 28 April 1998 in the *Kohll* (C-158/96) and *Decker* (C-120/95) cases and of 12 July 2001 in the *Smits and Peerbooms* (C-157/99) and *Vanbraekel* (C-368/98) cases¹, the Court of Justice ruled on the question of reimbursement of medical expenses incurred in a Member State other than the Member State of affiliation. This jurisprudence was reaffirmed, refined and amplified in the *Müller-Fauré/van Riet* Judgment of 13 May 2003 (C-385/99)².
2. By letter of 12 July 2002 to all the Member States, the Commission services reminded Member States of the Court's position and asked the national authorities to provide, using the questionnaire attached to the letter, information on measures taken at national level to comply with this jurisprudence³. In this letter, the Commission services pointed out that the Member States were responsible for managing their social security systems and hence it was also for them to amend their legal framework and internal practices, if necessary, to ensure their compatibility with Community law as interpreted by the Court.
3. The Commission services point out that this report is without prejudice to positions taken by the Commission in the context of infringement proceedings and preliminary rulings. They point out that they are indeed dealing with an increasing number of complaints from individuals who consider that their Member State of affiliation does not respect the conditions laid down by the Court. It is for the Commission, in its role as Guardian of the Treaties, to initiate the procedure laid down in Article 226 of the Treaty to ensure that Community law as interpreted by the Court is respected. The Commission services point out that certain complaints are the subject of both a national proceedings and a complaint to the Commission. The Commission services also emphasise that several preliminary rulings have been submitted by national courts to the Court of Justice under Article 234 of the Treaty⁴.
4. In view of the scope of these judgments, the Commission considers it necessary to engage in a general reflection and to involve the Member States in a constructive dialogue. This desire for a dialogue is in line with the Commission Communication of 11 December 2002 on better monitoring of the application of Community law.⁵ This report should also be a valuable contribution to the work of the High Level Reflection Group on Patient Mobility and Healthcare Developments in the European Union.

¹ Kohll Judgment, Case C-155/96 of 28 April 1998, ECR 1998 p. I-1931, Decker Judgment, Case C-120/95 of 28 April 1998, ECR 1998 p. I-1831, Smits and Peerbooms Judgment, Case C-157/99 of 12 July 2001, ECR 2001 p. I-05473, Vanbraekel Judgment, Case C-368/98 of 12 July 2001, ECR 2001 p. I-05363

² V.G. Müller-Fauré c/ Onderlinge Waarborgmaatschappij O.Z Zorgverzekeringen UA (C-385/99) and E.E. M. Van Riet c/ Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen
³ The letter is enclosed with the present report.

⁴ Patricia Inizan v. Caisse Primaire d'Assurance Maladie des Hauts de Seine (C-56/01); Ludwig Leichtle v. Bundesanstalt für Arbeit (C-8/02); Eva-Maria Weller v. Deutsche Angestellten-Krankenkasse (C-322/02); Karin Bautz v. AOK Baden Württemberg (C-454/02-1).

⁵ Communication of 11 December 2002, COM(2002) 725 final.

5. This report presents in summary form the information provided by the Member States following this consultation. Only Greece did not reply. For a better understanding of the situation, Member States are identified in the part of the report concerning the socio-economic data related to patient mobility. This report aims to take stock of the situation with a view, among other things, to facilitating an exchange of views with the Member States. It should be pointed out that in the *Müller-Fauré/van Riet* Judgment of 13 May 2003 the Court confirmed this jurisprudence and once more explicitly stated the conditions that Member States must fulfil in order to ensure that their healthcare systems are compatible with Community law, and particularly Article 49 of the Treaty. The Commission services considered it useful, therefore, to put the responses by the Member States into the context of the guidelines provided by the entire jurisprudence.
6. The aim is to approach the application of these judgments in a concerted and consistent manner so that patients obtain, subject to the conditions and limits laid down by the Court, reimbursement for medical services received in another Member State. Patients, health professionals and those responsible for healthcare systems all need to be given greater legal certainty in the exercise of a fundamental freedom guaranteed by the Treaty.

1. Follow-up to this case law at national level
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| <ol style="list-style-type: none">a) are discussions in progress?b) are any specific measures envisaged or have any already been adopted?c) how are the national authorities, institutions and courts applying this case law? |
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7. The jurisprudence of the Court with regard to the reimbursement of medical expenses incurred in another Member State has generated considerable interest in the Member States and particularly with the national social security bodies. The *Kohll* and *Decker* Judgments, and subsequently the *Smits and Peerbooms* and *Vanbraekel* Judgments have gradually made Member States aware that the mechanisms of the Internal Market apply to certain issues related to the health sector, regardless of how the social security systems are organised (reimbursement, benefits-in-kind or national health service). The *Müller-Fauré/van Riet* Judgment once again shows that there is no need, from the perspective of freedom to provide services, to draw a distinction between the various national health-insurance systems.
8. Inter-ministerial working parties (Ministries of Health, Social Affairs and Budgetary Affairs) or joint working parties (involving bodies responsible for the administration of social security) have often been set up to evaluate the impact of this jurisprudence at national level and to make recommendations on measures to apply it.

