Analytical Report 2016

Access to healthcare in cross-border situations

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EXECUTIVE SUMMARY

Although cross-border healthcare has existed for a long time, the adoption of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare has revived interest in this topic. Moreover, it has opened another legal path to access cross-border healthcare, next to the coordination Regulations and purely national legal provisions. It may provide cross-border patients with more options, but at the same time makes the interaction between distinctive legal instruments more complex.

There are two possibilities regarding cross-border healthcare. One is affiliation to the public healthcare system (i.e. social health insurance or national health service); the other is unplanned or planned cross-border healthcare, while maintaining coverage in the home public healthcare system.

(1) Although no major issues can be detected in the area of affiliation of EU mobile citizens to the Member States' healthcare schemes, it cannot be denied that legal, administrative and practical issues require specific attention. For active persons, contribution periods are as a rule aggregated and payment of contributions monitored. However, the complexity and diversity of affiliation to healthcare systems throughout the EU and especially diverging concepts of residence (with an emphasis on students and other non-active persons) and its interpretation by the Court of Justice of the European Union (CJEU) (of essence in particular in residence-based schemes) require further attention of the EU legislature.

Member States generally do not adopt measures which are specifically aimed at facilitating access to their healthcare scheme for mobile EU citizens. However, certain national legislations or administrative practices can be detected as enabling mobile citizens to affiliate to the local healthcare scheme, mainly through administrative intervention, smooth procedures for affiliation and the provision of information to citizens. The avoidance of gaps in health coverage when moving to another Member State can be found in case-by-case administrative practice.

Healthcare and health coverage may play an important role in applying other, non-coordination EU instruments. Access to healthcare, especially of indigent workers, may be considered as a social advantage under Regulation (EU) No 492/2011 and a residence requirement under Directive 2004/38/EC.

(2) Cross-border patients may remain covered by the public healthcare systems of their Member State of affiliation while receiving healthcare in another Member State. The articulation between EU cross-border healthcare routes is only very briefly envisaged in Directive 2011/24/EU. However, the Directive does not clarify its interaction with the Regulations despite the fact that regulating the relationship between the two instruments is one of its main objectives. The coordination Regulations ignore the case law on cross-border healthcare as free movement of services and do not mention the Directive at all. By contrast, the Directive cannot be read on its own. It constantly relates to the Regulations regarding key factors such as its scope of application or the Member State responsible for the reimbursement of healthcare costs.

Both the scope of unplanned and planned healthcare and the distinction between these two concepts are not always clear. The intention of the patient may not always be explicit and clear and may change when already in another Member State. Moreover, applying the Directive also to unplanned healthcare may lead to paradox situations, considering that prior authorisation may be required for certain kinds of healthcare, regardless whether it is unplanned or planned. This could be solved by not applying the Directive to unplanned healthcare (and leave it to the coordination Regulations and purely national law where reimbursement may be foreseen) or by expressly stipulating that prior

authorisation may not be required for necessary or even urgent treatment. Legislative action might be necessary in order to provide more clarity in this respect.

At the same time, it could be argued that unplanned healthcare under the Regulations is the most common application of cross-border healthcare. Nevertheless, it may present dilemmas as to the notions of temporary stay outside of the competent Member State, what can be considered as unforeseen and necessary healthcare, and the extent of reimbursement. Moreover, if the Directive is also applied to unplanned care it may lead to undesirable results (of freeriding between the two instruments) and increased administrative burden for national healthcare systems seeking the best possible option for the patient.

A parallel application of the Regulations, the Directive and purely national legislation may lead to legal and practical problems also with planned healthcare. It is argued that the automatic authorisation rule should be applied when the administrative procedure for granting prior authorisation would last too long, whereby the procedural time limits should be stricter than under general administrative procedural rules. Problems are detected not only in relation to lengthy and burdensome administrative procedures, but also to disadvantageous financial arrangements and the lack of comprehensive and reliable information provided to the patients. The situation gets even more complicated when special rules for frontier workers and pensioners are taken into account. Here, some simplification would be in order.

Practical problems may occur for a cross-border, i.e. mobile, patient if the same healthcare providers offer public and private healthcare. In many Member States public providers may offer private healthcare and *vice versa*, private providers may be included in the public healthcare provision, while at the same time they are allowed to offer private services as well. The latter are as a rule guaranteed without waiting lists, but with higher tariffs and direct payment. Therefore, it is "easier" for healthcare providers to treat mobile patients as private patients. Nevertheless, such steering is not allowed and is supervised and sanctioned in some Member States.

The behaviour of the mobile patient is decisive. S/he has to decide whether s/he would like to be treated as a public or a private patient, with a distinction in applicable tariffs. In order to exercise free choice, s/he has to be properly informed. One of his or her main concerns is the reimbursement of the healthcare costs, whereby Member States may apply distinctive reimbursement methods, more or less favourable to mobile patients.

Special problems may arise if purely private healthcare cannot be used (for public funds) in the home Member State, since it can be used in another Member State when the cross-border element is present. Moreover, purely private healthcare can be used also in the Member State where there is no such possibility in case of incoming mobile patients (who may claim reimbursement from public funds later on in the Member State of their affiliation). This opens a question of reverse discrimination of non-mobile national patients.

It is argued that all forms of access to high quality healthcare should be guaranteed to both mobile and national patients and EU law should not produce undesired effects for national patients, who are still in the majority, compared to mobile patients.

There are several possibilities to do so. One is legislative action at EU level. If CJEU case law was codified in the Directive, the time might have come to codify all cross-border healthcare rules in a single legislative instrument, which would bring clarity and ease a bit the complexity of cross-border healthcare possibilities. Moreover, access to clear and reliable information is emphasised with all aspects of affiliation to the healthcare system of another Member State as well as cross-border healthcare *stricto sensu*. It is argued that the same format should be used across the EU and even the EU itself should provide reliable information when diversity across Member States does not allow them do to so.

1. INTRODUCTION

Health is one of the most important values that influences the existence and further development of every individual and society as such. The right to health is one of the fundamental human rights, indispensable for the exercise of other human rights. Especially when health is impaired or lost, and sickness or injury occurs, it is essential to restore health as soon as possible, by means of high-quality and sustainable healthcare provision, accessible to all, be it in the home Member State or abroad.

People were and still are treated in another country for a variety of reasons. If healthcare can be provided in another Member State without waiting, by a (highly specialised) healthcare provider, who is of good reputation (assuring safe and good quality treatment), and possibly providing a method of treatment not available in the home State within the medically necessary time, persons are more willing to seek and receive healthcare abroad.

This is even more the case if the two Member States concerned have a similar language and culture, if there is less administrative complexity, if costs are predictable (and covered) and information on all economic, social and legal aspects is available. Hence, people may choose healthcare abroad out of necessity or out of preference.

Cross-border healthcare is enabled by bilateral and multilateral agreements concluded directly by the contracting States or passed by international organisations, and in the EU predominately by Regulation (EC) No 883/2004 on the coordination of social security systems and Directive 2011/24/EU on the application of patients' rights in cross-border healthcare. Hence, cross-border healthcare was not invented by the (transposition of) Directive 2011/24/EU. It existed long before, and unplanned medical treatment in another Member State was provided also by Regulation (EEC) No 3/58 on social security for migrant workers. The possibility of planned healthcare in another Member State, covered by the national public healthcare system, was introduced by Regulation (EEC) No 1408/71. It has been further developed through the case law of the Court of Justice of the European Union (CJEU).

It is recognised that different aspects related to the topic of access of EU citizens to healthcare in cross-border situations have already been the subject of several reports by the trESS[1] and FreSsco networks[2] and other reports.[3] Furthermore, with the adoption of Directive 2011/24/EU the European Commission (EC) services cooperated closely with the Member States on various topics of legal interpretation relating to the relationship of the new Directive with the existing social security coordination rules. In the past years several Working Parties of the Administrative Commission dedicated to this topic have taken place. Additionally, the EC adopted a report on the operation of the Directive on patients' rights in cross-border healthcare and submitted it to the European Parliament and to the Council in 2015. The next report is scheduled for 2018 and subsequently every three years.

[1] *Cf.* ROBERTS, S. (ed.), SCHULTE, B. (ed.), GARCÍA DE CORTAZAR, C., MEDAISKIS, T., and VERSCHUEREN, H. trESS Think Tank Report 2009, Healthcare for Pensioners; LHERNOULD, J.-P. (ed.), SCHULTE, B. (ed.), FILLON, J.-C., HAJDU, J., and VERSCHUEREN, H., trESS Think Tank Report 2010, Healthcare provided during a temporary stay in another Member State to persons who do not fulfil conditions for statutory health insurance coverage; and VAN OVERMEIREN, F., VERSCHUEREN, H. and EICHENHOFER, E. (2011), Social security coverage of non-active persons moving to another Member State, trESS Analytical Reports.

[2] JORENS, Y. and DE CONINCK, J., Reply to an ad hoc request for comparative analysis of national legislations: Administrative procedures for cross-border healthcare, FreSsco, European Commission.

[3] Among them a report submitted by ICF GHK in association with Milieu Ltd in 2013, A fact finding analysis on the impact on the Member States' social security systems of the entitlements of non-active intra-EU migrants to special non-contributory cash benefits and healthcare granted on the basis of residence.

The objective of the present report is to conduct a follow-up study of the earlier studies due to recent developments in cross-border healthcare; to look more in depth into certain aspects that were previously not examined in detail; and to analyse new legal aspects that came up recently as a result of new CJEU case law. To achieve these objectives, the report is structured around two distinct scenarios of access to healthcare in another Member State, namely access of EU nationals to the healthcare system in the residence Member State and access to healthcare in a Member State other than the Member State of social health insurance or national health service coverage.

Therefore, the next chapter (chapter 2) describes the national legal frameworks in the EU Member States as to affiliation to the healthcare system in the view of EU mobile persons. A disaggregation is made in categories of employed persons, self-employed persons, students, and non-active persons. At the same time potential problems to get affiliated are presented. It is also scrutinised whether the way of financing the individual healthcare systems is of particular relevance in this context. Moreover, the interrelation with other Union legislation, such as Directive 2004/38/EC and Regulation (EC) No 492/2011 is presented.

The subsequent chapter (chapter 3) analyses access to healthcare in another Member State and discusses possible practical problems with the implementation of Regulation (EC) 883/2004, Directive 20011/24/EU and purely national law. The distinction is made between unplanned and planned cross-border healthcare.

Special attention (under a separate chapter, i.e. chapter 4) is devoted to the relation between public and private provision of healthcare. More specifically, it is scrutinised which bodies are part of the public social security systems and which are to be considered as purely private providers in each Member State and how to distinguish between them in practice.

Information or a lack of it is of essential importance in all aspects of cross-border healthcare. Therefore, a separate chapter (under point 5 of the present report) is dedicated to the possibilities of better informing patients when they exercise their right to cross-border healthcare.

The starting point of the present report is coordination of national social security systems in the EU, as agreed by the Member States. The evolution of several possibilities for cross-border healthcare, provided especially by the judgments of the CJEU and codified in Directive 2011/24/EU are analysed in relation to the existing social security coordination mechanism.

2. AFFILIATION OF MOBILE EU CITIZENS TO THE NATIONAL HEALTHCARE SYSTEM

2.1. Conditions of affiliation to the Member States' national healthcare systems

As Regulations (EC) Nos 883/2004[4] and 987/2009[5] merely coordinate the social security systems of the Member States, the conditions of affiliation to the social security schemes have remained within the competence of the Member States. EU law does not detract from the Member States' powers to organise their social security schemes.[6] As social security law is not harmonised at EU level, it is for the national legislation to determine the conditions concerning the right or the duty to be insured with a social security scheme as well as the conditions for entitlement to benefits.[7] However, CJEU case law has confirmed at many occasions that, when exercising those powers, the Member States must comply with Union law.[8]

It goes without saying that this EU legislative framework is fully applicable to the healthcare schemes of the Member States, as a branch of what is defined as 'social security' at EU level[9] and despite national distinctions between 'social security' and 'healthcare'. This means that Member States are in principle free to decide on the financing of, access to and benefit entitlement of their national healthcare schemes. However, they should take into account the boundaries of that freedom as set by EU primary and secondary legislation.

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[4] Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems. OJ L 166 of 30 April 2004.

[5] Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems. OJ L 284 of 30 October 2009.

[6] See *Duphar*, C-238/82, EU:C:1984:45, 16; *Poucet and Pistre*, C-159/91 and C-160/91, EU:C:1993:63, 6; *Sodemare*, C-70/95, EU:C:1997:301, 27; *Decker*, C-120/95, EU:C:1998:167, 21; *Kohll*, C-158/96, EU:C:1998:171, 17; *Geraets-Smits and Peerbooms*, C-157/99, EU:C:2001:404, 44; *Müller-Fauré and Van Riet*, C-385/99, EU:C:2003:270, 100; *Inizan*, C-56/01, EU:C:2003:578, 17; *Leichtle*, C-8/02, EU:C:2004:161, 29; *Watts*, C-372/04, EU:C:2006:325, 92, 146; *Stamatelaki*, C-444/05, EU:C:2007:231, 23; *Hartlauer*, C-169/07, EU:C:2009:141, 29; *Commission v Italy*, C-531/06, EU:C:2009:315, 35; *Apothekerkammer des Saarlandes and Others*, Joined Cases C-171/07 and C-172/07, EU:C:2009:316, 18; *Commission v Germany*, C-141/07, EU:C:2008:492, 22; *Blanco Pérez and Chao Gómez*, Joined Cases C-570/07 and C-571/07, EU:C:2010:300, 43; *Commission v Spain*, C-211/08, EU:C:2010:340, 53, 75; *Elchinov*, C-173/09, EU:C:2010:581, 40, 57; *Commission v Luxemburg*, C-490/09, EU:C:2011:34, 16, 32.

Recitals 10 and 35 of the Preamble of Directive 2011/24/EU also confirm that it fully respects the responsibilities of the Member States for the definition of social security benefits relating to health and for the organisation and delivery of healthcare and medical care and social security benefits, in particular for sickness.

[7] See *Coonan*, C-110/79, EU:C:1980:112, 12; *Paraschi*, C-349/87, EU:C:1991:372, 15; *Stöber and Piosa Pereira*, Joined Cases C-4/95 and C-5/95, EU:C:1997:44, 36; *Decker* EU:C:1998:167, 22; *Kohll* EU:C:1998:171, 18; *Geraets-Smits and Peerbooms* EU:C:2001:404, 44, 45, 85; *Müller-Fauré and Van Riet* EU:C:2003:270, 100; *Inizan* EU:C:2003:578, 17; *Watts* EU:C:2006:325, 92; *Stamatelaki* EU:C:2007:231, 23; *Commission v Spain* EU:C:2010:340, 53; *Elchinov* EU:C:2010:581, 40, 57; *Commission v France*, C-512/08, EU:C:2010:579, 29; *Commission v Luxemburg* EU:C:2011:34, 32.

[8] See the AG's Opinion in *Decker* & *Kohll*, EU:C:1997:399, 17-25; *Decker* EU:C:1998:167, 23; *Kohll* EU:C:1998:171, 19; *Geraets-Smits and Peerbooms* EU:C:2001:404, 44, 46, 88; *Müller-Fauré and Van Riet* EU:C:2003:270, 100; *Inizan* EU:C:2003:578, 17; *Watts* EU:C:2006:325, 92; *Stamatelaki*, C-444/05, EU:C:2007:231, 23; *Hartlauer* EU:C:2009:141, 29; *Commission v Italy* EU:C:2009:315, 35; *Apothekerkammer des Saarlandes and Others* EU:C:2009:316, 18; *Commission v Germany* EU:C:2008:492, 23; *Blanco Pérez and Chao Gómez* EU:C:2010:300, 43; *Commission v Spain* EU:C:2010:340, 53; *Elchinov* EU:C:2010:581, 40; *Commission v France* EU:C:2010:579, 29; *Commission v Luxemburg* EU:C:2011:34, 16, 32.