The Kohll and Decker Judgments

9. The Member States reacted extremely cautiously to the *Kohll* and *Decker* rulings. This was because they considered that these judgments would only apply to those Member States that operated a system of reimbursement and that the Court's arguments could not be extrapolated to Member States with different social security systems. In the Member States operating a reimbursement system, the application of the judgments was patchy. For example, one Member State decided as a precautionary measure not to take account of this case law. These Member States ultimately acknowledged the possibility of reimbursement without prior authorisation for certain medical products and services supplied in another Member State. However, the definition of the products and services falling in this category varies considerably and the approach followed is often restrictive. Hence, in one Member State only optical products are reimbursed without prior authorisation; in another, costs are reimbursed only on condition that a total ceiling per trip abroad is not exceeded. Similarly, in one Member State the cost of out-patient treatment at a hospital is reimbursed without prior authorisation, while, in another, any treatment administered at a hospital is reimbursed only if there is prior authorisation.
10. Generally speaking, Member States that operate a system other than reimbursement have not adopted measures exempting certain medical services from the obligation of prior authorisation for the purpose of reimbursement. Indeed, several of them argue that the reasons acknowledged by the Court in the *Smits and Peerbooms* Judgment as justifying the principle of prior authorisation (planning so as to ensure sufficient and permanent access to a balanced range of high-quality hospital treatment, avoidance of the risk of seriously undermining the financial balance of the social security system, control of costs in order to prevent as far as possible of any wastage of financial, technical and human resources) entitle Member States operating a system of benefits-in-kind or a National Health Service to apply this requirement to medical services whether provided in a hospital or not. Several Member States mentioned in this context that the Court would have to make a ruling on the *Müller-Fauré/van Riet* case, which concerned non-hospital treatment given to a patient covered by a system of benefits in kind.
11. The Commission services would point out that in its judgment of 13 May 2003 on the *Müller-Fauré/van Riet* case the Court reaffirmed the distinction between hospital and non-hospital services already present in the *Smits and Peerbooms* Judgment as regards the prior authorisation requirement for the assumption of costs (under a national security system) of hospital treatment provided in another Member State. It has thus reaffirmed that, where non-hospital services are concerned, this requirement constitutes an unjustified obstacle to the cross-border provision of services and should be removed. Moreover, one Member State applying a system of benefits-in-kind stated that it reimburses non-hospital treatment received in a future Member State without prior authorisation. This example tends to endorse the observation made by the Court in the *Müller-Fauré/van Riet* Judgment (point 105) to the effect that it would be possible to include reimbursement arrangements in a system of benefits-in-kind or a National Health Service without calling into question the essential characteristics of such systems.

The Smits and Peerbooms Judgment

12. Two points from the *Smits and Peerbooms* Judgment particularly caught the attention of the Member States: firstly, the fact that Community law is not *per se* opposed to a prior authorisation procedure and, secondly, the fact that this authorisation cannot, on the other hand, be refused if an identical or an equally effective treatment cannot be obtained "without undue delay" from an establishment with which the insured person's sickness fund has contractual arrangements.
13. Following the Court's reasoning with regard to the possibility of maintaining a system of prior authorisation, the Member States interpret the actual scope of this authorisation in different ways. The Court indeed accepted 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 specific characteristics that justified the use of a system of authorisation. Some Member States reject this distinction, arguing that a prior authorisation procedure is essential to the planning of their own health systems and that, in order to ensure the effectiveness of this planning, such a requirement should apply to any medical treatment that patients may obtain in another Member State. Other Member States require such authorisation only for hospital services. The definition of hospital services also varies. Some Member States adopt a broad definition, including establishments known as hospitals, clinics, maternity homes, spas, rehabilitation centres, convalescent homes and nursing homes. On the other hand, as mentioned above, one Member State takes the view that patients do not need prior authorisation in order to receive out-patient treatment.
14. In the *Müller Fauré-Van Riet* Judgment, the Court clarified these points. As stated above in point 10, the Court reaffirmed that the prior-authorisation requirement constitutes an unjustified obstacle to the cross-border provision of non-hospital services and should be removed. At the same time, the Court took the precaution of listing a number of reasons why the removal of such a requirement would not result in a serious financial impact on the national health systems.

As regards hospital services, the Court admits that prior authorisation may be justified. As in the *Smits and Peerbooms* Judgment, the Court lays down conditions which an authorisation system must fulfil in order to be compatible with Community law.

The Court nevertheless notes that the distinction between hospital services and non-hospital services may sometimes prove difficult to draw. It can be concluded that:

- the reasons of general interest acknowledged by the Court as justifying an authorisation requirement are intrinsically linked to the hospital context and can apply only to hospital treatment;
- these reasons of general interest do not apply in the case of treatment provided in a hospital environment but which are also capable of being provided by a practitioner in his surgery or in a health centre. The Court therefore applies a narrow definition of hospital services;
- as regards non-hospital services, the Court draws a distinction between the administrative authorisation that should be removed and the conditions on which benefits are granted, which

remain enforceable (paragraph 106). The Court quotes the example of the requirement that a general practitioner should be consulted prior to consulting a specialist.

15. Among the conditions laid down by the Court to ensure that a system of authorisation complies with Community law, it is the criterion of medical necessity as interpreted by the Court which has given rise to the most comment. This is because in paragraph 103 of the *Smits and Peerbooms* Judgment, the Court considers that authorisation may only be refused where a treatment that is identical or equally effective can be obtained without undue delay from an establishment with which the insured person's sickness fund has contractual arrangements. In paragraph 104 of that same judgment, the Court makes this concept of "without undue delay" dependent solely on the medical condition of the patient. This condition imposed by the Court seems particularly relevant in the context of the waiting lists, sometimes long ones, existing in certain Member States for patients to obtain treatment. Nevertheless this is contested; some Member States object that this condition cannot apply automatically. One Member State argues that even if the medical state of the patient is to be the main criterion for authorisation, it cannot be the only one. Due account has also to be taken of the number and medical state of individuals awaiting that treatment in that Member State. However, one Member State has actually adopted measures aimed at allowing patients to go to hospitals in other Member States if the waiting period is more than two months. The waiting times are shorter in the case of life-threatening illnesses. The authorities of that Member State have concluded contracts with hospitals in other Member States to which to refer these patients. This contractual approach, intended to provide a temporary solution to the waiting list situation in certain Member States, appears to be being followed by others. Some Member States mentioned bilateral agreements aimed at providing a legal framework for receiving patients who are on a waiting list in another Member State. Specific programmes have been set up in some Member States for assuming the entire medical and non-medical costs of treatment provided outside the national territory.
16. In the *Müller Fauré-Van Riet* Judgment, the Court complemented its assessment of the condition concerning the necessity of the treatment. It unambiguously confirms that this condition must be considered exclusively on the basis of all the circumstances of each individual case. The Court once more stresses that account must be taken not only of the patient's medical condition at the time when the authorisation is sought but also of the patient's medical history. It states that account should be taken of the degree of pain or the nature of the patient's disability, which might, for example, make it impossible or extremely difficult to carry out a professional activity. The Court explicitly dismisses the existence of waiting lists in the Member State of affiliation as a valid reason for refusing to grant prior authorisation for treatment in another Member State. Indeed, where the concrete circumstances of the patient's health condition are not taken into consideration, the obstacle to the fundamental principle of the free provision of services (the prior authorisation) cannot be justified any longer by the protection of public health. On the contrary, a waiting time which is too long or abnormal would be more likely to restrict access to balanced, high quality hospital care.
17. The other conditions stipulated by the Court (objective, non-discriminatory criteria which are known in advance; possibility of appeal in the event of refusal) do not give rise to any specific comments. One Member State, however, said that the national authorisation procedure provided for in Article 22(1)(c) of Regulation 1408/71 was being examined in the light of the jurisprudence. Generally speaking, Member States

take the view that their authorisation schemes meet the requirements of the jurisprudence as regards proportionality.

18. The adoption of the maximum waiting periods mentioned above and the amendment of one Member State's legislation in order to permit the purchase of goods and services in other Member States seem therefore to be the only specific measures adopted in relation to the *Smits et Peerbooms* Judgment and now the *Müller Fauré-Van Riet* Judgment.

The Vanbraekel Judgment

19. The application of the *Vanbraekel* Judgment seems to raise a number of issues. Once again the Member States seem to be of the opinion that this concerns only Member States operating a reimbursement system. Some believe that this judgment applies only if treatment is followed voluntarily in another Member State (E-112) and not in the other situations provided for in Regulation 1408/71 (for example, the E-111 form for persons temporarily living in another Member State).

Disputes

20. Even if disputes are more common in some Member States than in others, the majority refer to cases brought before their national courts. The purpose of some of these legal actions is to have the authorisation requirement declared contrary to Community law. Others contest the legality of the criteria for granting this authorisation in the light of the conditions mentioned by the Court. The Member States point out that these cases have not yet been settled by their higher national Courts.
21. The Commission points out that five judgments have been delivered by the Court⁶ on the question of reimbursement of medical expenses incurred in another Member State, all using the preliminary ruling mechanism laid down in Article 234 of the Treaty and that four references for a preliminary ruling are currently pending⁷.

2. The system of prior administrative authorisation:

- a) Is there a system of prior administrative authorisation for domestic access to health-care services and/or for access to such services in another Member State?
- b) What is the scope of such a system? Does it cover only medical treatment provided in a hospital or does it also include medical treatment provided by medical practitioners at their surgeries or in patients' homes?
- c) What are the conditions for the granting of such authorisation?
- d) What procedure is to be followed in order to obtain it?
- e) what means of redress are available if it is refused?

⁶ See footnote 1 and 2

⁷ See footnote 4

A system of prior administrative authorisation applicable exclusively for access to health-care services in another Member State

22. In the *Müller Fauré-Van Riet* Judgment, the Court drew a distinction between the conditions for the granting of benefits, which include the requirement to consult a general practitioner before consulting a specialist, and administrative authorisation in the strict sense (see point 14 of this report). Thus, while several Member States make the granting of benefits subject to various constraints, they do not make them subject to prior administrative authorisation. In all the Member States, on the other hand, prior administrative authorisation is required for the assumption of the costs of medical treatment in another Member State. As mentioned in the previous chapter (see point 13), the actual scope of this authorisation varies from one Member State to another and only a few of them make a distinction between hospital and non-hospital treatment.
23. The procedures for granting benefits vary widely from one Member State to another. In the Member States with a system of reimbursement, access to benefits is in general free. In those operating a system of benefits-in-kind, patients must normally go to a practitioner who has been contracted by the social security bodies; they must be granted an authorisation for consulting non-contracted care providers. In the Member States with a national health service, patients are registered with a "reference" doctor, who in one Member State is designated by the administrative authority. In other Member States, patients can choose their reference doctor within a given geographical area; once registered they cannot freely change. The reference doctors are regarded as the gatekeeper of the system since, on the one hand, patients are required to seek primary care services from them and, on the other, the reference doctors are responsible for referral of patients to specialised or hospital care. In all Member States - even those where access to treatment is not subject to such conditions - certain specialised treatments (dental prostheses, orthodontic treatment, physiotherapy, spa treatment) are subject to the opinion of the medical officers employed by the social security organisations.

Conditions for granting authorisations

24. Several Member States report that they authorise the assumption of the costs of medical treatment received in another Member State only in the cases specified in Article 22(2), second subparagraph, of Regulation (EEC) 1408/71.

– Article 22(1) of this Regulation reads as follows:

"A worker who satisfies the conditions of the legislation of the competent State for entitlement to benefits, taking account where appropriate of the provisions of Article 18, and:
[a) ...b) ...]

c) who is authorised by the competent institution to go to the territory of another Member State to receive there the treatment appropriate to his condition, shall be entitled [i) ...ii) ...]"

(i) to benefits in kind provided on behalf of the competent institution by the institution of the place of stay or residence in accordance with the provisions of the legislation which it administers, as though he were insured with it; the length of the period during which benefits are provided shall be governed, however, by the legislation of the competent State [ii ...]