[9] Article 3 of Regulation (EC) No 883/2004. The different social security branches were summed up in Article 3 of Regulation (EC) No 883/2004. To categorise a given branch of social protection of a Member State in the light of EU law as social security, it does not matter whether the benefits are enshrined in a general or a special scheme, are financed out of taxes or contributions or whether the administration is based on public or private law.

The central instruments of secondary legislation which impact the EU mobile citizen's access to healthcare are Regulations (EC) Nos 883/2004 and 987/2009 and their respective provisions concerning the coordination of "*sickness benefits in kind*", hereinafter also simply referred to as 'healthcare'.[10] With its foundations and legal base in the free movement of workers,[11] the EU social security coordination system has developed into a real EU citizenship instrument,[12] impacting on cross-border social security entitlements for both economically active and inactive persons moving within the EU.

As to the general impact of EU social security coordination on access to healthcare, it should be noted that socially insured EU mobile citizens, both economically active and inactive, are in principle entitled to healthcare in their Member State of residence. The latter may not be the competent State which is financially responsible for the healthcare services provided, but the insured persons will benefit from the residence State's mandatory healthcare services as if they were insured there. In that regard, the concept of residence is crucial for the coordination of sickness benefits in kind under the coordination Regulations.

It should already be noted that the area of healthcare is indulged with different concepts of residence at the national level (habitual residence, permanent residence, permanent stay, lawful residence, lawful presence, permanent establishment *etc*) and at the EU level, where the concept of habitual residence for social security coordination purposes is found next to the concept of legal residence as inferred by Directive 2004/38/EC.[13]

Within the meaning of the coordination system, the Member State of residence is the State where the person's centre of interests is located. Several factors were identified by CJEU case law,[14] and a non-exhaustive list of factors can be found in Article 11 of Regulation (EC) No 987/2009. This list mentions the duration and continuity of presence; the person's situation (working status and family ties); the exercise of a non-remunerated activity; the source of income of students; the housing situation (permanent or not); and tax residence.[15] If these criteria are not definitive, the persons' intention, especially the initial reason to move abroad, should be considered. This European concept of residence supersedes any other deviating notion of residence at the national level, for the application of the coordination system.

In principle and in the current state of EU law, there is no direct link between the above concept of habitual residence in the field of coordination of sickness benefits in kind (healthcare) and the concept of legal residence in accordance with Directive 2004/38/EC. Indeed, as opposed to the impact of the latter on the access for non-active persons to social benefits like special non-contributory benefits (SNCBs) in other Member States,[16]

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[10] Some argue that 'health care' refers to provider actions, whereas 'healthcare' is a system. Moreover, sometimes 'health care' is used as a noun (e.g. 'your health care is important') and 'healthcare' as an adjective (e.g. 'find a healthcare professional'). None of these distinctions is consistently applied and both forms are widely used. Moreover, Regulation (EC) 883/2004 uses a third form, i.e. "*health-care*" (recital 33). Since the Directive 2011/24/EU uses "*healthcare*" rather consistently, it is also used in the present report.

[11] Article 48 TFEU.

[12] JORENS, Y. & VAN OVERMEIREN, F. (2009). General principles of coordination in Regulation 883/2004. European Journal of Social Security 11(2) 16.

[13] See also COUCHEIR, M. (ed.), SAKSLIN, M.; GIUBBONI, G.: MARTINSEN, D.; VERSCHUEREN, H. (2008): trESS Think Tank Report 2008 – The relationship and interaction between the coordination Regulations and Directive 2004/38/EC. Note that several concepts elaborated in this report may require reconsideration in the light of developments in the recent case law of the CJEU.

[14] *Swaddling*, C-90/97, EU:C:1999:96, paragraph 29 and *Knoch*, C-102/91, EU:C:1992:303.

[15] These criteria can also be found in the European Commission Practical Guide on the applicable legislation in the EU, EEA and Switzerland, issued in December 2013.

[16] *Brey*, C-140/12, EU:C:2013:565, 77; *Dano*, C-333/13, EU:C:2014:2358; *Alimanovic*, C-67/14, EU:C:2015:597; and *García-Nieto*, C-299/14, EU:C:2016:114. See also VAN OVERMEIREN, F., VERSCHUEREN, H. and EICHENHOFER, E. (2011), Social security coverage of non-active persons moving to another Member State, trESS Analytical Reports, 1-54.

entitlement to healthcare in the residence State should currently still be evaluated solely under the concept of habitual residence, i.e. the person's centre of interest as delineated by Regulation (EC) No 883/2004. However, the CJEU's recent ruling in *Commission v United Kingdom*[17] is pointing in another direction, which could be the future direction for all "genuine" and "non-hybrid" social security benefits, including healthcare. In this case, the CJEU has indeed accepted that legal residence in accordance with Directive 2004/38/EC can be required by a Member State for the purpose of granting the social benefits at issue (tax-financed family benefits), as such legal residence requirement is merely an entitlement condition provided by the national legislation, which is determined as the applicable legislation by (Article (11)(3)(e) of) Regulation (EC) No 883/2004.

From a national perspective, Member States may refer to the Directive's concept of legal residence for entitlement to healthcare on their territory. Although a requirement to be legally residing on the territory for access to healthcare is as such not problematic, the interdependence between sickness coverage and legal residence might raise issues. Particularly, the condition of having comprehensive sickness coverage in order to establish legal residence as a non-active person could become the centre of the attention. It goes without saying that such requirements might be problematic from the coordination perspective and it remains to be seen whether legal residence requirements of Directive 2004/38/EC might also prevail over the EU coordination system's residence concept in the field of healthcare, as it was the case for access to SNCBs and now also tax-financed family benefits (and with those, probably also other social security benefits).[18]

It goes without saying that the mentioned access to the residence State's healthcare system cannot be influenced by the provisions of Directive 2011/24/EU,[19] as the latter merely impacts access to healthcare in a Member State of stay, i.e. in the case of a temporary residence in a Member State as opposed to habitual residence. Whilst staying in another Member State, the individual keeps her or his centre of interest elsewhere.

With a view to the above, below it is first analysed what are the conditions of affiliation to the healthcare systems of the Member States in order to have a view on how EU citizens can access the healthcare schemes of the Member States when moving within the European Union.

As both the European and national legislative framework are clearly diverse for different categories of persons, the results of this analysis will be disaggregated for employed persons, self-employed persons, students and the wider category of economically inactive people, hereinafter also referred to as "non-active persons".

2.2. Affiliation of economically active persons: employed and self-employed persons

If an EU citizen moves to another Member State to reside and work there, s/he and her/his family members[20] will be entitled to healthcare in that State.[21] As s/he will be entitled to equal treatment, s/he will have the same rights and obligations as insured nationals and can affiliate under the same conditions as nationals.[22] If s/he is confronted

[17] *Commission v United Kingdom*, C-308/14, EU:C:2016:436.

[18] *Dano* EU:C:2014:2358; *Alimanovic* EU:C:2015:597; and *Garcia-Nieto* EU:C:2016:114.

[19] Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.

[20] Article 1 (i) (1) (ii): any person defined or recognized as a member of the family or designated as a member of the household by the legislation of the Member State in which he/she resides. In case the family members are not entitled to healthcare according to the legislation of the residence State, the legislation of the competent MS applies. See *Delavant*, C-451/93, EU:C:1995:176.

[21] Article 11 of Regulation (EC) No 883/2004.

[22] Article 4 of Regulation (EC) No 883/2004.

with qualifying periods, s/he can invoke the periods completed under the legislation of another Member State.[23] In the same regard, s/he will be able to appeal to the principle of assimilation when it comes to the legal effects of benefits, income, facts and events.[24] This access for mobile workers and their family members is fairly straightforward, as this is largely an internal affair of affiliation of non-nationals within the EU residing in the competent Member State.

However, if an EU national works in one Member State and resides in another, s/he will be socially insured in her/his State of work, but will also be entitled to healthcare in her/his residence State as if s/he was insured there.[25] To that end, the Member State where s/he is insured will issue an S1 form[26] with which s/he can register for healthcare with the healthcare system in the residence State.[27] S/he will be entitled to healthcare in the competent State as well.[28]

In that regard, economically active mobile citizens are entitled to healthcare in their residence State, even if they are insured in another Member State. This also applies to family members residing outside the competent State whilst the insured person resides inside the competent State and *vice versa*. This has as an effect that residence requirements for access to healthcare in the competent State as well as requirements of contribution payment in the residence State are waived by EU social security coordination provisions.

Categorising healthcare schemes is *in se* a difficult exercise, but in general a distinction is made between social insurance schemes and national health services, also known as *Bismarckian* versus *Beveridgean* systems. Social insurance systems (with a sub-distinction between reimbursement systems and benefit-in-kind systems) offer protection to insured categories of persons and are funded through social security contributions. A national health service is universal, protects all residents and is mainly financed via general taxation.[29]

In general, it is clear that the distinction between the different classical types of social security systems, i.e. *Bismarckian* versus *Beveridgean* systems or contribution-based systems versus residence-based systems, is fully reflected in the conditions for affiliation to the healthcare systems of the Member States. Also the fact that this distinction cannot be upheld in a dogmatic way becomes very clear, as a lot of Member States have a mixed system.[30]

2.2.1. Contributory schemes

In some Member States, the conditions for affiliation are clearly linked to the payment of contributions for economically active persons seeking access to healthcare (*e.g*. **AT**, **BE**, **BG**, **CZ**, **DE**, **HU**, **HR**, **LT**, **LU**, **NL**, **PL**, **RO**, **SK** and **SI**). Such contributions are paid by the employer and the employed persons or by the self-employed person him or herself. This payment must often be demonstrated by certifications or attestations to the competent institutions, or are verified via an automated system.

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[23] Article 6 of Regulation (EC) No 883/2004.

[24] Article 5 of Regulation (EC) No 883/2004.

[25] Article 17 of Regulation (EC) No 883/2004. See also VERSCHUEREN, H. (2001): Financing Social Security and Regulation (EEC) 1408/71. European Journal of Social Security, Vol 3 Issue 1, p. 14.

[26] Portable Document replacing the former E106 form.

[27] Article 24 (1) IR.

[28] This is the case for frontier workers and sometimes their family members.

[29] JORENS, Y. (2002): The Right to Health Care across Borders, in: MCKEE, M., MOSSIALOS, E., BAETEN, R. (eds): The Impact of EU Law on Health Care Systems Brussels: P.I.E.-Peter Lang, p. 83-84.

[30] HATZOPOULOS, Health law and policy the impact of the EU. In DE BURCA (ed.), EU Law and the Welfare State: In Search of Solidarity, 116-117.

Regardless of the above, several Member States that have a healthcare system based on contribution payment also have specific legislation enabling persons residing on the territory to access the healthcare system. These can be specific categories of persons in a situation where it is deemed that it is the state's responsibility to provide healthcare as they are in a situation which merits consideration, but also more general safety net measures in order to guarantee the provision of healthcare to all persons (legally) residing on the territory of the Member State concerned (*e.g*. **BE**).

In the contribution-based systems, the payment of contributions to the competent institutions is often the sole requirement for affiliation to healthcare. For employed persons, the contributions are generally paid directly by the employer, who is responsible for both employer and employee contributions, which are deducted from the salary of the employed person. Self-employed persons are individually responsible for the payment of contributions, which is calculated on their professional income.

Examples of specific administrative requirements related to contribution payment in the Member States are affiliation to a health insurance fund or sickness fund or registration in the employment register for employed persons or in the commercial register for self-employed persons. Administrative formalities, however, vary greatly throughout the Member States.

In certain Member States, affiliation to the mandatory healthcare scheme is dependent on wage levels. In **Austria**, employees must earn an income of more than € 415.72 per month. Self-employed persons must also achieve a yearly income of € 4,988.64. In **Germany**, in principle all employers are covered, but employed persons earning more than € 56,250 per year may opt out of public health insurance and can then be covered by private health insurance. Self-employed persons should only affiliate to the German mandatory healthcare scheme if their profession is explicitly mentioned in the national health insurance legislation. Other self-employed persons should register with a private insurance.

Upon presentation of an S1 form to be registered with the healthcare institutions of the Member State of residence with a contribution-based system, no contributions can be required, as the person is already insured in the competent State. However, this does not exclude the payment of certain contributions for additional services or complementary insurance with the health insurance fund or sickness fund to which the person registers.

2.2.2. Residence-based schemes

In most residence-based and tax-financed systems, *i.e*. the *Beveridgean* systems based on a national health service (NHS) concept, the distinction between economically active and economically inactive persons is fully redundant. The only condition for affiliation to the healthcare scheme is (legal) residence and no contribution payment is linked to access. Such schemes have often only included a reference to affiliation based on economic activity on the territory as a result of EU coordination legislation, as a result of which access should be guaranteed for economically active persons exercising professional activities on the territory.

A good example of this explicit referral to EU-based inclusion of persons working on the territory can be found in the **French** healthcare system. Any person, whether s/he exercises a professional activity or is non-active, enjoys statutory healthcare insurance coverage if s/he has a stable and lawful residence in France. A person may lose coverage only if the condition of residence is no longer fulfilled. In this regard, the French healthcare system has clearly shifted from a genuine contribution-based scheme to a mixed scheme in which residence has even become a dominant factor.[31] However, the

[31] See also point 2.2.3, regarding recent developments in French healthcare legislation.

universal healthcare scheme also supports persons who exercise an employed or a self-employed activity in France, even if their residence is not located in France, as well as persons who work abroad and who are subject to French social security in accordance with EU law and international conventions. For people who exercise a professional activity, insurance is granted without any condition of minimal remuneration/minimal working hours. In other words, affiliation is granted from the first working hour.

In such schemes, mere legal residence (regardless of certain minimum entitlements to healthcare for illegal residents) on the territory of the Member State suffices to be affiliated to the healthcare scheme and no distinction is made between employed, self-employed and economically inactive persons (**CY**, **DK**, **EL**, **FI**, **IE**, **IS**, **IT**, **LV**, **MT**, **PT**, **SE** and **UK**). In this case, the resident EU citizen merely needs to register with the competent authorities and will accordingly gain access to healthcare in the Member State like other residents of that State.

In **Denmark**, a person is eligible to healthcare as soon as s/he has residence in Denmark and is registered in the Danish population register. Hence, any categorisation of persons is redundant in this specific context. Similarly, the ground rule to be entitled to treatment in the **Finnish** public healthcare system for a user fee, one must be a resident of a Finnish municipality. To be insured for healthcare benefits – or social security in general – one must fill in an application at the Social Insurance Institution (*Kela*). To be a resident of a municipality, an EU national needs to register with the police within three months, after which the magistrate files the place of domicile which determines which municipality is in charge of the person's social and health services. However, for employed persons working more than four months in Finland, the work must meet specific criteria for coverage by the health insurance system (a minimum of 18 working hours per week and a salary according to a collective agreement or at least 1,173 € per month) to be entitled to all the benefits awarded by *Kela* under the Health Insurance Act. Any categorisation of persons is also redundant in Sweden, as residence is decisive.

2.2.3. Mixed schemes

In other Member States, affiliation is clearly based on a combination of residence and contribution payment. In actual fact, it can safely be said that all Member States, although in essence categorised as a contribution-based system, have some kind of mixture of both. A clear example can be found in **Estonia**. There are two main criteria to get affiliated to the Estonian health insurance system. Firstly, a person has to be a permanent resident of Estonia, or a person residing in Estonia on the basis of a temporary residence permit or the right of residence, or a person legally staying and working in Estonia based on a temporary ground for stay. Secondly, as the Estonian health insurance is financed through social taxes, for the person to be an insured person a payer of social taxes should pay social taxes for him or her or s/he has to pay social taxes him or herself.