– Article 22(2), second subparagraph, stipulates:

"The authorisation required under paragraph 1(c) may not be refused where the treatment in question cannot be provided for the person concerned within the territory of the Member State in which he resides."

In its judgment in the *Kohll* case, the Court indicated that Article 22(1) of Regulation N° 1408/71 is intended to allow an insured person, authorised by the competent institution to go to another Member State to receive there treatment appropriate to his condition, to receive sickness benefits- in-kind, on account of the competent institution but in accordance with the provisions of the legislation of the State in which the services are provided, without that person incurring additional expenditure.

25. The Commission services would point out that, in its judgment in the *Kohll* case, the Court stated that this article is not intended to regulate, and hence does not in any way prevent, the reimbursement by Member States, at the tariffs in force in the competent Member State, of costs incurred in connection with treatment provided in another Member State, even without prior authorisation. Indeed, the Court confirmed this interpretation in its subsequent rulings by accepting the possibility for a Member State to demand an authorisation only where such a measure was justified, appropriate and proportionate. The Commission services therefore wish to draw the attention of the Member States to the fact that the systematic requirement of an authorisation granted on the basis of the minimum conditions set out in Article 22(2), second subparagraph, of Regulation (EEC) 1408/71 is not in conformity with Community law as interpreted by the Court. Indeed, one Member State has expressly acknowledged, following the *Kohll* and *Decker* Judgments, that these judgments have put an end to the way in which Article 22(1)(c) of Regulation 1408/71 has been interpreted for nearly 40 years. The Commission services would point out that, in the *Müller-Fauré* Judgment, the Court has clarified the scope of authorisation, as described in point 14 of this report.
26. However, several Member States apply more favourable conditions than the minimum conditions laid down in Article 22(2), second subparagraph.
27. Some Member States subject the granting of authorisation to the conditions that the treatment be "normal" and "necessary". These conditions were examined by the Court in the *Smits and Peerbooms* Judgment. In relation to the criterion of medical necessity, it should be pointed out that national legislation often specifies that the authorisation can be granted only in cases where the treatment is not available or not available within a reasonable time, in the Member State of affiliation. In some national legislation, the criterion of medical necessity is spelt out more explicitly, referring to the greater chances of success in another Member State or to hospital care provided in better conditions abroad.
28. The Commission services would point out that the Court has specified the criteria which such conditions have to meet in order to comply with Community law. In particular, the Court stated that the determination of whether a treatment is normal had to be based on criteria that were objective, non-discriminatory and known in advance, and that the decision had to be capable of being challenged in judicial or quasi-judicial proceedings. The Court further stated that only an interpretation on the basis of what is sufficiently tried and tested by international medical science can be regarded as satisfying these criteria. Similarly, the Court stated that the medical

necessity for a particular treatment had to be assessed in the light of the concrete circumstances of the patient concerned. As mentioned in point 16 of this report, in the *Müller-Fauré/van Riet* Judgment, the Court stated this criterion explicitly and mentioned certain aspects that should be taken into account when assessing the patient's condition. However, none of the Member States applying these criteria has amended its legislation to reflect the requirements of the Court's jurisprudence.

29. In some instances, national legislation allows for the possibility of obtaining authorisation for treatment in another Member State in the case of highly specialised treatments requiring scarce professional skills or high-technology equipment. In such circumstances, the non-availability of such treatment nationally is also a criterion for authorisation.

Procedure for granting authorisation and possibility of redress in the event of refusal

30. In general, the procedure for granting authorisation falls into several stages involving both medical and administrative aspects. The general practitioner is often the instigator of the patient's request. In some cases this is a requirement laid down in national legislation. The request is then forwarded to the social security bodies. Depending on the case, the decision on whether or not to authorise is taken at either national or regional level, often after consulting technical committees or medical officers. Only a few Member States have mentioned deadlines for taking these decisions and only one refers to the existence of an urgent procedure with very short deadlines and even the possibility of issuing an authorisation *a posteriori*. One Member State mentions the existence of authorisation request forms. Others state that the application must include certain information such as the pathology, types of treatment envisaged and the hospital where the patient is likely to be treated. On the latter point, some Member States conclude contracts with hospitals in other Member States which may accept patients.
31. If authorisation is refused, there are a number of possible levels of non-judicial settlement. Ultimately, patients can challenge the decision before the national Courts. The competent courts tend to be specialised courts.

3. The economic and social aspects:

- a) Are any data available on:
- the number of patients who are nationals of other Member States who have received treatment in your Member State?
 - the number of individuals in your Member State who have applied for authorisation for treatment in another Member State?
 - the percentage of authorisations granted and the number of patients who have claimed, without having had prior authorisation, for reimbursement of expenses incurred in another Member State?
- b) What is the number of cases covered by forms issued on the basis of the provisions of Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72?
- c) what are the amounts reimbursed and/or defrayed on the basis of the relevant provisions of these regulations and on the basis of cases outside the scope of the regulations?