Another example of a mix of residence and contribution payment is the healthcare coverage in **Switzerland** (and **Liechtenstein**). Every person that has her or his residence in Switzerland is required to choose a sickness insurer and affiliate to this insurer within three month after arrival in Switzerland. Concerning the obligation to be insured, the law does not make any difference between employed, self-employed, non-active persons *etc*. However, affiliated persons, whether economically active or inactive, need to pay healthcare contributions, which is only replaced by state intervention in specific cases.

Finally, it is interesting to note that the **French** system is undergoing a shift from a genuine contribution-based system towards a residence-based system. The trend became obvious in 1999 with the Universal Healthcare Coverage (*Couverture Maladie Universelle – CMU*). The universal tendency has been deepened with the reform which entered into force on 1 January 2016, where the *CMU* was replaced by the *Protection universelle maladie* (*PUMA*), a more fully residence-based insurance. However, the system remains partly (and illogically) under the historical influence of a professional

approach. It is still mostly funded by social security contributions shared between employers and employees (or self-employed persons). However, contributions now represent only 60% of the overall budget, whereas taxes (of various forms) count for approximately 33%. Also Spain has a hybrid system, which is explained more in detail below.[32]

2.2.4. Healthcare as a social advantage

As employed persons moving within the Union are using the free movement of workers as stipulated in Article 45 TFEU, Regulation (EU) No 492/2011[33] regarding the equal treatment of workers and their families may come into play. However, it is abundantly clear that healthcare is generally not considered or treated as a social advantage within the meaning of that Regulation, but solely as a social security benefit coordinated according to Regulation (EC) No 883/2004. Equal treatment of mobile workers is considered to be guaranteed by the latter.

Notwithstanding the above, some healthcare-related benefits could be considered as social advantages, as broadly defined by the CJEU, covering not only all benefits connected with contracts of employment, but also all other advantages which are open to citizens of the host Member State and consequently are also open for workers primarily because of their objective status as workers or by virtue of the mere fact of their residence on the national territory.[34]

In some Member States, healthcare benefits for indigent people could be qualified as such. What could be considered as a social advantage is state payment of the cost-sharing part of medical care for all social assistance recipients in **Slovenia**. It is possible that an EU worker earns below the poverty line and is entitled to social assistance and thus to the coverage of the cost-sharing part as a social advantage. In the same way, in **Hungary** means-tested health service is paid by local governments and provided via healthcare providers to persons in need. Similarly, the subsidy to allow indigent persons to pay their sickness insurance premium in **Switzerland and Liechtenstein** could be regarded as a social advantage under Regulation (EU) No 492/2011.

In **Austria**, according to national legislation, long-term care benefits are not subject to mandatory healthcare insurance but to a specific long-term care scheme. As long-term care benefits are considered sickness benefits in the sense of Regulation (EC) No 883/2004, this might cause problems in a cross-border situation, for example for a person receiving *Pflegekarenzgeld* – a long-term care benefit – living in another EU Member State. There is a pending case that concerns an employee working in Austria and residing together with his disabled child in Germany, while claiming Austrian *Pflegekarenzgeld*. This is a social benefit for employees which aims to compensate the loss of income caused by a reduction of working time to care for a family member. The Austrian authorities refused such an entitlement with the argument that the Austrian *Pflegekarenzgeld* must be considered a long-term care benefit in kind for the disabled person in the sense of Regulation (EC) No 883/2004 and therefore must not be exported to Germany. However, the Austrian Chamber of Workers holds the view that an export obligation can be based on Regulation (EC) No 492/2011 since the *Pflegekarenzgeld* must be qualified (at the same time) as a social advantage for the employee working in Austria in the sense of Article 7(2) of Regulation (EC) No 492/2011. So if the caring person was an employee in Austria before the employment ceased, a right to export the *Pflegekarenzgeld* might be based on Article 7 of Regulation (EU) No 492/2011, as has

[32] See 2.3.3.2. below.

[33] Regulation (EU) No 492/2011 of the European Parliament and the Council of 4 April 2011, which has replaced Regulation (EEC) No 1612/68 of the Council of 15 October 1968 on freedom of movement for workers within the Community. However, the new Regulation has not altered the provisions of the former.

[34] *Hoeckx*, C-249/83, EU:C:1985:139, 973.

been the case for other social advantages for which national residence clauses were waived.[35]

2.3. Affiliation of economically inactive persons: pensioners, students and other non-active persons

Firstly, economically inactive persons are subject to the legislation of the Member State of residence.[36] This includes, in principle, the right to equal treatment with the citizens of this host State, also with regard to healthcare coverage.[37] However, taking into account the CJEU's recent case law,[38] inactive citizens' equal access to social benefits, including genuine social security benefits as coordinated by Regulation (EC) No 883/2004, can clearly be limited by legal residence requirements as set out in Directive 2004/38/EC (*cf. infra* for further comments in that regard).

Secondly, pursuant to specific rules in the sickness benefits chapter of Regulation (EC) No 883/2004, in a number of situations the access to healthcare in the host State is at the expense of another State, even for economically inactive persons. This is the case for mobile citizens who are only temporarily staying in the host Member State while continuing to be covered by the health insurance of their residence State (which for that purpose issued a European Health Insurance Card – EHIC, *cf*. *infra*). This may also be the case for mobile persons habitually residing in the host State, such as pensioners only drawing a pension from another State. The latter State will reimburse, according to specific provisions agreed in this respect, the costs of the treatment for these pensioners.[39]

2.3.1. Pensioners

Pensioners can indeed be considered as a very specific category of economically inactive persons, as a specific coordination framework has been incorporated in the Regulations with regard to their healthcare entitlements.[40] Pensioners are, like economically active persons, equally entitled to healthcare in their residence State, on account of a "pension State". If they reside in a Member State other than that competent Member State, they will be entitled to healthcare in their residence State as if the pension entitling them to healthcare was paid by the latter. For this purpose, they must register in the residence State usually by means of an S1 form issued by the competent State and healthcare will be provided on account of that State.[41]

The financial responsibility for the healthcare will always be allocated to a State from which the pensioner receives a pension. Indeed, for pensioners, the competent State is the Member State of residence, if the person receives a pension from that State entitling him or her to benefits in kind. If the pensioner does not receive a pension from his or her residence State, it will be the Member State paying the pension entitling the pensioner to benefits in kind if s/he resided there. This remains if the pensioner is entitled to

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[35] *Meints*, C-57/96, EU:C:1997:564; *Meeusen*, C-337/97, EU:C:1999:284; *Hendrix*, C-287/05, EU:C:2007:494; *Geven*, C-213/05, EU:C:2007:438; *Hartmann*, C-212/05, EU:C:2007:437.

[36] Article 11(3)(e) of Regulation (EC) No 883/2004. This Article does not make a distinction between beneficiaries of long-term benefits (invalidity, old-age or survivors' pensions, pensions in respect of accidents at work or occupational diseases or sickness benefits in cash covering treatment for an unlimited period) and "*other non-active persons*". All economically non-active persons falling within the scope of the Regulations are envisaged.

[37] Article 4 of Regulation (EC) No 883/2004.

[38] *Commission v United Kingdom*, C-308/14, EU:C:2016:436.

[39] Articles 23-26 of Regulation (EC) No 883/2004.

[40] See also ROBERTS, S. (ed.), SCHULTE, B. (ed.), GARCÍA DE CORTAZAR, C., MEDAISKIS, T., and VERSCHUEREN, H.: trESS Think Tank Report 2009, Healthcare for Pensioners.

[41] However, not every Member State always issues a PD S1 for their pensioners. For instance, there are some German pensioners in Spain without a PD S1, as far as they no longer have the right to healthcare in Germany. In order to legally reside in Spain they must have private comprehensive sickness insurance.

healthcare in the residence State only by virtue of his or her residence. If s/he receives pensions from several Member States other than the residence State, the competent State is the Member State that is paying a pension entitling the pensioner to healthcare if s/he resided there and to whose legislation, applicable to pension insurance, s/he was subject for the longest period.[42]

Thirdly, the host State may not always be able to claim reimbursement of the costs for healthcare delivered to economically inactive EU mobile nationals from another Member State. In such situations, the equal treatment provision of Article 4 of Regulation (EC) No 884/2004 guarantees such persons' entitlement to health coverage under the same conditions as the nationals of the host State resident in that State (e.g. entitlement purely based on residence, based on contributions for non-active legal residents). However, exactly in this area we can find the seeds for a potential clash between the EU social security coordination system and Residence Directive 2004/38/EC, *cf*. *infra*.

The group of economically inactive mobile EU citizens is a large and diverse population of persons who may claim healthcare in the host Member States. In that regard, for the sake of clarity, we have divided this group into students on the one hand and other economically inactive persons (including pensioners) on the other hand.

From this group, the present analysis excludes all insured persons who are temporarily inactive but still relying on their status of employed or self-employed person, receiving cash benefits because or as a consequence of their activity as an employed or self-employed person (unemployed/jobseekers). They are still to be regarded as economically active as regards the coordination of sickness benefits.[43]

2.3.2. Students

The category of EU mobile students can roughly be classified in three main categories. The vast majority of students will remain insured in their capacity as family members in the Member State of habitual residence. In their Member State of studies, they will not be insured and will only be able to appeal to the sickness benefits coordination provisions in the event of a temporary stay.[44] Secondly, if the mobile student is economically active (e.g. by performing a part-time job or evening/weekend work) and is regarded as an employed or self-employed person, s/he will benefit from the abovementioned coordination provisions for economically active persons and thus be ensured in the Member State of activity. Thirdly, a student can also be insured in the Member State where s/he studies, possibly in a specific healthcare scheme for students.

For students, it should indeed be noted that this category of persons is generally regarded as a category benefiting from derived rights as family members of insured relatives, mostly their parents. Apart from their status of family member, personal affiliation of students to the Member States' healthcare systems is usually linked to attending educational courses, registration with a school or university or paying school fees. Their affiliation to the healthcare scheme is generally subsidised by the state and subject to age limits.

As to mobile EU students, it is repeatedly reported that Member States consider them as a category that is as a rule not affiliated to the healthcare system of the Member State of studies, as they normally do not habitually reside in the country where they study and consequently remain affiliated to the healthcare system of their Member State of residence. They are thus regarded as a typical category of mobile EU citizens which uses

[42] Articles 23-25 of Regulation (EC) No 883/2004.

[43] Article 11, 2 of Regulation (EC) No 883/2004.

[44] VAN DER MEI, A.P., Free Movement of Persons within the European Community. Oxford: Hart Publishing, p. 259.

the EHIC in order to receive medical treatment in the Member State where they are staying during the period of studies abroad, notwithstanding the fact that they could self-evidently also shift residence temporarily to the Member State of studies.

Students as such are in principle not covered as a separate insurance category by the mandatory healthcare scheme in **Austria** (unless they are employed, a family member or voluntarily insured), **Finland** (unless employed), **France** (unless ad hoc affiliation), **Croatia and Malta** (unless employed). Almost all Member States refer to the EHIC as the standard way for mobile students to receive medical care.

Anyway, if a student shifts residence to her or his Member State of studies, s/he might seek access to the healthcare scheme of the latter in her or his own right and should be treated equally with national students in that regard. As to national conditions of affiliation specifically for students, we can refer to educational requirements such as those in **Bulgaria**, where they are insured under the state budget as persons under 18 or, after they have reached that age, as full-time students until they have graduated from high school, but not later than they are 22 years old. Also students in full-time education in higher education institutions are covered until they are 22 years old, and PhD students in full-time state order education schemes. Foreign students in full-time education schemes are also covered until they are 26 years old and PhD students enrolled full-time by higher education institutions and scientific research organisations in **Bulgaria**.

Specific coverage can be supported by the educational institution, like in **Croatia** (health insurance contribution to be paid by the scholarship provider), **Hungary** (provided by the university via private insurance companies during their first year of residence) or **Poland** (until students reach 26 years of age, they have health insurance as members of an insured person's family; if the latter is not the case, they are insured by the college).

Affiliation for healthcare as a student is logically often linked to a certain age requirement, as is e.g. the case in **Germany** (14 semesters of study and 30 years of age maximum), **Estonia** (no contributions under the age of 19, which can be continued for students over 19 when acquiring basic or general secondary education or formal vocational education in educational institutions founded in Estonia), **Luxembourg** (if they are under the age of 30 and if their income is less than the guaranteed minimum income), **Romania** (students under 26 with no income do not pay health insurance contributions but are insured by law), **Slovenia** (up to the age of 26) and **Sweden**.

Students who have already been residing in **Hungary** for longer than 1 year (and have a registry card and address card) must be enrolled in the Hungarian State Health Insurance System (unless they have a valid European Health Insurance Card) and pay 7,050 HUF (*i.e.* €22) a month.

2.3.3. Other non-active persons

Other categories of **non-active persons** except students are a broad category which is treated very diversely in the Member States' healthcare schemes. In general and regardless of the abovementioned specific coordination rules for certain categories of non-active persons (like pensioners), we can make a distinction in the Member States' national legislations between (1) affiliation of non-actives based on a specific status as opposed to (2) affiliation of non-actives based on residual provisions in order to guarantee an inclusive healthcare scheme for all persons legally residing on the territory of a Member State (and to a certain extent coverage for illegal residents).

2.3.3.1. Affiliation based on a specific status

This category of affiliation to national healthcare systems is related to the fact that a person has a specific social security status by receiving specific benefits or by being in a specific (health or other) condition or situation that is recognised by the Member States' legislation as leading to inclusion in the healthcare scheme.

The first category can be detected in many Member States and relates to the affiliation of persons in receipt of social security benefits such as unemployment benefits, sickness benefits in cash, invalidity benefits or old-age pensions (or persons who are very close to retirement, e.g. **EE**). Also indigent people receiving social assistance are often integrated as a specific category of persons to be affiliated to the mandatory healthcare scheme.

Next to this, affiliation can also be based on a very specific status meriting consideration by the healthcare scheme such as 'war veteran' (**BG**), 'pregnant woman' (**EE**) or 'non-working parent with a minimum of 3 children' (**EE**) or 'persons in the possession of a UK passport' (**MT**).

2.3.3.2. Affiliation based on residuary provisions to cover legal residents

The second category of affiliation to the national healthcare system is based on national measures that can be regarded as inclusive measures to guarantee that persons who are residing in the territory of a Member State can gain access to healthcare, even though they lack the required status to be regarded as insured persons. Under this category, we for instance find 'residence-based' measures in contribution-based schemes, but also the possibility to affiliate on a voluntary basis to the mandatory scheme or an obligation to affiliate with a private insurance company.

Examples of contribution-based systems that are broadened by residence-based measures can be found in several Member States. Although the **Belgian** healthcare system is in principle a contribution-based system, all persons domiciled in Belgium are covered and must pay personal contributions (€ 59, € 348 or € 697 per quarter) depending on the income level. Also in **Croatia** residence will lead to affiliation if no other insurance is available. In **Hungary**, economically inactive (EU and EEA citizens) residents (with a residence permit and an address registration card without income) pay a lump sum of HUF 7,050 (€ 22) as a flat-rate contribution to be covered against healthcare risks. In **Lithuania**, non-active EU nationals as well as their family members can participate in the Lithuanian health insurance system provided they have the certificate proving their right to live in the Republic of Lithuania. In such case, they pay the compulsory health insurance contributions or the latter will be paid on their behalf by the State (for certain categories like pensioners, children, unemployed persons *etc*).

In certain Member States, voluntary insurance is offered as a residual back-up for non-active persons, like for instance in **Austria** (non-active persons are not affiliated to the mandatory healthcare insurance scheme as long as they are not family members of an insured person or voluntarily insured),[45] **Luxembourg** (a contribution of € 107.58 per month must be paid and the right to sickness benefits will be granted after three months) and **Poland** (persons who reside in Poland and are not covered by public health insurance may acquire the right to healthcare services by registering for voluntary insurance, in which case voluntary contributions need to be paid to the National Health Fund).