32. Virtually all Member States supplied economic and social data expressed in terms of either numbers of patients or overall cost. Most Member States, however, were unable to reply systematically to all the questions. In particular, several Member States mentioned difficulties in collecting the information because authorisations are often managed at regional level without being consolidated at national level or because of the slowness of the reimbursement procedures between institutions laid down in Regulation 1408/71, both internally and at Community level (Administrative Committee for the Social Security for migrant workers of Regulation 1408/71). This means that the availability of figures is seriously delayed. While these data may not be sufficient in order to provide the exact scale of patient mobility, they do allow at least an approximate economic assessment of it.
33. Only Belgium and Austria were able to provide detailed information directly linked to the implementation of the *Kohll* and *Decker* Judgments. In Belgium the figures show a large annual increase in the amount spent on reimbursements of medical treatment under *Kohll* and *Decker* in other Member States (+ 54% between 1999 and 2000, +67% between 2000 and 2001), but the amount involved remained insignificant (€224,639 in that Member State in 2001). In Austria, the number of patients voluntarily travelling abroad each year to receive care appears to be steady (58,030 per year). This Member State was reimbursing even before the *Kohll* and *Decker* Judgments.
34. The number of patients or the costs related to the jurisprudence are not proportional to the population. Rather they seem to depend on the geographical location of the Member State in question. It is symptomatic of this that Austria, which has a common border with Hungary where medical costs (dental costs in particular) are lower, reimburses, without authorisation, the largest number of patients for non-hospital medical services. The Austrian authorities point out, as mentioned in point 33 that the number of patients going abroad each year is stable. This Member State boasts the largest number - in absolute terms - of patients treated abroad (58,030), corresponding to 1.0517% of the persons covered by the national insurance scheme. The expenditure amounts to €3,445,470 per year, or 0.03% of the annual social security budget.
35. The Commission services wish to point out that the attitude of the national authorities is important for the development of cross-border provision of services. Indeed, it would appear from the data supplied that patients residing in Member States that have taken steps to implement this jurisprudence are more inclined to exercise a right deriving not only from the Court's decisions but more specifically from the laws of their State of affiliation. In Member States which do not apply this case law, on the other hand, patients do not, on the basis of these judgments by the Court of Justice alone, risk going to another Member State without authorisation. As a result, legal certainty is an essential element in ensuring the effective right of patients to be treated in another Member State.

Number of patients who are nationals of other Member States treated in your Member State

36. It is difficult to compare the data supplied by the Member States, given that some of the figures are expressed in financial terms and others in numbers of patients. Most Member States replied to this question by giving the number of patients treated under E-111 forms (persons temporarily living in another Member State) and E-112 forms

(voluntary care), often cumulatively. The Commission will confine itself, therefore, to providing the following information:

- The figures reveal major differences between Member States. For instance, Belgium indicates having accepted 14,061 patients from other Member States in 2000, in particular from the Netherlands, Luxembourg and Italy, while the United Kingdom for instance accepted 871 patients in 2001.
- In some countries which are popular tourist destinations, by far the majority of patients from other Member States are treated under an E-111 form. Spain indicates having treated 133,958 patients under E-111 form in 2001. By contrast, Italy mentions the figure of 1,022 as the total number of patients originating from other Member states in 1999.
- Under the E-112 form alone, the largest number of cases treated in one Member State is Belgium with a number of 14,061 persons, corresponding to €25,907,697 in 2000.
- France takes the largest number of patients treated under the E-111 and E-112 forms in a single Member State with 435,856 persons in 2001, giving rise to claims totalling €297.2 million. This figure is by far the highest, the next highest being 137,114 persons - costing €20,559,825.

Number of individuals in your Member State who have applied for authorisation for treatment in another Member State

Percentage of authorisations granted and the number of patients who have, without prior authorisation, claimed for reimbursement of expenses incurred in another Member State

37. Once again the data forwarded by the Member States are difficult to compare, particularly because some figures refer to the number of patients and others to amounts of money. Moreover, some refer to E-111 and E-112 forms cumulatively or separately. So, here too, the Commission will confine itself to providing the following information:

- The figures reveal major differences between Member States which are unrelated to the size of the country. For instance, in the case of voluntary care, Luxembourg issues 11,751 authorisations per year while France issued 789 authorisations over three years.
- The actual scope of the services for which an authorisation has to be requested varies considerably from one Member State to another. As mentioned earlier, some have implemented the *Kohll* and *Decker* rulings and refund non-hospital care without an authorisation, whereas in most Member States an authorisation is required irrespective of whether or not the treatment is dispensed in a hospital. Furthermore, even in those Member States that apply the *Kohll* and *Decker* Judgments, patients can, in order to be reimbursed at the rate applicable in the country in which the service is provided, apply for an authorisation.
- The number of E-111 forms delivered by far exceeds that for E-112 forms. For example, Sweden issued 400,000 E-111 forms compared with six E-112 forms; Finland issued 24,143 E-111 compared with seven E-112, and Spain 57,648 E-111 compared with 651 E-112.
- The number of requests for authorisation under E-112 seems quite small, ranging from around 10 to around 100, per year with the exception of two Member States, Italy and Luxembourg where the number of requests is more than 10,000.

38. Few Member States have supplied data on the percentage of authorisations issued and the number of persons applying for reimbursement without having been granted a prior authorisation. As indicated above, in Belgium, data have been collected since 1999 and show a major upward trend, year on year, in the number of patients travelling to another Member State for non-hospital treatment without authorisation. In Austria, the figures are stable. In these two Member States, the figures reported are insignificant in relation to the total number of insured persons or to the total social security budget (in Belgium, €224,639 in 2001, and in Austria €3,445,470 or 0.03% of its social security budget for 58,030 persons, which corresponds to 1.0517% of the total number of persons insured under the national scheme).

4. Public health and the possible impact of patient mobility on the health-care system of your Member State:

- a) are there any agreements between health authorities regarding the treatment of patients coming from another Member State - particularly for border regions?
- b) do you intend to put in place quality assurance procedures in this context?

39. A number of Member States mention co-operation agreements designed to facilitate the care of patients in border areas. These agreements are sometimes concluded between national authorities, but most often are the result of agreements between the health authorities of the border regions themselves. There are also contracts between the national authorities or the bodies managing social security and hospitals located in other Member States in order to receive patients.

40. As far as quality is concerned, there are few specific measures. Some Member States reported that patients go abroad on the recommendation of their doctors or the medical team responsible for them. It is, therefore, a question of advice based on the doctors' experience or the reputation of the foreign service-provider. Some Member States check that establishments are recognised by the Member State in question.