It goes without saying that such inclusive measures will not be found in genuine residence-based systems, as affiliation to these systems is based purely on (legal/habitual) residence in the Member State.

The **Spanish** hybrid system needs specific attention in this regard as legal residence plays a subsidiary role in order to be entitled to healthcare. The entitlement to healthcare

[45] The right to voluntary healthcare insurance in AT applies only to those – independently of their nationality – who have their place of residence, *i.e.* centre of interests, in AT. An exception is made for students, as they only need to be temporarily staying on the territory. Benefits in kind based on voluntary healthcare insurance can be claimed only after a waiting period of three or six months, respectively. Also in this case an exception is made for students. They are not confronted with any waiting periods.

in Spain is identified in a specific law on healthcare, different from the Social Security Law. This law created in 2012 the concept of an "insured" person entitled to healthcare who is not always a "person insured in the Social Security System". Both "insurances" are granted by the National Institute of Social Security (*INSS*). However, while the "persons insured in the Social Security System" pay social security contributions, the "healthcare insured persons" do not pay contributions (healthcare is financed by taxes).

In order to determine whether a person is entitled to healthcare, the *INSS* checks first if s/he fulfils the general requirements to be considered a "healthcare insured person" (i.e. whether the person is an employee or a self-employed person active and insured under the social security system; whether s/he is a pensioner or is receiving a periodical benefit from the social security system including unemployment benefits; or whether s/he is an unemployed person whose unemployed benefits have expired). If the person does not fulfil any of the above, s/he could, subsidiarily, be considered a "healthcare insured person" if s/he is legally residing in Spain and has no right to compulsory healthcare coverage in any other way. Until August 2016, this latter group of insured persons also had to fulfil a specific requirement that was declared null and void by a Constitutional Court judgment.[46] In essence, in order to be considered a "healthcare insured person", the person's income could not exceed a certain threshold to be fixed in a Royal Decree (set at € 100,000). The Court considered that this clause infringed the hierarchy of rules as far as any amount had to be established by a Law. Thus, nowadays any legal resident can without any threshold be "healthcare insured" irrespective of income until an amended Law is passed.

2.4. Access to healthcare and legal residence based on Directive 2004/38/EC

Although access to healthcare is coordinated at EU level by Regulation (EC) No 883/2004 and No 987/2009, health insurance for non-active persons is also crucial for the assessment of their legal residence on the territory of a Member State in the framework of Directive 2004/38/EC. The condition of having comprehensive sickness insurance cover in a host Member State for a stay of more than three months for students and (other) non-active persons according to Article 7 (1) (b) and (c) of Directive 2004/38/EC is indeed vital for their right to reside in the host State, conferred on them by EU legislation.

The concept of comprehensive sickness insurance as laid down in Article 7 of Directive 2004/38/EC is not further defined, neither in Directive 2004/38/EC nor by the CJEU. The only attempt to define the concept can be found in the Communication on better transposition of the Directive[47] in which it was defined as "*any insurance cover, private or public, contracted in the host Member State or elsewhere, as long as it provides comprehensive coverage and does not create a burden on the public finances of the host Member State. In protecting their public finances while assessing the comprehensiveness of sickness insurance cover, Member States must act in compliance with the limits imposed by Community law and in accordance with the principle of proportionality*." As this definition does not elaborate on the possible criteria to assess the comprehensiveness and thus remains rather vague, this may leave room for different national interpretations of what can be regarded as sufficient coverage in order to legally reside in the host State. As this residence requirement is aimed at preventing disproportionate pressure on the Member States' public purse, this lack of guidance on how to implement may have a negative impact on the rights of mobile citizens if Member States were to interpret this too strictly.

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[46] TC 139/2016 15 August 2016.

[47] Communication from the Commission to the European Parliament and the Council on guidance for better transposition and application of Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States COM/2009/313. See also case *Baumbast*, C-413/99, EU:C:2002:493.

Comprehensive coverage could be based on both mandatory health insurance as well as on private health insurance. Moreover, mandatory coverage can be based on insurance in another Member State (evidenced by an EHIC or a S1 form) but also on equal access to the healthcare scheme of the host State.

In a situation where the Regulation designates the Member State of residence as the competent Member State, this Article guarantees equal access to the residence-based sickness benefits of a host Member State as soon as the person establishes his or her habitual centre of interest there. Moreover, it even seems fully supported by the text of Directive 2004/38/EC that the entitlement to sickness benefits under Regulation (EC) No 883/2004 cannot be regarded as a burden on the "*social assistance system*" of a host Member State. Indeed, Article 7(1)(b) and (c) of Directive 2004/38/EC does not contain any reference to "not becoming a burden on the social assistance system of the host Member State" with regard to the comprehensive sickness insurance requirement, as is the case for the sufficient resources requirement of the same Article. This indicates that the appeal to sickness benefits in the host Member State cannot be regarded as an appeal to the social assistance system of that Member State, although the abovementioned proposed definition of comprehensive sickness coverage in Communication 2009/313 seems to point in another direction. In that regard, it is interesting to see that the comprehensive sickness insurance condition is monitored differently throughout the EU, if it is monitored at all.

In some Member States, the fulfilment of the comprehensive sickness insurance cover is not verified at all (**EE**, **EL**, **IT** and **LT**), whereas specifically in the **Netherlands** it is not verified *ex ante* but can be verified at a later stage during the period of residence on the territory. Union citizens who wish to reside in the Netherlands for more than 4 months must register within five days in the municipality where they wish to live (in the Personal Records Database). However, since January 2014 there is no longer a duty for Union citizens to inform the immigration authorities of their arrival and intention to reside in the Netherlands. The authorities do not, or no longer, structurally establish whether Union citizens actually satisfy the conditions for lawful residence. However, the National Healthcare Institute and the Social Insurance Board do have access to the Personal Records Database and can contact a person who is registered as a resident and ask him or her to present evidence of being insured for medical care.

In the other Member States, the comprehensive sickness coverage condition is verified by specific legislation or administrative practices as a transposition of the provisions in Directive 2004/38/EC upon application for residence in the Member State concerned (e.g. in **ES** upon registration in the Central Register of Foreign Nationals, or by means of Identity Malta upon residence application in **MT**).

For some Member States, it is explicitly mentioned that the condition of having a comprehensive sickness insurance cover is interpreted very broadly and not restrictive, like in **Austria** (travel insurance for the Schengen area is sufficient), **Croatia** (all mandatory or private insurances are accepted) and **Romania** (Romanian, other EEA or private insurance are accepted). In **Switzerland**, the lack of health insurance leads to an automatic affiliation to a Swiss insurer. The cantons exercise supervision over every person living or working in Switzerland, they inform the population about the mandatory sickness insurance, and request persons to prove that they have chosen an insurer. If a person does not comply with this obligation, the administration of the canton affiliates a person by a formal decision to any insurer of the canton's choice.

In **France**, the requirement is thoroughly verified as the coverage should be comparable to French mandatory health coverage. For the French authorities, the insurance is deemed to be comprehensive if it covers the basket of care such as listed by the French Social Security Code. This condition can be fulfilled by the sole application of the foreign legislation or by the combined application with Regulation (EC) No 883/2004. When an EU citizen is privately insured, it is required by French local healthcare institutions to

verify that the care basket is comparable to the French statutory one. For the administration, the main criterion is that there cannot be any categories of care, goods or services excluded from the coverage which would be covered by the French statutory insurance. However, some differences are tolerated, for instance on the conditions of coverage/reimbursement. Reimbursements need not be exactly identical. The local institutions must verify that the private contract will not be a source of financial burden for the French social security system.

In **Slovenia**, the Ministry of the Interior has published guidelines on what is considered as 'suitable' health insurance for foreigners. For non-active EU citizens, it should cover at least urgent treatment. It is a condition for the right to reside and a residence permit may be annulled if there is no (longer) suitable health insurance. This may be obtained by inclusion in the Slovenian mandatory health insurance, guaranteed by bilateral social security treaties, Regulation (EC) 883/2004, voluntary inclusion (of foreigners) in the mandatory health insurance in Slovenia or private health insurance.

Non-active EU nationals entering the **UK** are required to have full healthcare insurance. In order "*to avoid the overburdening of the National Health Service - NHS with treatments for unemployed and economically inactive non-UK citizens, access to the NHS is not considered to be sufficient to meet the requirement of comprehensive sickness insurance for EU migrants, and instead private health insurance is required. However, in 2012 the Commission addressed a reasoned opinion to the UK, requesting it to consider NHS cover as sufficient sickness insurance when assessing whether or not a non-active EU citizen has a right to reside in the country*".[48]

The UK position is indeed a very good example of the tension between EU coordination and the EU Residence framework, which can be regarded as a new 'chicken or egg' debate similar to that regarding SNCBs falling under the Residence Directive's definition of social assistance. In essence, the main question is whether the Regulation's equal treatment rights for inactive persons after a residence and therefore social security competence shift (in application of Article 11(3)(e)) can be prevented by Member States' requirements on legal residence. From the recent case *Commission v United Kingdom*,[49] it can be concluded that the answer has already been provided by the CJEU, as it clearly considers legal residence as meant in Directive 2004/38/EC as "neutral entitlement condition" in a Member State's social security legislation. Indeed, also access to social security benefits as coordinated by Regulation (EC) No 883/2004 can be restricted by legal residence requirements in accordance with Directive 2004/38/EC. Although this now seems to be a well-established legal development, this cannot prevent some critical reflections.

It should be observed that the CJEU has always referred to the burden on the social assistance system or the protection of public finances with clear references to the sufficient resources requirement for legal residence. Relying on healthcare in the Member State of residence is however connected to the separate requirement of comprehensive sickness cover. In that regard, a distinction can still be made between the sufficient resources requirement and the comprehensive sickness cover requirement. As already mentioned, the text of the Directive itself does not indicate whatsoever that the entitlement to sickness benefits in a host State could be regarded as a burden on the social assistance system of that State. On the contrary, as to sickness coverage, it does not mention this goal of preventing the overburdening of the host State's system.

Moreover, where SNCBs clearly have a link with social assistance as hybrid benefits with features of both social security and social assistance, this is not the case for healthcare. The latter is a classic benefit that fully corresponds to the CJEU's definition of genuine

[48] European Commission, Free movement: Commission asks the UK to uphold EU citizens' rights, press release, 26.04.2012, cited by Eva-Maria Poptcheva Members' Research Service European Parliamentary Research Service 'Freedom of movement and residence of EU citizens' 10/06/2014 140808REV1.

[49] *Commission v United Kingdom*, C-308/14, EU:C:2016:436,

social security benefits.[50] Such argument has nevertheless already been overruled in *Commission v United Kingdom* for family benefits.

In that judgment, the CJEU has made a chronological and systemic distinction between the conflict rule of Article 11(3)(e) of Regulation (EC) No 883/2004 and a legal residence requirement for entitlement to a social security benefit. According to the CJEU, they are unrelated, as the first provision is merely a conflict rule determining the applicable legislation to avoid positive and negative law conflicts, whereas the latter is merely a national provision framing access to a social security benefit within the competence of the Member States. One cannot disregard that this reasoning seems to contain a flaw, as it neglects the overlapping of the national requirement with the EU conflict rule. Indeed, the artificial distinction between the determination of the legislation of the Member State of "residence" as the applicable legislation and the legal "residence" requirement as an entitlement condition is problematic. It circumvents the essence of the debate, namely that the national requirement in actual fact can be said to go against the conflict rule by introducing a different concept of residence (legal residence instead of factual residence). In that regard, it could be considered as national legislation that should be waived due to the direct applicability of Regulation (EC) No 883/2004, paving the way for equal treatment. However, the problem is that this national legislation is fully supported by EU legislation, namely Directive 2004/38/EC. The debate is slightly similar to that in the framework of the patient mobility case law, in which the CJEU was wriggling every which way to hold that the prior authorisation requirement for planned care in Regulation (EEC) No 1408/71 was perfectly compatible with the case law condemning such prior authorisation at numerous occasions. Nowadays, it is the Regulation that is the victim of such systemic-legal correct but still – from the *ratio legis* of EU social security coordination – at least contestable case law.

On top of this, looking at the 'welfare tourism prevention' aspect behind the mentioned case law, it cannot be neglected that 'seeking healthcare services' is *in se* more circumstantial than the entitlement to SNCBs or to social security benefits providing financial aid. Whereas the latter mainly aim to provide for financial support (in the event that a person does not reach the minimum subsistence level, in the event of costs for children *etc*) in the Member State of residence, healthcare primarily intends to address physical (and mental) needs due to the specific health circumstances of the beneficiary. The underlying principles of, respectively, financial aid versus circumstantial health needs should therefore be taken into account when assessing the "drivers to shift residence". As such, one could come to the conclusion that the financial aid as provided by SNCBs would more likely inspire welfare tourism rather than the provision of healthcare services. This is also supported by the fact that persons clearly have a preference of being medically treated close to their home and within the system they are familiar with, rather than seeking care in other countries with another healthcare system and in another language. Residence shifts inspired by healthcare tourism therefore come across as a *contradictio in terminis*.

Finally, a central part of the dialogue is without any doubt the fact that the right to healthcare is a fundamental right acknowledged in Article 35 of the Charter of Fundamental Rights of the European Union. In that regard, the CJEU's legal reasoning that a conflict rule leads to the application of legal residence requirements in the national legislation in the Member State of residence, resulting in inactive persons falling between two stools, does not suffice.

Although apart from the direction in *Commission v United Kingdom*, of which it is unsure whether it would 'contaminate' healthcare, there is no other indication that the comprehensive sickness coverage requirement would follow the same route as the sufficient resources requirement, recent case law of the CJEU has proven to be very

[50] *Hoeckx* EU:C:1985:139, 973.

much in favour of Member States' arguments to protect their social welfare circle from unjustified claims of non-active persons. In that regard, it would not be surprising if a claim for equal treatment to healthcare provision under Regulation (EC) No 883/2004 might be considered as the non-fulfilment of the sickness coverage requirement for legal residence in Directive 2004/38/EC, in order to prevent 'welfare tourism'. It could indeed be argued that both requirements (on sufficient resources and comprehensive sickness cover) follow the same logic, *i.e*. avoiding equal treatment between a person in temporary residence and nationals, not only with regard to social assistance but also regarding healthcare. This situation would only change once s/he becomes a permanent resident.

Considering the above, a more unified information and an EU-wide clarification of the "*comprehensive sickness coverage*" condition under Directive 2004/38/EC would be required. A clarification of the relationship between the comprehensive sickness requirement and sickness benefits coordination would be necessary in order to avoid distinctive (narrower or broader) interpretations by the CJEU (as is the case with the sufficient resources requirement for non-actives). Moreover, the distinctive concepts of residence in the Regulations and in the Directive cause problems. For instance, if a person stays in another Member State for more than three months, s/he has to register as a resident. To that end, s/he needs comprehensive sickness insurance cover. It needs to be clarified which role healthcare entitlements based on EU social security coordination can play in that regard. In that regard, the social security coordination rules should be adapted to elucidate the relationship between the fundamental principle of equal treatment and its possible limitations based on legal residence for economically inactive persons. This will definitely support legal certainty for mobile citizens and national administrations.

2.5. Problems related to the affiliation of EU mobile citizens to the healthcare schemes of the Member States

In the vast majority of the Member States, no problems are reported regarding the affiliation of EU citizens to the healthcare scheme. If the latter comply with the conditions of affiliation or can provide proof of their insurance in another Member State, they are granted equal access.