CONCLUSIONS

The Internal Market in health services is not functioning satisfactorily and European citizens are encountering unjustified or disproportionate obstacles when they apply for reimbursement, from their Member State of residence, of costs for non-hospital treatment incurred in another Member State, or for authorisation for assumption of the costs in the case of hospital treatment. Few patients avail themselves of their rights under the Treaty in this field.

The Commission services will endeavour to ensure that European citizens benefit, irrespective of their country of origin, from the reimbursement of medical costs incurred in another Member State under the conditions laid down by the Court. In line with the Commission Communication on better monitoring of the application of Community law, the Commission services are considering what would be the most appropriate means for achieving this.

When launching the consultation process which resulted in this report, the Commission services indicated a preference for a constructive dialogue with Member States. In that respect, they welcome the active co-operation of the Member States. The Commission services consider that this report is an important transparency tool for all parties concerned and in particular national authorities, patients, health professionals and managers of health systems. It will form a valuable contribution to the discussions within the High Level Reflection Group on Patient Mobility and Healthcare Developments in the European Union.

The Commission' services are considering other tools, such as, for instance, providing better information to patients, health professionals and managers of social security systems. When examining complaints lodged with the Commission, the Commission services will use as far as possible the SOLVIT network. SOLVIT is a network linking the national administrations of every Member State. Its task is to find rapid solutions to problems arising from the application by the Member States of the rules governing the Internal Market. In those cases where the Commission has to make use of the procedure provided for in Article 226 of the Treaty, the Commission services will pay particular attention to the pre-litigation administrative stage prior to the infringement proceedings in order to encourage the Member States to conform voluntarily with the requirements of the Treaty. Creating a Community legal framework could be another option.

It should also be pointed out that the Commission has launched the High Level Reflection Process on Patient Mobility and Healthcare Developments in the European Union.

ANNEX 1



EUROPEAN COMMISSION

Internal Market DG
Director General

Brussels, 12/07/2002
MARKT E-1/GF/gc D(2002) 396

Sir,

Subject : Recent case law of the Court on the application of Internal Market rules in the field of health care services – implications for Member States

In its judgments of 28 April 1998 in the cases of Kohll (C-158/96) and Decker (C-120/95) and of 12 July 2001 in the cases of Smits and Peerbooms (C-157/99) and Vanbraeckel (C-368/98), the Court of Justice ruled on the question of the reimbursement of medical expenses incurred in a Member State other than the Member State of registration.

In these judgments, the Court, while recalling that the management of social security systems lies within the competence of Member States, indicated that in exercising this responsibility they must comply with Community law and, in particular, the principle of the free movement of goods laid down in Article 28 of the Treaty and of the freedom to provide services set out in Article 49 of the Treaty.

As far as medical products are concerned, the Court, in particular in the Decker judgment, confirmed that any measures taken by Member States in the field of social security that may have an impact on the marketing of medical products and that may indirectly affect trade in such products, are subject to the rules of the Treaty governing the free movement of goods. Certain Member States have already, following inter alia infringement proceedings against them, amended their legislation so as to make it compatible with the principle of the free movement of goods. The Commission will continue to take action to ensure that Member States comply with the Court's case law.

As far as services are concerned, the Court points out in the other above-mentioned judgments that medical activities do fall within the scope of the freedom to provide services, including when they are exercised in a hospital and whatever may be the practical arrangements for the payment of benefits by the sickness insurance scheme of the country in which the person is insured.

The Court has taken the view that rules of a Member State which make the reimbursement of medical expenses incurred in another State subject to prior authorisation, and deny such reimbursement to insured persons who have not obtained that authorisation, deter insured persons from approaching providers of medical services established in another Member State and constitute, both for insured persons and service providers, a barrier to the freedom to provide services.

However, the Court accepts that it cannot be excluded that the risk of seriously undermining the financial balance of the social security system may constitute an overriding reason in the general interest capable of justifying a barrier of that kind and that, under Articles 46 and 55 of the EC Treaty, Member States are also permitted to restrict the freedom to provide services on grounds of public health.

In this regard, the Court accepts that where medical care is dispensed in a hospital, it takes place within an infrastructure with, undoubtedly, certain very distinct characteristics. The Court also acknowledges that there is a need for planning in order to ensure sufficient and permanent access to a balanced range of high-quality hospital treatment on the territory of the Member State concerned, and to make it possible to control costs. In consequence, the Court indicated that prior administrative authorisation to incur the cost of treatment provided in a hospital in another Member State may be considered to be a measure which is both necessary and reasonable.

The Court considers, however, that the conditions attached to the grant of such authorisation must be justified with regard to the overriding considerations mentioned above and must satisfy the requirement of proportionality. More specifically, the Court points out that such an administrative authorisation scheme must be based in any event 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. The scheme must likewise be based on a procedural system which is easily accessible and capable of ensuring that a request will be dealt with objectively and impartially and within a reasonable time. Refusal to grant authorisation must also be capable of being challenged in judicial or quasi-judicial proceedings.

These judgments have aroused great public interest, particularly in Member States where patients are confronted with waiting lists. The Commission, moreover, is examining in the context of the procedures instituted by Article 226 of the Treaty a number of complaints from individuals on the grounds that the Member State in which they are insured is not abiding by the conditions laid down by the Court. Furthermore, the European Parliament is monitoring this matter closely and the Commission has already had to answer several parliamentary questions.

A debate on the mobility of patients has started at Community level both in the Health Council and in the Employment and Social Affairs Council and the Commission will contribute to it. Clearly, any discussion of the future of the Internal Market for health care services must take into consideration health and social security aspects and be taken forward in consultation with the Member States and other stakeholders. In this regard, guidelines have been set out by the Commission in two Communications. First, in its Communication on the Health strategy of the European Community (COM(2000)285 of 16 May 2000), the Commission sets out general objectives in the field of public health, based on the relevant provisions of the Treaty. Second, in its Communication of 5 December 2001 (COM(2001) 723) on the future of health care and care for the elderly, the Commission identified objectives for health care systems, in particular with a view to guaranteeing the accessibility, quality and financial viability of these systems.