In some Member States, the complexity of the system or the lack of information regarding the process of affiliation can pose a problem. In **Estonia**, a person has to be registered in different registers before s/he gets the insurance cover, which could cause some confusion, but at the same time the registration processes are easy and quick. In Finland, such confusion could be generated by the complex insurance scheme, but also as to the exact entitlement to benefits and due to language barriers. In **Hungary**, especially the process to receive an insurance number (*TAJ*) is very cumbersome. Some informational problems may also arise when a mobile citizen enters the Portuguese territory, but it is expected that the central and local services, healthcare centres and units of the NHS have the capability to transmit the information and to undertake all necessary measures to ensure that healthcare is provided on time.

In some Member States, the requirement of legal residence on the territory in order to be able to affiliate to the healthcare scheme could be problematic, as is shown by the below examples.

Those who fall under the residual category that is insured because they are domiciled in **Belgium** may fail to obtain a right to healthcare. Foreigners who are not entitled to stay for more than three months or who are not entitled to establishment are excluded. Economically inactive EU citizens have a right to reside only if they have a full healthcare insurance. Therefore, certain citizens may fail to obtain a right to reside, and thereby fail to obtain a right to benefits in kind.

In **France**, the current insurance system was implemented in January 2016. Therefore, no urgent practical problem has yet been identified by national healthcare institutions. However, past experience indicates that at least two problems may occur at local level. One is the evaluation of the condition of stable residence. The person must establish a continued presence for at least three months on the French territory. The definition of stable residence may be problematic in practice. A Circular[51] explains how to determine whether someone's residence is stable. Furthermore, the way of counting the three months of residence raises questions. To what extent should account be taken of prior periods of residence completed in other EU Member States? Another Circular[52] considers that the principle of aggregation must apply as long as the periods of residence in the other country opens healthcare rights (in other words, as long as the periods of residence were completed in a country with a residence-based healthcare scheme). Other administrative sources consider that aggregated periods of residence abroad should be taken into account if they correspond to a period of insurance for any of the risks covered by the coordination Regulations. It is unlikely that the principle of aggregation is correctly implemented at local level. This is also the conclusion of NGOs who deal with practical cases. Another issue is that, even if an EU citizen is subject to French social security law according to EU rules, he or she may not be insured in France if there are remaining healthcare rights in another EU country. He or she might keep using the EHIC instead of claiming healthcare insurance in France. Indeed, according to the central administration, as long as a patient can present a valid EHIC there is no reason to assess whether he or she should be insured in France. This situation would affect mainly non-active EU citizens and non-active persons who are family members of workers.[53]

Finally, in **Switzerland**, specific affiliation problems are related to residence outside Switzerland. Persons who have their residence outside Switzerland but in an EU Member State may have to pay higher contributions than persons living inside Switzerland because sickness insurers are allowed to calculate contributions according to the country where a person has his or her residence. Furthermore, family members of a person working in Switzerland do not have the choice of insurer if they are living outside Switzerland; they are automatically affiliated to the insurer of the working parent, which is an exception to the general rule of the free choice of insurer.

Although reportedly no major issues can be detected in the area of affiliation of EU mobile citizens to the Member States' healthcare schemes, it cannot be denied that legal, administrative and practical issues require specific attention. Especially the complexity and diversity of affiliation to healthcare systems throughout the Union should inspire reflection with regard to better information exchange (*cf*. *infra*).

2.6. The financing of the scheme

As to the financing of the schemes,[54] it is accepted EU-wide that this does not seem to have an impact on the affiliation of EU mobile citizens. Whether the scheme is financed through contributions or general taxation, or through a mix of both like in most Member States, is not directly related to affiliation problems or affiliation in general. In most Member States, it is explicitly reported that there is no correlation between financing and affiliation. In a very limited number of Member States, some distant interdependence is detected between financing and affiliation.

In **Germany**, the way of financing a system of healthcare coverage has a dimension with regard to social policy and with regard to coverage. Germany has decided in favour of

[51] Circular DSS/2A/2B/3A n°2008-245 of 22 July 2008.

[52] Circular DSS/DACI/2010/461 of 27 December 2010.

[53] Letter from the Social Security Minister, 24 August 2012.

[54] See THOMSON, S, FOUBISTER,T., and MOSSIALOS, E. (2009): Financing health care in the European Union. Copenhagen: World Health Organization, p. 23-48.

insurance also because this increases a system's detachment from day-to-day fiscal politics and thus gives the system more autonomy. The gaps, such as the ones which an insurance system linked to employment may have, are filled by expressive rules covering certain other groups and professions and finally by the provision that also those persons are covered who have no other health insurance and who, on the basis of their status, are entitled to statutory health insurance or who were in the past insured by the statutory health system.

In **Croatia**, the way of financing in some cases influences the affiliation to the Croatian healthcare system and the level of benefits. Firstly, persons residing in Croatia but falling neither within the scope of insured persons, nor of family members or other categories of insured persons, have to pay the mandatory health insurance contributions themselves. They are entitled to health insurance benefits, provided they have previously paid a one-time contribution (the amount of such a contribution is calculated on the basis of a minimum contribution base multiplied by the number of months between the last mandatory affiliation to the health insurance system in Croatia or another Member State, but can amount to a maximum of 12 months). Secondly, all insured persons have the right to healthcare benefits in kind, regardless of the basis of their affiliation. Nevertheless, the level of benefits in kind differs depending on who is obliged to pay social security contributions and on the fact whether the contributions were actually paid. Persons for whom someone else is obliged to pay social security contributions (*e.g.* workers, since the payment of contributions is the employer's obligation) or those whose healthcare is financed through taxes have all the rights as long as they have the status of an insured person. However, insured persons who are obliged to pay social security contributions themselves but have failed to do so for 30 days or more only have the right to emergency healthcare. They can regain the right to standard healthcare only after paying the owed amount of contributions with interest.

2.7. National legislative measures and/or administrative practices to facilitate the access to healthcare for mobile EU citizens

2.7.1. General measures to facilitate access for mobile EU citizens

Regardless of the EU social security coordination-based facilitation (equal treatment, aggregation, assimilation), Member States generally do not seem to adopt measures which are specifically aimed at facilitating access to their healthcare scheme for mobile EU citizens. In the majority of the Member States, no measures designed to facilitate such access can be reported. However, it should be noted that in somewhat less than half of the Member States certain national legislation or administrative practices can be pinpointed as enabling mobile citizens to affiliate to the local healthcare scheme, mainly through administrative intervention, smooth procedures for affiliation and the provision of information to citizens.

In **Belgium**, the avoidance of gaps can be found in case-by-case administrative practice. A reported case concerns a person who was insured in France and received a number of treatments there, before becoming subject to Belgian law. Belgian law provides that eight treatments are due. The question was whether the treatments received in France should be deduced from that number. The Belgian institution decided that the patient would remain entitled to eight treatments, regardless of the number of treatments received before the Belgian law became applicable.

Another case of potential gaps in healthcare coverage concerns a person who was insured in the Netherlands, where he worked and resided. Having committed an offence in Belgium, he was extradited to that country, where he was put in pre-trial detention. The Netherlands terminated his insurance. Later, the person concerned was free on parole with an ankle monitor in Belgium. Belgian healthcare covers persons who have an ankle monitor provided that they are condemned, which the person concerned was not. In order to avoid an interruption in social protection, the Belgian authorities considered that his place of habitual residence lied in Belgium.

These two examples illustrate that interruptions in coverage can be very fact-specific. While admittedly a small sample, they seem to suggest that there is a willingness to avoid interruptions in coverage, by tailoring solutions to the facts of the case.

In **Switzerland** and **Liechtenstein**, if an individual affiliates to the healthcare scheme in time, the affiliation works retroactively and such "as of the day of arrival", as a result of which no gaps should occur. Such smooth affiliation in the event of a timely registration and the consequent smooth administration is also reported in **Estonia** (state and local government bodies work very quickly; most things can also be done electronically, and the exchange of data between the bodies is quite good), **Finland** (if a person has difficulties to get healthcare, s/he may ask the competent authorities for a certificate of entitlement to medical care in Finland), **Croatia** (if the competent institution establishes that the EU national has neither public nor private health insurance from another Member State, it establishes for such a foreigner the status of insured person and informs the competent tax authorities), **Iceland** (you can apply for an exemption for not being registered to healthcare in the event of sudden illness or injury, for kidney patients and for individuals who have an infectious disease and get full treatment), **Malta** (Maltese legislation applies from the moment the person pays the first weekly social security contribution) and **France** (coverage as of the first day of work).

In different Member States, the avoidance of gaps is explicitly linked to providing sufficient and accessible information, *e.g*. on websites, or via brochures or leaflets. The website of the Czech Health Insurance Bureau offers, in English, quite detailed instructions for patients coming to the **Czech Republic** concerning cases in which they would need healthcare.[55] In **Greece**, clarifications on affiliation are provided through newsletters or circulars, drafted by the competent authorities. Also in **Italy**, many information channels can be consulted containing useful information for EU citizens.[56]

In **Portugal**, the Central Administration of the Health Service prepared the 'Welcome Guide on Access to the Health System by Foreign Citizens', the main objectives of which were to provide a set of guidelines to ensure the identification and the necessary procedures for the registration and access of foreign nationals to the Portuguese Health System (*SNS*). Amongst the specific goals of the document, these guiding instruments were specifically designed to identify all foreign citizens and nationals with priority rights in another country assisted in units providing healthcare. They also serve to clarify the necessary procedures for registration of foreign citizens and nationals with priority rights in another country in the health system.

In the **UK**, the Department of Health has published a toolbox[57] to help NHS trusts comply with their responsibilities to EEA patients, including pre-attendance forms for all patients to fill in when being admitted. According to the Department of Health carrying out checks is "*a quick and simple matter that need not add more than a few seconds to the booking-in process*".[58]

If visitors from the EEA ask for information on accessing healthcare in the UK, they can be directed to a dedicated website.[59]

Sufficient information for patients is undoubtedly a crucial point for facilitating access to healthcare, especially given the great diversity of healthcare systems across the EU. In

[55] http://www.kancelarzp.cz/en/temp-in-cr/eu-insured-temporary.

[56] *E.g*. the website of the Ministry of Health: http://www.salute.gov.it/portale/temi/p2_6.jsp?lingua=italiano&id=2560&area=Assistenza%20sanitaria&menu=stranieri.

[57] www.gov.uk/dh/nhscostrecovery.

[58] Department of Health Guidance on implementing the overseas visitor hospital charging regulations 2015.

[59] www.nhs.uk/healthcareabroad.

that regard, it is highly recommendable to take further initiatives at EU level in order to guarantee a common minimum framework of information provision on healthcare affiliation as well as to share best practices with regard to facilitating access to healthcare for EU mobile citizens.

2.7.2. Specific measures concerning access to maternity benefits in kind

It is remarkable that in largely the same Member States as those where specific measures or practices to avoid gaps for EU mobile citizens were reported, also specific measures for access to maternity benefits in kind could be detected.

In **Switzerland** and Liechtenstein, the affiliation is also retroactive for healthcare related to maternity and childbirth. Therefore, a pregnant woman that settles in Switzerland is insured as from day one, once she has her residence in Switzerland and Liechtenstein.

In **Estonia**, all pregnant women whose pregnancy has been verified by a doctor or midwife are considered to be persons equal to insured persons up to three months after the predicted date of delivery. This also applies to EU citizens who have registered their right of residence in the Estonian Population Register. Having insurance cover, they get all the health services they need. In the same line, in Portugal a pregnant woman and infants are considered priority groups in medical assistance either in healthcare centres or hospitals. They are also exempt from the payment of fees. In Romania the birth is ensured for all women in maternities, assisted by specialised medical personnel.

In **Italy**, EU citizens who hold an E112 form issued in their country of origin and who are pregnant have the right to register with the *SSN* and therefore enjoy all the health benefits related to the period from immediately before to immediately after the delivery under the same conditions as Italian citizens. Furthermore, EU citizens (as well as non-EU citizens) lacking health coverage who do not have the pre-requisites to register with the *SSN*, who neither have a risk certificate issued by their country of origin nor a private insurance, and who are indigent can still enjoy urgent and non- deferrable benefits, among which the protection of maternity and the voluntary interruption of pregnancy on equal terms compared to women registered with the *SSN*.

In **Cyprus**, special rules have been reported but only for socially vulnerable groups such as Roma, refugees *etc*.

In **Spain**, **Poland** and **Sweden**, specific entitlements for pregnant women in national healthcare legislation do not seem to apply to mobile EU citizens, which is rather controversial.

In **Spain**, specific measures for pregnant women are in place but not for EU mobile citizens. Treatments during pregnancy, child birth and the post-partum period are provided free of charge to third-country nationals in an irregular administrative situation (not registered as residents nor authorised to reside).[60] According to the national legislation, this regulation does, however, not apply to EU nationals, who have to rely on their own regulatory framework (the EU coordination Regulations). Furthermore, the same regulation envisages that if their stay is for less than three months, they cannot be considered as foreign persons neither registered nor authorised to reside in order to receive the mentioned treatments linked to pregnancy. However, in general terms, EU nationals cannot enjoy fewer rights than third-country nationals in an irregular

[60] Most Autonomous Communities (*Comunidades Autónomas*), responsible for granting and providing healthcare, go even further than this legal provision (Law 16/2003, Article 3ter(b)) and grant complete healthcare to all foreigners in an irregular administrative situation, even if since 2012 the national law states that they cannot be considered healthcare insured persons in Spain. A recent judgement by the Constitutional Court considered that such legal exclusion is in accordance with the Spanish Constitution (TC 139/2016, 15 August 2016).

administrative situation. In practice, EU national women will presumably also be covered even if they are not insured under another social security system and cannot be treated based on the EHIC or S1 form.

In **Poland**, a constitutional provision is related to healthcare for pregnant women, but this is not applied to all EU citizens. The Polish Constitution obliges the state to extend particular care to persons younger than 18 years of age and pregnant women. According to the Act on Publicly Funded Healthcare Benefits, women in pregnancy, during childbirth and for up to six weeks in the postnatal period have the right to healthcare benefits regardless of whether they are insured. However, these regulations only apply to persons with Polish citizenship, refugee status, subsidiary protection or the status of a temporary resident to connect with the family after meeting conditions from the refugee act. EU citizens can receive healthcare benefits only if they are insured in their country of origin or in Poland.

In 2006, **Sweden** was criticised for not offering undocumented migrants the same healthcare, on the same basis as residents in Sweden, and Sweden therefore did not comply with its international human rights obligations. In July 2013, a new Swedish law entered into force granting undocumented migrants entitlement to healthcare on the same basis as asylum seekers, though not the same entitlement to healthcare as residents in Sweden. According to the law, they are entitled to maternity benefits in kind and other care that "may not be deferred" to a subsidised price. However, whether the law is applicable to EU citizens staying in Sweden without a right to residence is not clear and today some County Councils offer care to this group whereas others do not.

3. ACCESS TO HEALTHCARE IN ANOTHER MEMBER STATE

3.1. Various legal routes

This chapter deals with the different legal routes that persons insured in one Member State have at their disposal to access healthcare in another Member State. Such patients could, in theory, be treated under

- the coordination Regulations (EC) No 883/2004 and No 987/2009;
- Directive 2011/24/EU and its national implementation; or
- their own national legislation.

Besides, in some Member States there are International Social Security Agreements (bilateral or multilateral) that provide for additional rights to access cross-border healthcare.

Below, the three legal routes mentioned are examined in detail, including a summary of their main principles, an assessment of their impact and the interaction between them. Moreover, a review of the challenges derived from their application and the repercussions of both EU legal instruments on national healthcare systems are analysed.

3.1.1. The Coordination Regulations as a starting point

The structure of this chapter is based on that of the EU coordination Regulations, distinguishing firstly between unplanned and planned healthcare situations, continuing with an analysis of the impact of the Directive in both scenarios[61] and ending with a review of the alternative options for accessing cross-border healthcare envisaged by national legislation and international agreements.