However, as emphasised above, it is the Member States who are responsible for managing their health and social security systems and so it falls to them to assess the impact of this case law on both their legal framework and internal practices and, if necessary, modify these so as to ensure compatibility with Community law as interpreted by the Court.

The Commission services are aware that Member States may face questions of interpretation arising from these judgments. In order to approach these issues in a concerted and coherent way, the Commission intends to initiate a constructive dialogue with national authorities.

For that purpose, the Commission services consider that an overview of the situation in the Member States would be useful. They would therefore be grateful if the national authorities would provide certain information, within three months of receipt of this letter, by means of the enclosed questionnaire. This letter and questionnaire are being sent to all Member States.

Yours faithfully

John F. Mogg
signed

Encl.

Contact person:

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Recent case law of the Court on the application of Internal Market rules in the field of health care services - implications for Member States

In order to gain an overview of the situation in the Member States, the Commission would like to have access to certain information, particularly as regards

1. Follow-up to this case law at national level:

- a) are discussions in progress ?
- b) are any specific measures envisaged or have any already been adopted ?
- c) how are the national authorities, institutions and courts applying this case-law ?

2. The system of prior administrative authorisation:

- a) is there a system of prior administrative authorisation for domestic access to health care services and/or for access to such services in another Member State ?
- b) what is the scope of such a system ? Does it cover only medical treatment provided in a hospital or does it also include medical treatment provided by medical practitioners in their practices or in patients' homes?
- c) what are the conditions for the granting of such authorisation ?
- d) what is the procedure to be followed in order to obtain it ?
- e) what means of redress are available if it is refused?

3. The economic and social aspect:

- a) are any data available on:
 - the number of patients who are nationals of other Member States who have received treatment in your Member State,
 - the number of individuals in your Member State who have applied for authorisation for treatment in another Member State,
 - the percentage of authorisations granted and the number of patients who have claimed, without having had prior authorisation, for reimbursement of expenses incurred in another Member State?
- b) what is the number of cases covered by forms issued on the basis of the provisions of Regulation (EEC) No. 1408/71 and Regulation (EEC) No. 574/72?
- c) what are the amounts reimbursed and/or defrayed on the basis of the relevant provisions of these regulations and on the basis of cases outside the scope of the regulations?

4. Public health and the possible impact of patient mobility on the health care system of your Member State:

- a) are there any agreements between health authorities regarding the treatment of patients coming from another Member State, particularly for border regions?
- b) do you intend to put in place quality assurance procedures in this context?

We would also be grateful if you would send us any other information, analyses or studies your authorities might have available which may be related to the subjects mentioned above.

ANNEX 2

DATA ON PATIENT MOBILITY

Table 1: Number of patients who are nationals of other Member States treated in your Member State

Table 2: Number of individuals who have applied for authorisation for treatment abroad

Table 3: a) Percentage of authorisations granted

b) Number of individuals who have claimed reimbursement without having had prior authorisation

Table 1: Number of patients who are nationals of other Member States treated in your Member State⁸

Belgium	<p>The Belgian authorities transmitted information expressed in financial terms.</p> <p>For 2000:</p> <p>Expenditure in Belgium on employed persons insured abroad: BF6,683,209,508 (€165,672,436) - rising 6% per annum</p> <p>Expenditure in Belgium on self-employed persons insured abroad: BF125,797,373 (€3,118,435) - up 7.94% on the previous year but falling steadily up until then.</p> <p>The total amount of Belgian claims on other Member States for the category of persons authorised to receive treatment in Belgium under form E-112: €25,907,697.17 (BF 1,045,113,913) corresponding to 14,061 persons, of which Netherlands: €453,320,575 corresponding to 6,262 persons; Luxembourg: €242,124,142 corresponding to 3,551 persons; Italy: €10,655,435 corresponding to 2,832 persons.</p>
Denmark	In 2001: 2,401 persons, of which 1,130 came from Germany.
Spain	<p>In 2001:</p> <p>E112: €457,821.9 corresponding to 3,156 persons</p> <p>E 111: €20,102,004.2 corresponding to 133,958 persons</p> <p>Total: €20,559,825 corresponding to 137,114 persons</p>
France	<p>In 2001: 435,856 persons</p> <p>In 2002: claims: €297.2 million</p>
Italy	In 1999, 1,022 persons.
Ireland	Only one patient was treated in Ireland in recent years.
Luxembourg	<p>In 2001:</p> <p>E111: 4,101 persons</p> <p>E112: 250 persons</p>
Netherlands	For 2000: 3,316 persons.

⁸ This table only includes those Member States which provided data.

Austria	In 2000: c. €5,160,000 corresponding to 1,000 persons.
Portugal	The collection of these data is decentralised, and no information is available at national level. The Portuguese authorities are seeking this information.
Finland	For 2001: E112: 9 cases for which around €17,400 have been reimbursed to Finland. E111: 11,483 forms have been issued In total, Finland invoiced the other Member States for €77,000 in 2000, and €51,000 in 2001.
Sweden	The Swedish authorities transmitted information expressed in financial volumes. For 2000: SEK 33.5 millions (\pm €3,666,411) reimbursed for the treatment of citizens of other Member States SEK 53.1 million (\pm €5,838,000) paid for the treatment of citizens of other Nordic countries. The countries in question are not asked to reimburse these amounts.
United Kingdom	In 2001, 871 patients were treated under E-112 in the United Kingdom corresponding to a total of £5.56 million (\pm €3,720,428). 641 were from Ireland and 121 were from Italy. In 2002, this figure stood at 776 corresponding to a total of £1.21 million (\pm €1,897,791), with Ireland accounting for 659 and Italy 60.