Regulations (EC) No 883/2004 and No 987/2009, the first route, set a common legislative framework for the coordination of social security systems, including healthcare as a sickness benefit in kind. They are based on the principle of free movement of persons,[62] originally workers, and lay mainly outside the freedom to provide services principle.[63]

Directive 2011/24/EU and its national implementation, the second route, is derived from relevant CJEU case law on the refusal of reimbursement claims for planned healthcare costs that lacked previous authorisation under the Regulations. This case law grants patients the right to a different kind of reimbursement on the basis of the freedom to provide services enshrined in the Treaties since the late 1990s.[64] Until 2006, as a result of *Watts*,[65] it was not clear whether that affected all national healthcare systems regardless of how they are organised, managed or financed.[66]

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[61] Scenarios which, as is well-known, are not envisaged by the Directive itselfw.

[62] For the purpose of healthcare, insured persons entitled to healthcare in a Member State.

[63] With the exception of the so-called *Vanbraekel* supplement, see 3.3.1.4., below.

[64] *Decker* EU:C:1998:167; *Kohll* EU:C:1998:171. It has been considered that this case law is connected to a 1984 judgment on the exportation of foreign currency, *i.e*. *Luisi and Carbone*, C-286/82 and C-26/83, EU:C:1984:35. After *Kohll* and *Decker,* judgments in *Vanbraekel*, C-368/98, EU:C:2001:400; *Smits and Peerbooms* EU:C:2001:404 were also relevant.

[65] *Watts,* EU:C:2006:325.

[66] This delay could be considered a key factor to explain why the findings of the case law were not included in the new simplified Regulations. See CARRASCOSA BERMEJO, D. Cross-border healthcare in the EU: Interaction between Directive 2011/24/EU and the Regulations on social security coordination, ERA forum (2014) 15. p. 361.

Obviously, the inclusion of CJEU case law in the Directive does not prevent the direct application of evolving CJEU case law and the Treaty principles on which it is based. The risk of this third route cannot be ruled out as far as the CJEU case law and the Treaties can differ from the Directive and its implementation.[67] The CJEU interpretation of the Treaties and of previous case law can evolve,[68] not to mention that circumstances under which a ruling took place may change.

Special attention should be given to the special rules envisaged by EU legal instruments regarding two specific groups of persons and their family members: frontier workers and pensioners (whose legal position has already been analysed in the past). residence outside the competent Member State could give rise to particular legal issues and interpretative problems, which merits further analysis.

Side by side with these EU instruments and case law, there are parallel schemes that can be more beneficial for patients. Under certain circumstances, such as urgency, some Member States reimburse patients for medical expenses incurred abroad based exclusively on national law. Others envisage a worldwide reimbursement of treatment costs against national tariffs, not always subjected to prior authorisation. Finally, some Member States entitle their insured persons to access healthcare in another State under a bilateral or multilateral agreement on social security. International agreements signed between Member States and Third States are out of the scope of this report.[69]

3.1.2. Interaction between the EU cross-border healthcare routes

The relationship between EU cross-border healthcare routes is only envisaged, briefly, in the Directive. As they were adopted before the entry into force of the Directive, the Regulations ignore the case law on cross-border healthcare and free movement of services[70] and do not mention the Directive. Neither has this been taken into account in all the reforms introduced after 2011.

The Directive, by contrast, cannot be read on its own. It constantly relates to the Regulations regarding key factors such as its scope of application or the Member State responsible for the reimbursement of healthcare costs. Here there is a significant terminological divergence. Under the Directive, the "*Member State of affiliation*", debtor State or the one responsible for the reimbursement, is defined as the competent authorising Member State under the Regulations,[71] *i.e*. the one responsible for issuing the PD S2 or the authorisation for getting planned healthcare. In general, the competent Member State under the Regulations and the Member State of affiliation under the Directive are the same. There is an exception for pensioners and their family members residing in a Member State different from the competent one, when the said State is refunded the healthcare provided by means of fixed amounts.[72] In this case, the Member

[67] See FILLON, J.-C. Cross-border healthcare: towards coordination of two patient mobility routes in JORENS, Y (ed.) *et al,* 50 Years of Social Security Coordination Past-Present-Future*,* European Commission, Luxembourg (2010). p. 218.

[68] See STRBAN, G., Patient mobility in the European Union: between social security coordination and free movement of services, ERA Forum (2013) 14(3). p. 406.

[69] They could, however, be relevant when receiving unplanned healthcare abroad. According to AC Recommendation S2 (2014/C 46/09), the principle of equal treatment should apply, in principle, in cases where the competent Member State has concluded a bilateral agreement with a third country in which provisions on sickness benefits in kind which become medically necessary in a third country (during a period of stay) are included, and provided that the third country is prepared to cooperate in individual cases. This right to healthcare derives directly from the CJEU judgment in *Gottardo*, C-55/00, EU:C:2002:16, establishing that the bilateral conventions on social security involving a Member State and a third country should apply to all EU nationals unless there is an objective justification for not applying it.

[70] With the exception of the so-called *Vanbraekel supplement*, see 3.3.1.4.

[71] Regardless of whether or not prior authorisation is envisaged under the Directive.

[72] Article 63 of Regulation (EC) No 987/2009. There is a list of Member States charging fixed amounts in Annex 3, currently including CY, ES, IE, NL, PT, FI, SE and UK.

State of residence is responsible for issuing the PD S2 for planned healthcare under the Regulations and, consequently, is the State of affiliation under the Directive. If the pensioner resides in a Member State refunded on the basis of actual expenditure, the competent Member State under the Regulations would continue issuing the PD S2 and therefore would continue being the State of affiliation. Therefore, if in the future fixed amounts were generally replaced by actual expenditure as the only way to be refunded, this exception and the distinction between the Member State of affiliation and the competent Member State will disappear.[73]

Surprisingly, the Directive does not devote a specific article[74] to its interaction with the Regulations despite the fact that it declares, in its first Article, that regulating their relationship is one of its main objectives. However, considering other articles and recitals of the preamble, the following conclusions can be reached.

The main rule of interaction, also the most obvious one, is that both routes of reimbursement cannot be used simultaneously. Logically, double reimbursement is forbidden.[75]

A basic premise, in order to carry out a further analysis, is determining if both instruments can be used simultaneously or not.[76] It should be taken into account that even if their scope of application largely overlaps, they are not identical. This question is better answered in a negative way, that is by establishing when only one instrument is applicable and interaction is not an issue.

The Regulations are the *only* applicable route in the following three situations:

- Firstly, in **Switzerland**, as the Directive is only applicable in the EU and is being implemented in the EFTA countries.[77]

- Secondly, in the case of healthcare received in some third countries on the basis of social security agreements[78] between a Member State and a third country. Thanks to the so-called "*external dimension of social security co-ordination*",[79] which does not apply to the Directive.

[73] There is a work group led by the United Kingdom identifying the possible problems derived from changing the refund system from fixed amounts to actual expenditure. Germany has already experienced this change, although it does not have a national healthcare system.

[74] Some recitals of the Directive are devoted to this task. Its legal enforceability, however, is doubtful as far as preambles only clarify the legislature's intention and the interpretation of the articles.

[75] In this regard see Recital 30 of the Directive Preamble; Article 2(m), stating that the Directive applies without prejudice to the Regulations; and the first sentence of Recital 28, *i.e.* "*This Directive should not affect an insured person's rights in respect of the assumption of costs of healthcare which becomes necessary on medical grounds during a temporary stay in another Member State according to Regulation (EC) No 883/2004*".

[76] In practice both routes can be used in a complementary way. In Member States where the authorisation under the Directive route is imposed, the patients can use this latter for being reimbursed from a first outpatient visit to a doctor. Once they decide to receive surgery, they can ask for an S2 authorisation to receive healthcare under the Regulations as long as the provider is included in the social security system or the national legislation authorises it.

[77] The Directive has been applicable in Norway since March 2015. In Iceland the implementation has been in force since 1 June 2016. In Liechtenstein it has not yet been approved.

[78] The judgment in *Gottardo* EU:C:2002:16 points out that the bilateral conventions on social security involving a Member State and a third country should apply to all EU nationals unless there is an objective justification for not applying it. AC Recommendation S2, for its part, establishes that the healthcare provisions included in the bilateral convention apply to anyone entitled according to the legislation of the Member State, regardless of where they reside.

[79] Regarding the external dimension see European Commission COM (2012) 153, 30 March 2012.

- Thirdly, in the case of treatments that are explicitly excluded from the material scope of the Directive.[80]

For its part, the Directive is *exclusively applicable* in two situations:

- Firstly, and the most relevant situation, when the patient requires healthcare from a purely private provider that is not affiliated or contracted with the social security system. This is a game changer for patients from national health systems, such as in the **United Kingdom**, where private healthcare is normally not covered. However, it should be underlined that patients from Member States that already envisaged the reimbursement of healthcare costs incurred with a purely private provider abroad, such as **Austria**, **Belgium**, **Finland**, or the **Netherlands**, were already entitled under the Regulations to the reimbursement of healthcare costs incurred with a foreign private provider against their national tariffs, according to Article 25(B)(7) of the implementing Regulation.[81]

- Secondly, for third-country nationals insured in **Denmark**, as far as they are excluded from the Regulations route.[82]

If *both the Regulations and the Directive are applicable*,[83] the patients should choose one instrument over the other after being actively and thoroughly informed of their rights by the National Contact Point. In the absence of an explicit choice in favour of the Directive, the Regulations should be applied. The patients cannot be deprived of the presumably more beneficial rights granted by the Regulations. This preferential application is only referred to explicitly in a provision devoted to healthcare treatments that require *prior authorisation* under the Directive and under the Regulations.[84]

To find out which route is more beneficial for the patient several aspects must be taken into consideration. For instance, if the national implementation envisages prior authorisation and other administrative requirements, if there is co-payment of the differences between the tariffs of reference in the Member States involved. A further analysis of these aspects, distinguishing between unplanned and planned situations, will be carried out in this chapter.

3.2. The distinction between unplanned and planned healthcare

Among the various discrepancies between Regulation (EC) No 883/2004 and Directive 2011/24/EU, one of the most obvious is that the latter does not make a distinction between unplanned[85] and planned[86] healthcare, but applies to health services[87] in general.

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[80] Long-term care, organ transplants and public vaccination programmes. Long-term care is controversially excluded from the scope of the Directive although it is a sickness benefit in kind that falls within the scope of freedom to provide services. See Article 1(3) of Directive 2011/24/EU.

[81] Regarding the meaning of this obscure Article see 3.3.1.3, section *Healthcare subjected to upfront payment*.

[82] "*The Directive applies to all third country nationals who are entitled to healthcare benefits in Denmark. Said beneficiaries are not covered by the Regulations as Denmark is not bound by Regulation 1231/2010/EU OJ L 344, 24 December 2010. For them, Denmark cannot be a Competent MS under the Regulations but could be a MS of Affiliation under the Directive. It should be noted that the right to cross-border healthcare does not in itself entitle a patient to enter, stay or reside in a MS (Recital 18 of the Preamble of Directive 2011/24/EU). The Directive does not bypass national laws on immigration."* CARRASCOSA BERMEJO, D. Cross-border healthcare in the EU: Interaction between Directive 2011/24/EU and the Regulations on social security coordination, ERA forum (2014) 15.p. 366.

[83] This possibility was recognised by CJEU case law regarding the right of reimbursement based on the freedom to provide services before the Directive was in force. See the judgment in *Vanbraekel* EU:C:2001:400, paragraphs 37 to 53 and *Watts* EU:C:2006:325, paragraph 48.

[84] See Article 8(3) of Directive 2011/24/EU.

[85] Article 19 and 27 (1) of Regulation (EC) No 883/2004.

The Regulation has traditionally applied this distinction since the beginning of the 1970s, when the rules on planned healthcare were introduced.[88] To date, different rules apply to these two scenarios, while the decisive criterion between unplanned and planned healthcare is the *(initial) intention of the patient*. Unlike in case of *unplanned or occasional care*, where the need for healthcare during a temporary stay abroad manifests itself unexpectedly,[89] healthcare is considered as *planned or scheduled* when a patient travels to another Member State with the *intention* to receive medical treatment there.

Nevertheless, the *intention of the patient* is not always as explicit as not to raise the question how it can be investigated among real life circumstances. The CJEU faced this dilemma in the case of a chronically ill patient who travelled to Germany to visit his son. During his temporary stay in Germany, he was admitted to a clinic in Munich for cardiovascular disease. His health insurance fund refused to reimburse his medical costs on the ground that his hospital treatment in Germany had been planned. The CJEU ruled that when a person with a pre-existing pathology travels abroad, it cannot be automatically presumed that s/he intends to obtain medical treatment in that Member State.[90] However, it can happen that a chronically ill patient or a pregnant woman who prefers to give birth abroad tries to make his or her medical travel look like a holiday – during which medical necessity occurred – and the authorities do not have many tools to prove otherwise.

Austrian authorities also reported on a recent problematic case of distinction between unplanned and planned healthcare, which concerned an Austrian national who wanted to undergo a sex-changing operation in Germany. The planned treatment was not authorised, but the patient obtained the desired healthcare anyway. However, after the operation, due to post-operative complications, another surgery was needed and he had to stay in the German hospital for another week. The patient argued that the latter operation was not planned and occurred as a necessary treatment, so he claimed for reimbursement of the related costs. The request for reimbursement was turned down and the Austrian authorities confirmed that *"(w)hat is essential for the distinction between 'planned' and 'occasional' healthcare is the purpose of the stay abroad which led to healthcare."*[91] Thus, the question is not only how the intention of the patient can be investigated and proved when uncertain, but also at which moment in time the intention is decisive: is the question settled already in the moment of travel as it can be seen in the Austrian argumentation based on the "*purpose of the stay*", or may the intention of the patient change over time?

This latter issue can be demonstrated in cases where the patient receives treatments of different kinds. For example, if an insured person suffers an accident and breaks his or her leg and subsequently it gets operated on, the situation is rather clear. However, if – at the same time – his or her kidney stones are removed (and no prior kidney pain could be demonstrated, as a result of which necessity would be clearly present), the competent institution might question whether this service consumption was still unplanned. If we

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[86] Article 20 and 27 (3) of Regulation (EC) No 883/2004.

[87] Article 1 (2) of Directive 2011/24/EU stipulates that the Directive applies to the provision of healthcare to patients, regardless of how it is organised, delivered and financed; except for the services enumerated in Article 1 (3), *i.e.* long-term care services, services related to organ transplantation and public vaccination programmes.

[88] The possibility to obtain non-planned medical care during a temporary stay abroad was already offered by the very first set of coordination Regulations (Regulation No 3 of the Council concerning social security for migrant workers and Regulation No 4 of the Council laying down detailed rules for implementing and supplementing the provisions of Regulation No 3 concerning social security for migrant workers), whereas – as a rather progressive step at that time and that level of European integration – provisions on planned care were introduced in 1972 by Regulation (EEC) No 1408/71 (see especially Articles 22 (1) (c) and 22 (2) of Regulation (EEC) No 1408/71).

[89] The healthcare has to be unforeseen in the sense that it has to become necessary during a trip that a person has undertaken for non-medical purposes.

[90] *Ioannidis*, C-326/00, EU:C:2003:101.

[91] JORENS Y. and LHERNOULD J-P., trESS European Report 2013, p. 29-30.

apply the Austrian authorities' interpretation, we might come to the conclusion that at the moment of the journey abroad, none of the medical interventions were planned, but it might happen that the patient who had to undergo surgery anyway, decided to fix another health problem all at once.

It can be argued that this approach, namely applying a distinction between unplanned and planned healthcare, seeks to balance between the migrant person's right to access to healthcare and the competent Member State's interest in controlling resources. While in case of unplanned care the possible occurrence of healthcare provision, and thus the financing obligation of the competent Member State, is adventitious, in case of planned care the healthcare provision is the reason and the goal of the journey, and thus almost certainly evokes the financing obligation of the competent Member State. This logically explains why different administrative procedures are in place and unplanned care can be received simply by presenting an EHIC, whereas obtaining planned care under the Regulation's regime requires a prior authorisation from the competent institution in the form of a Portable Document S2.

Directive 2011/24/EU does not differentiate between such types of medical treatments. The reason for this is that – as already mentioned in the previous subchapter – unlike Regulation (EC) No 883/2004, which is based on the *free movement of persons*, the Directive grew out of the case law of the CJEU on the *free movement of healthcare services*. This case law repeatedly underlined not only that the freedom to provide services includes the *freedom for the recipients of services* (including persons in need of medical treatment) to go to another Member State in order to receive those services there,[92] but also that medical treatments are subject to the Treaty rules on free movement of services.[93] The CJEU confirmed that indeed both unplanned and planned care falls under the scope of healthcare services in the meaning of the Treaty.[94]

The *lack of distinction* between unplanned and planned care in the Directive has both advantages and disadvantages.

A good side is that neither different rules must be applied, nor must the intention of the patient be taken into account. The lack of distinction annuls the problem that the difference in the administrative procedures under the Regulation's regime might be a source of *fraudulent use* of patients' mobility rights. Since unplanned healthcare does not require prior authorisation and its coverage is not limited to the benefit basket of the competent Member State, if the basket of treatments is more generous in another Member State, some patients might see it as a 'back door' to receive healthcare in the latter country. Thus, patients might be tempted to take a short trip to this Member State and pretend to require an unforeseen treatment instead of embarking on a less attractive administrative process. The treating medical professional, who is in charge of deciding whether a treatment is necessary for the patient, might not be in the position to detect such techniques.[95] For example, in **Spain** dental coverage by the public healthcare system is limited to certain urgent treatments. An urgent dental extraction is covered, but the dental filling is not. If a patient insured in Spain goes on holiday in **Luxembourg** for a month and has a toothache, s/he could visit any dentist working with the Luxembourg National Health Fund (*Caisse Nationale de Santé – CNS*) and should receive the same treatment as anyone insured in Luxembourg, considering the duration of the stay. If the doctor considers it necessary to perform a dental cleaning and a filling, Spain

[92] See among others *Luisi and Carbone* EU:C:1984:35, paragraph 10; *Watts* EU:C:2006:325, paragraph 87; *Stamatelaki* EU:C:2007:231, paragraph 20; *Commission v Spain* EU:C:2010:340, paragraphs 48-50; *Elchinov* EU:C:2010:581, paragraph 37; *Commission v France* EU:C:2010:579, paragraph 31; *Commission v Luxembourg* EU:C:2011:34, paragraph 35.

[93] *Kohll* EU:C:1998:171, paragraph 21.

[94] *Commission v Spain* EU:C:2010:340, paragraph 50.

[95] Concerning this kind of abuse, see JORENS, Y., DE SCHUYTER, B., and SALAMON, C. (2007), Towards a rationalisation of the EC Co-ordination Regulations concerning Social Security?, Ghent: Academia Press, p. 139.

should reimburse the invoice envisaged under Luxembourg social security law.[96] Moreover, dilemmas related to some specific groups of patients, such as pregnant women and chronically ill persons,[97] in case of which the investigation of the patient's intention can be even more problematic due to a pre-existent medical condition, are irrelevant.

As a disadvantage, applying the same set of rules to each healthcare provision can result in paradox situations. This is especially true when we apply the Directive's authorisation rules consistently in each situation regardless whether the healthcare service required is unforeseen.

Since the Directive permits Member States to provide for a system of prior authorisation for the reimbursement of certain costs of cross-border healthcare services, theoretically it would be possible that a Member State refuses to reimburse the costs of unplanned hospital treatment obtained without a prior authorisation at a purely private provider. For instance, suppose an insured person suffers a ski accident during a skiing holiday abroad and the emergency helicopter takes him or her to the nearest private clinic located in the ski resort. In this case, the application of the Regulations does not even come into play, since purely private providers operating outside the statutory healthcare system are excluded from their scope.[98] Under the Directive's rules, the patient can request reimbursement of the medical costs based on the domestic tariffs in the Member State of affiliation. However, since the Directive allows – and as it is shown later in this report numerous Member States used this possibility – to make the reimbursement of hospital costs dependent on prior authorisation, the competent Member State is free to refuse the reimbursement due to the lack of prior authorisation. Although it was not reported that any Member State would apply this exact method, the reality of this problem is proven by the fact that this question was expressly addressed in the Administrative Commission (AC). The Secretariat of the AC was of the view that a treatment should be reimbursed if it becomes necessary during a temporary stay and prior authorisation cannot be requested.[99] Undeniably, this interpretation is perfectly logical and realistic – in case of an accident (*i.e*. urgency or immediate necessity) it is unrealistic to expect the patient to request an *ex ante* authorisation under the Directive just in case s/he suffers an accident and is admitted to a private facility. However, it is not entirely in line with the current wording of the Directive, which does not even recognise the notion of medical necessity in this respect. Additionally, the interpretation given by the Secretariat is not binding for the Member States either.

This 'legal hiccup' leads back to a more basic question which has been the subject of academic debate[100] ever since the adoption of the Directive: does the Directive apply to unplanned care, and also, was the Directive intended to be applicable to unplanned care in the first place?

While answering the first question, namely whether the Directive applies to unplanned care, attention shall be paid to the *definition of patient*, according to which natural persons both *seeking to receive and actually receiving healthcare* are considered patients[101] including both planned ("*seek to receive*") and unplanned healthcare

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[96] Dental care is reimbursed in Luxembourg at the rate of 88%. Specific reimbursement rates and conditions apply for dental prostheses.

[97] See *Ioannidis* EU:C:2003:101.

[98] However, sometimes this kind of private coverage could be reimbursed under the Regulations, but only in some Member States and always considering their own tariffs (Article 25(B)(7) of the implementing Regulation). See 3.3.1.2, section *Healthcare subjected to upfront payment*.

[99] Administrative Commission for the Coordination of Social Security Services (2011), Minutes of the Working Party of the Administrative Commission on Patients' mobility, AC 332/11, 4 October 2011.

[100] See among others BIEBACK, K-J. (2013), Rechtlinie 2011/24/EU – Patientenrechtlinie, in: FUCHS, M. (ed.), Europäisches Sozialrecht. Baden-Baden: Nomos, p. 656; and STRBAN, G., Patient mobility in the European Union: between social security coordination and free movement of services, ERA Forum (2013) 14(3), p. 398.

[101] Article 3 (h) of Directive 2011/24/EU.

("*receive*" – it can be argued that in the event of unforeseeable medical treatment evoked by an accident or sudden illness the patient is usually not in the position to actively seek healthcare). It is far from clear-cut, though, because at the same time the Preamble provides that the Directive should apply to individual patients who *decide to seek healthcare* in a Member State other than the Member State of affiliation,[102] where the word *decide* and *seek* suggest that the Directive was basically constructed to cover only planned care. However, the Commission's interpretive note cleared up the situation by pointing out that *both the Regulations and the Directive apply to planned and unplanned healthcare*.[103] Although the note itself is legally not binding, the Member States did implement the Directive accordingly. Either way, whether it was the original intention of the European legislature to include unplanned care in the scope of the Directive, remains debateable.[104]

Although the Directive undoubtedly strengthens European patients' right to access to unplanned healthcare abroad, as it opens up the general possibility to be reimbursed for treatments obtained from private providers outside of the statutory scheme, it would be desirable to expressly codify into the Directive that the reimbursement of costs of medical services which become necessary during a temporary stay abroad cannot be made dependent on a prior authorisation of any kind, including the requirement of a referral from a medical doctor. Nevertheless, this change would necessitate the introduction of certain – not completely unproblematic – terms as well, such as necessary care[105] or temporary stay.[106]

3.3. Unplanned healthcare

3.3.1. Unplanned healthcare under Regulation (EC) No 883/2004

The term unplanned is not mentioned in the Regulations but is used in contrast to planned or scheduled healthcare, the authorised type of healthcare treatment defined in Article 20 of Regulation (EC) No 883/2004. Unforeseen healthcare treatment is, undoubtedly, the most common cross-border healthcare situation: millions of European Health Insurance Cards have been issued and are used in the EU every year.[107]

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[102] Recital 11 of the Preamble of Patient Mobility Directive 2011/24/EU.

[103] 'Guidance note from the Commission on the relationship between Regulations (EC) No 883/2004 and 987/2009 on the coordination of social security systems and Directive 2011/24/EU on the application of patients' rights in cross border healthcare', AC 246/12, p. 4.

[104] In the proposal, the Commission indicated that the new Directive "*would allow patients to seek any healthcare in another Member State.*" The expression *seek* unequivocally implies that the original intention was to "*put in place an alternative mechanism based on the principles of free movement and building on the principles underlying decisions of the Court of Justice,*" which at that time exclusively concerned planned care abroad. European Commission: *Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare*. COM (2008) 414 final, 2.7.2008, p. 4.

Moreover, the preamble of the proposed Directive expressly stated that "*(t)his Directive does not address the assumption of costs of healthcare which become necessary on medical grounds during a temporary stay of insured persons in another Member State*" (Recital 20 of the Preamble, COM (2008) 414, p. 25.) and similarly, in Chapter III the proposal referred to "*insured persons travelling to another Member State with the purpose of receiving healthcare there or seeking to receive healthcare provided in another Member State*." (Article 6 (1), COM (2008) 414, p. 25.)

Later on, in an infringement procedure against the Kingdom of Spain, the CJEU ruled that necessary healthcare as well as planned healthcare is classified as a service within the meaning of the Treaty. *Commission v Spain* ECLI:EU:C:2010:340, paragraphs 47-50. This is the approach which was codified in the Directive.

[105] The concept of 'necessary' under the Regulation's regime needed to be clarified partly by the CJEU and partly by the Administrative Commission on several occasions, as is analysed later in this report, see 3.3.1.2, section *Necessary healthcare treatment*.

[106] The unclear nature of this notion was illustrated well by a recent case before the CJEU (*I v Health Service Executive*, C-255/13, EU:C:2014:1291). This case is scrutinised later in this report. See 3.3.1.1, section *Temporary stay*.

[107] In 2013 35.5 million EU cards were issued and almost 200 million cards were in circulation; PACOLET, J. and De Wispelaere, F., The European Health Insurance Card – EHIC Questionnaire, Network Statistics FMSSFE,

Unplanned healthcare can be described as the necessary and unforeseen healthcare received during a temporary stay outside the competent Member State that has a non-medical purpose. As will be shown, the notion of unplanned healthcare is based in undefined legal concepts such as *temporary stay* or *necessary treatment*,[108] with 'chronic' interpretation problems. The Implementing Regulation,[109] the AC Decisions and Recommendations[110] and case law have tried to clarify this blurred legal outline that sometimes makes it difficult to determine which situation the insured person is in, and more importantly, which Member State has to bear the healthcare expenditure and to what extent.

3.3.1.1. The scope of unplanned healthcare

Temporary stay

In order to receive unplanned healthcare under the Regulations, the insured person or family member must be on a *stay outside* the competent Member State.[111] It is important to distinguish between staying and residing in a Member State. When a person resides in a Member State, in principle, s/he would neither be entitled to unplanned healthcare using the EHIC, nor to healthcare reimbursement under the case law or Directive 24/2011/EU, as far as the situation lacks the cross-border element on which the freedom to provide healthcare is based.[112] Besides, the number of residents is a key factor in correctly determining the healthcare services needed under a national health system.

The difference between staying and residing, however, is not always easy to establish. According to Regulation (EC) No 883/2004 "*staying*" means temporarily residing,[113] while "*residing*"[114] means setting the habitual residence. The Member State of residence, with only one existing for the purpose of social security coordination,[115] is defined as the State where the person's centre of interests is located.[116] As mentioned above,[117] the factors included in Article 11 of Regulation (EC) No 987/2009 can be used in the event of disputes regarding residence between national institutions or between an insured person and a national administration.[118]

The unique situation of *Mr I.* is a good example of the underlying complexity.[119] In the judgment in *Mr I*. the CJEU established that remaining continuously during a long period

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European Commission, June 2014, http://ec.europa.eu/health/ph_overview/co_operation/healthcare/docs/COM_en.pdf.

[108] Despite the efforts for clarification (AC Decisions and explanatory notes) Member States still ask for enlightenment regarding the interpretation of "*necessary treatment*".

[109] Article 25 of Regulation (EC) No 987/2009.

[110] http://ec.europa.eu/social/BlobServlet?docId=4987&langId=en.

[111] Title of Article 19 of Regulation (EC) No 883/2004.

[112] In that sense see *Petra Von Chamier Glisczinski*, C-208/07, EU:C:2009:455.

[113] Article 1(k) of Regulation (EC) No 883/2004.

[114] Article 1(j) of Regulation (EC) No 883/2004.

[115] *Wencel*, C-589/10, EU:C:2013:303, paragraphs 45 and 46.

[116] *I v Health Service Executive* EU:C:2014:1291, paragraph 44.

[117] See point 3.

[118] *I v Health Service Executive* EU:C:2014:1291, paragraph 44. In his Opinion (EU:C:2014:178), the Advocate General considered that Article 11 of Regulation (EC) No 987/2009 was only relevant in the event of disagreements between Member States' institutions and therefore did not apply in the case of Mr I.

[119] Mr I. was an Irish national that went on holiday to Germany in 2002 and had to receive urgent unplanned healthcare. He was initially diagnosed with tetanus but then he suffered a rare stroke (brain infarct) that led to severe quadriplegia, so it was impossible for him to return to Ireland. Years later he was diagnosed with cancer. Due to his acute medical condition, Mr I. could not return to Ireland. He required continuous healthcare and had to stay in Germany. To that end the Irish service had issued an S2 form (authorising planned healthcare). After 11 years in Germany and more that 20 renovations of the S2 form, the Irish service claimed that Mr I. was no longer residing in Ireland despite the fact that he received a disability allowance from Ireland. Mr I. explained that he wanted to return to Ireland where his two children live, as he remained in regular contact with them. On the other hand, he did not own a property in Germany and had barely worked there. He had just delivered a

of time in another Member State (more than 11 years in the case of Mr I.) does not necessarily mean a change of residence for the purpose of the coordination Regulations.[120] As the other criteria defining residence, mentioned under Article 11 of the implementing Regulation, were not useful to clarify the situation it should be checked if said situation reflects a personal choice or not. In this regard, as mentioned above, the initial purpose of the trip (especially the reasons that led the person to move) has to be analysed. In Mr I's case he was on holiday, on a non-medical purpose trip, compelled to stay in Germany on medical grounds, not integrated in Germany and willing to return to Ireland. As the CJEU established, he stayed in Germany in an unplanned healthcare situation that should be borne by Ireland as the competent Member State, and the situation did not change over the years.

Most of the Member States found the circumstances of this case so exceptional that they did not implement any national measures to comply with it. However, the legal basis of this ruling, namely the importance of the insured person's personal choice in determining the Member State of residence could be applied in other cases, although it generates legal uncertainty, *e.g*. with regard to pensioners living each half of the year in a different Member State and whose centre of interests is not clearly located.

Unforeseen healthcare treatment

As already mentioned, the Regulations establish that unplanned healthcare has to be unforeseen, meaning that it has to *become necessary* during a trip that a person has undertaken for non-medical purposes,[121] *i.e*. for a reason other than receiving healthcare abroad, such as holiday, business or visiting family or friends.

The concept of unforeseen healthcare, however, requires clarification in some cases, as it has been considered broader than emergency care. If the purpose of the journey is not to receive healthcare, a pregnant woman has the right to receive care during childbirth if she travels on a date close to the delivery date. So does a chronically ill patient who can travel and use the EHIC to receive the healthcare that s/he knows that s/he is going to need abroad. To this extent, the Administrative Commission has established a list of benefits in kind which, in order to be provided during a temporary stay in another Member State, require a *prior agreement* between the person concerned and the institution providing the care for practical reasons,[122] *i.e*. because they require specialised medical units, staff or equipment.[123] This prior agreement should not be mistaken with the aforementioned prior authorisation.