Table 2: Number of individuals who have applied for authorisation for treatment abroad⁹

<p>Belgium</p>	<p>The Belgian authorities transmitted information expressed in financial terms.</p> <p>For 2000:</p> <p>Expenditure abroad by employed persons insured in Belgium: BF4,213,474,790 (€104,449,312), down 12.50% since 1999</p> <p>Expenditure abroad by self-employed persons insured in Belgium: BF113,149,378 (€2,804,890), down 23.49% since 1999</p>
<p>Denmark</p>	<p>There are no precise data on the number of applications for authorisation made or granted. However, following the entry into force of Decree No 536 of 15 June 2000 which makes provision for maximum waiting times, between 1.07.02 and 30.09.02, 50 persons received treatment in another Member State (Sweden and Germany).</p> <p>In 2000, 70 patients whose state of health was such that it required specialist treatment were treated abroad, including in the EU. In 2001, there were 75 such patients.</p> <p>In 2000, 21 cancer sufferers received radiotherapy treatment in Germany. In 2001, the total was 29.</p>
<p>Spain</p>	<p>In 2001, 651 E-112s were issued and 57,468 E-111s.</p>
<p>France</p>	<p>Over the period 1996-1999, 1,240 persons applied for authorisation for treatment abroad, 789 of which were granted (64%).</p>
<p>Ireland</p>	<p>In 2000 and 2001 around 650 persons per annum applied for authorisation for treatment abroad, around 600 of which were under forms issued on the basis of Regulation (EEC) No 1408/71. Ireland reimbursed c. €7 million in 2000 and 2001 for patients treated in other Member States.</p> <p>In 2002, Ireland set up the "National Treatment Purchase Fund" with the aim of reducing waiting lists by calling on private providers in Ireland and abroad. This fund spent €6million in 2002 on 1 920 patients who were treated in private clinics either in Ireland or the United Kingdom.</p>
<p>Italy</p>	<p>In 1999, 21,300 persons applied for authorisation for treatment abroad.</p> <p>The number of cases covered by forms issued on the basis of Regulation (EEC) No 1408/71 was 16,280 in 1999, which corresponds to €9,952,314 (incomplete data). The corresponding total for authorisations granted outside of the Regulation was €19,980,840 (incomplete data).</p>

⁹ This table only includes those Member States which provided data.

Luxembourg	<p>In 2001:</p> <p>11,751 persons applied for authorisation for treatment abroad, of which 4,272 were for hospital treatment and 74 thermal cures</p> <p>245 applications were refused.</p>
Austria	<p>Number of E-112s: 850 corresponding to 0.0154% of the total number of insured persons in Austria or €4,724,000.</p> <p>The number of refusals is not available.</p>
Portugal	<p>As decision-making is decentralised, data on E-112s are not available.</p> <p>In 2001, 260 applications for authorisation were made under Decree-Law No 177/92. 246 were granted.</p>
Finland	<p>In 2001, 9 authorisations were issued under E-112 corresponding to €17,900.</p> <p>In 2002, 4 authorisations were issued under E-112.</p> <p>In 2001, 24,143 E-111 forms were issued.</p> <p>In total, in 2001, Finland reimbursed €1.7 million to other Member States.</p>
Sweden	<p>The Swedish authorities say that they have received few applications for treatment abroad.</p> <p>In 2002, 6 applications were made under E-112 and all were refused. The Swedish authorities issue around 400,000 E 111s per annum.</p>
United Kingdom	<p>In 2000, 1,100 persons applied for authorisation for treatment abroad under E-112. In 2001, this figure was 1,134.</p> <p>No data are available centrally concerning non E-112 procedures which are administered by the local authorities (Primary Care Trusts). However, the UK has set up a project offering patients awaiting treatment the possibility of being treated in another Member State. This project is run by the local authorities (Primary Care Trusts). 190 patients were treated during the pilot phase, and 269 since the end of the pilot phase. The cost of the pilot phase was £1.1 million (± €1,725,265) and the next phase £770 000 (± €1,207,685)</p>

**Table 3: a) Percentage of authorisations granted
b) Number of individuals who have claimed reimbursement without having had prior authorisation¹⁰**

Belgium	Expenditure linked to the application of the Kohll and Decker judgments: 1999: BF 3,521,039 (€7,284) 2000: BF 5,423,627 (€134,448) 2001: BF 9,061,907 (€224,639).
France	a) Over the period 1996-1999, 64% of authorisations were granted. b) data collected by regional sickness insurance funds – not available.
Ireland	a) over 90% of applications are accepted. b) Recently, 14 persons claimed reimbursement of medical expenses incurred in another Member State without prior authorisation.
Italy	a) In 1999, 91.5% of authorisations were granted. b) In 1999, 4 claims were made for reimbursement without prior authorisation.
Luxembourg	In 2001: a) Number of refusals: 245 Reasons for refusal: claims made <i>a posteriori</i> . However, when the claims are for non-hospital treatment, the Luxembourg authorities proceed with reimbursement on the basis of the Kohll and Decker judgments. b) Number of persons covered by forms: E-112: 11,751 Other forms: 71,792, of which E 106: 67,658 Totals: €133,768,556, of which E 112: €24,513,299 cross-border workers: €95,265,481
Austria	58,000 persons are reimbursed without prior authorisation for health care abroad (1.0517% of insured persons in Austria) which corresponds to €3,445,470. The Austrian authorities state that these are non-hospital services (mainly dental costs) provided in Hungary.
Portugal	b) 1 claim in 2001.
United Kingdom	a) 193 E112 applications were refused in 2000 and 253 in 2001. b) The authorities are aware of some cases but do not have detailed information.

¹⁰ This table only includes those Member States which provided data.