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few lectures in the University of Dusseldorf. He did not even have a German bank account. The Advocate General disagreed with the Irish service. He considered that Mr I. did not plan to move to Germany, but was now compelled to stay on medical grounds. The length of the stay does not itself entail the consequence that the place of treatment should be considered the habitual residence. So, from the point of view of social security coordination, he must be considered a resident in Ireland and a kind of 'medical refugee' in Germany. The odd thing is that, although it was almost impossible for Mr I. to travel in scheduled airlines, he travelled to Lisbon in 2004 and to Ireland in 2009. Mr I. passed away on 7 April 2014, but the preliminary question was answered by the CJEU considering it relevant for the purposes of the national proceedings. Case *I v Health Service Executive* EU:C:2014:1291.

[120] It is an autonomous concept, different from tax residence or the free movement residence defined by Directive 2004/38/EC.

[121] See Recital 6 of AC Decision S1 "*The European Health Insurance Card should be used in all situations of temporary stay during which an insured person requires health care irrespective of the purpose of the stay, be it for reasons of tourism, professional activity or study. However, the European Health Insurance Card cannot be used when the purpose of the stay abroad is solely to obtain healthcare*."

[122] Article 19 (2) of Regulation (EC) No 883/2004.

[123] See AC Decision S3, establishing that the patient and the unit in the Member State of treatment should reach a prior agreement to ensure that this kind of special healthcare is available during the stay. Its objective is to guarantee the continuity of the treatment needed by an insured person during a stay in another Member State. The prior agreement has to concern the vital nature of the medical treatment and the fact that this treatment is accessible only in specialised medical units and/or by specialised staff and/or equipment. The non-

Logically, it is not always easy for a social security system to determine the purpose of a journey or a patient's actual intentions. In many cases it is simply impossible, as it was pointed out above (see 3.2).

3.3.1.2. Healthcare coverage

The insured person has the right to treatments that become necessary on medical grounds during her or his stay, taking into account the nature of the benefits and the expected length of the stay.

Necessary healthcare treatment

The concept of necessary treatment remains in need of clarification despite the efforts by the CJEU or the Administrative Commission.

The treatment has to be *necessary* on medical grounds according to the doctors of the Member State of treatment and its basket of services, not necessarily urgent or immediate but *sufficient* for the patient to continue her or his stay under safe medical conditions without being forced to return in advance.[124] The treatment no longer needs to be linked to a sudden illness,[125] *i.e*. it may be linked to a pre-existing pathology of which the patient is aware.[126]

The coverage is the same as the one a person insured in the Member State of treatment would receive, but adapted to the *duration of the stay* which should be known and taken into account by the doctors and pharmacists.

The insured mobile patient has the right to equal treatment in the Member State of treatment, *i.e*. s/he should be treated in the same way and within the same timeframe as domestic (national) patients. However, there is an important difference: s/he has the right to treatments considered medically necessary by the doctors of the social security systems where s/he is treated in order to continue her or his stay. For instance, a tourist could feel sick, go to the doctor and be diagnosed with cancer. If the treatment is not urgent and s/he can be medically stabilised to continue her or his stay, this patient would not receive the whole treatment envisaged for a national patient insured in the Member State of treatment but only those services considered necessary for not being forced to return in advance.

In practice, it is not easy to determine what treatments and pharmaceuticals should be considered necessary in each case to continue a stay. When the temporary stay lasts for a long time – not necessarily as much as in the case *Mr I*[127] – should there really be any difference between the unplanned healthcare coverage and the average national insurers' coverage?[128] Is a gynaecological check-up necessary for a woman staying in another Member State for two months? What about a polio vaccine for her baby?

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exhaustive list based on these criteria given in the Annex of AC Decision S3 mentions kidney dialysis, oxygen therapy, special asthma treatment, echocardiography in case of chronic autoimmune diseases and chemotherapy.

[124] Article 25(A)(3) of Regulation (EC) No 987/2009.

[125] This requirement of "*immediately necessary care*" disappeared in June 2004 with the amendment of Regulation (EC) No 1408/71 by Regulation (EC) No 631/2004. This amendment brought into line the rights of all insured persons regarding unplanned healthcare. Until that date only pensioners had the right to "*necessary healthcare*". See also *Ioannidis* EU:C:2003:101.

[126] Recital 3 of AC Decision S3. As mentioned above, in the case of a chronic illness the treatment can be subjected to a "*prior agreement*" to assure the availability of the required service.

[127] See 3.3.1.1, section *Temporary stay*.

[128] CARRASCOSA BERMEJO, D., Cross-border healthcare in the EU: Interaction between Directive 2011/24/EU and the Regulations on social security coordination, ERA Forum (2014) 15. p. 371.

As a result of this unclear definition, several problems arise. Healthcare providers could be tempted to reduce the scope of medically necessary treatments rejecting the usage of the EHIC and demanding upfront payments.[129] Competent Member States, on their part, cast doubt on whether treatments provided are medically necessary to continue a stay or are a result of some kind of abuse.

There is an obligation to accept the medical decisions, findings and choices of treatment made by the doctors of the Member State of treatment in accordance with the current state of medical knowledge, unless there are reasonable grounds to suspect abuse.[130] If a benefit was provided within the validity period of the EHIC, a claim of refund to the competent Member State that issued the card can only be rejected[131] on specific grounds related to the formal claim.[132]

Duration of stay

The length of stay is not limited under the Regulations. The CJEU has established[133] that a temporary stay can be extended for years and it does not need to have a planned duration. The temporary stay ends when the person changes her or his residence, *i.e*. s/he has a new centre of interests.

However, as mentioned above,[134] there are other concepts of residence at an EU level regarding the free movement of persons and linked to social security benefits. Directive 2004/38/EC[135] establishes that if a person stays in another Member State for more than three months, s/he has to register as a resident (administrative residence). To that end, s/he needs a comprehensive sickness insurance cover. A valid EHIC cannot always be used to fulfil this requirement. Member States may accept it in some cases but reject it in others. For instance, Lithuania accepts it in the case of students and inactive persons and Spain accepts it only in the case of students under an EU programme.

Availability of treatment

The availability of treatment in the Member State of destination is also an important issue. Apart from the cases mentioned above, when a prior agreement is needed, the patient may have to wait for a treatment as any other domestic patient depending on clinical priority. Patients under unplanned healthcare should be offered the option to join the waiting lists for receiving any non-urgent but necessary treatment if it is compatible with the expected length of the stay. S/he cannot be discriminated against on the grounds of nationality but medical services do not have to prioritise her or his treatment to the detriment of national patients either.

If a request for providing a treatment is rejected, the healthcare provider has to prove that it concerns a general lack of capacity, especially in the case of urgent vital cases.

3.3.1.3. The payment and reimbursement procedure

The EHIC, as already mentioned, is both the proof of entitlement to unplanned cross-border healthcare and the payment guarantee for the foreign healthcare provider and the

[129] In this regard, the implications of the implementation of Directive 2011/24/EU are analysed under 3.4.4.

[130] See Article 3 of AC Decision S9 as clarified by the CJEU in *Keller*, C-145/03, EU:C:2005:211.

[131] Article 67(5) of Regulation (EC) No 987/2009.

[132] See 3.3.1.3.

[133] *Mr I.* EU:C:2014:1291.

[134] See also part 2.4.

[135] Article 8(3) of Directive 2004/38/EC.

Member State of treatment.[136] Under exceptional circumstances, such as theft or loss of the EHIC or departure at too short a notice for an EHIC to be issued, the patient may receive and use a provisional replacement certificate (PRC).[137]

The competent Member State is responsible for issuing the EHIC. The card is normally issued as an independent one, although some countries, such as **Italy**, issue it on the backside of the national healthcare card.[138] In other countries the EHIC should be requested, normally online. Its validity varies significantly. For example, in **Spain** it is two years, in the **United Kingdom** it is five years and in **Slovenia** it is one year except for children and pensioners, in which case it is five years; by contrast, in **Bulgaria** pensioners are covered for 10 years.

The competent Member State, as the State issuing the EHIC, is also responsible for reimbursing the healthcare costs to the Member State of treatment or to the patient.[139] The competent Member State, as the debtor Member State, can only reject a claim for reimbursement if the claim is incomplete or incorrectly filled out; if the claim concerns benefits which have not been received within the validity period of the EHIC or PRC used by the patient;[140] or if there are reasonable grounds or relevant reasons to suspect abuse in accordance with CJEU case law.[141] Since 2013, **Spain** issues a PRC to inactive persons who are entitled to healthcare only on a legal residence basis. In these cases, the PRC provides coverage abroad for a maximum period of 90 days as said inactive persons will lose their entitlement to healthcare in Spain if they reside abroad for more than 90 days.

If an insured person staying abroad and asking for healthcare does not have a valid document of entitlement, *i.e*. an EHIC or PRC, the institution of the Member State of treatment, upon request or if otherwise necessary, may contact the institution of the competent Member State in order to obtain proof of entitlement.[142] When the patient requires an urgent treatment there may not be enough time to check her or his entitlement to healthcare in the competent Member State, so s/he will probably be charged upfront.

The EHIC entitles the insured person to be treated as a national insured patient, which, depending on the Member State, means being treated free of charge at point of use or being subjected to upfront payment. In most cases this also means being subjected to the co-payment of medical treatments, transportation and/or pharmaceuticals.[143]

Most Member States[144] have a national health service or a health insurance fund[145] that provides healthcare for free at point of use by means of public and/or private providers.[146] Some States (*e.g*. **FI**) provide treatment at public providers free of charge and treatment at private providers subjected to upfront payment and partial *ex post* reimbursement.

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[136] AC Decisions S1 and S2.

[137] The PRC has a limited duration. See Recital 6 of AC Decision S1.

[138] It seems reasonable as both rights are joined: if you are insured at a national level you have the right to cross-border healthcare.

[139] AC Decision S1.

[140] Article 1 of AC Decision S9.

[141] Article 67(5) of Regulation (EC) No 987/2009 and Article 3 of AC Decision S9, mentioning the judgment in *Keller* EU:C:2005:211.

[142] Article 25(A)(1) of Regulation (EC) No 987/2009/EC and Recital 5 of AC Decision S1. In some Member States such as Spain or Denmark it is possible to get a PRC automatically by mail.

[143] The majority of the Member States envisage certain co-payment of both treatments and pharmaceuticals. Some, such as BE or DE, also envisage co-payment of transport. Others, mainly tax-funded or residence-based systems such as EL, ES, IE or UK, envisage, as a general rule, only co-payment of pharmaceuticals.

[144] AT, BG, CY, CZ, DE, DK, EE, EL, ES, FI, HR, HU, IS, IT, LI, LT, LV, MT, NO PL, PT, RO, SI, SK, SE and UK.

[145] Countries may have several regional healthcare services (ES) or insurance funds (DE).

[146] It varies from one country to another. For example, in AT providers are private ones contracted by the regional healthcare services, while in UK providers are usually public.

Some Member States (*e.g.* **BE**, **FR**, **LU** and **CH**) have reimbursement systems, although most of these systems are hybrid. In general, most healthcare provided is subjected to upfront payment and *ex post* reimbursement and may provide some treatments free of charge at point of use, depending on the type of treatment or on the type of provider. For example, in **Belgium** or **France** primary care is provided by private doctors and subjected to upfront payment, while hospital care is provided free of charge at point of use.

Healthcare free of charge at point of use

When healthcare is free of charge at point of use, providers under a national health service cannot demand upfront payment from patients. In this regard, the Regulations are clearly more advantageous than Directive 2011/24/EU, which always imposes upfront payment.

The reimbursement of cross-border healthcare costs takes place between social security institutions.[147] The Member State of treatment has to issue a claim based on the actual healthcare expenditure in order to be refunded. As national health services were not used to invoicing or reimbursing, they had to do a significant organisational and investment effort to implement an invoicing system used only by patients insured abroad.[148] In fact, national health services usually prefer, when possible, to be reimbursed on the basis of fixed amounts per patient treated instead of invoicing the actual healthcare expenditure.[149]

In some countries, providers may offer public and private healthcare simultaneously.[150] Healthcare under the Regulations requires an EHIC or PRC and is often provided free of charge at point of use. Purely private healthcare, in contrast, has to be paid upfront and is not refundable under the Regulations. Healthcare providers must inform the foreign patients whether or not the services offered are part of the public healthcare. If a patient is required to pay upfront in a country where healthcare is usually provided free of charge, it probably means that s/he is not being treated under the Regulations.[151] S/he could, however, claim reimbursement from an possible private insurance or under Directive 2011/24/EU.[152]

Healthcare subjected to upfront payment

When healthcare is subjected to upfront payment, insured patients are reimbursed *ex post* for the medical costs incurred at authorised healthcare providers. In the case of treatments that require a *substantial expenditure*, the competent institution may

[147] Via the E125 form / SED S080.

[148] For instance, establishing public prices that take into consideration the actual cost of the treatment or dedicating staff and IT resources to invoicing. According to Point I(3)(a) of AC Decision S5, the *"expenditure linked to the administration of the sickness insurance scheme, for example costs which are incurred by the handling and processing of reimbursements to individuals and between institutions"* cannot be charged as part of the treatment costs as far as they are not considered benefits in kind.

[149] The Member States *"where the use of reimbursement on the basis of actual expenditure is not appropriate"*. Article 63 and Annex III of Regulation (EC) No 987/2009, listing eight Member States.

[150] In some countries, such as PL, PT and SK, public hospitals can treat patients publicly and privately. In ES some private providers simultaneously offer public healthcare on behalf of the social security system and private treatments subjected to payment. See also chapter 4 of this report.

[151] The European Commission developed in 2015 a useful, free multi-language app which warns about this risk and can be a helpful instrument to avoid it. It provides information on how to use the EHIC in different countries within the EU and the EEA as well as information on the healthcare systems themselves, including tips to distinguish between providers under the national health service and purely private ones. It also summarises, for all countries, updated information on treatments, costs, co-payments, procedures for reimbursement, emergency numbers or access to dialysis, oxygen therapy or chemotherapy abroad.

https://itunes.apple.com/be/app/european-health-insurance/id516504241.

[152] As far as the treatment does not require prior authorisation under the Directive.

advance part of the cost of the treatment as soon as that person submits the application.[153] The amount that is considered a substantial expenditure usually differs according to the patient's economic resources. Perhaps, in order to limit the national administrations' margin for discretion, it would be better to define 'substantial expenditure' as a percentage of the monthly wage. This measure would require a previous budget form or template, translated into all official languages, to be filled in by the providers. Anyhow, this kind of measure seems most appropriate under planned healthcare.

The reimbursement of healthcare costs is logically limited by the costs actually incurred.[154] The patient must produce all receipts, prescriptions and invoices, and can choose between two options:[155]

1) Being reimbursed by the Member State of treatment according to its tariffs and legislation. In this case, the competent Member State would refund the State of treatment later.

2) Being reimbursed by the competent Member State according to the tariffs of the Member State of treatment.[156]

Both of them are the standard options. However according to two obscure paragraphs of Article 25(B) of the implementing Regulation – concerning the procedure and scope of the right to unplanned healthcare – the competent Member State could even reimburse the patients according to its own tariffs:

1) The first one, Article 25(B)(6)[157] of the implementing Regulation, only applicable if the insured person agrees, was envisaged for cases where the Member State of treatment does not have tariffs to quantify the healthcare provided. After the implementation of the Directive this scenario no longer seems possible, as far as public and private providers have to be paid upfront and have to produce an invoice, so it seems that it has lost its original aim.

2) The second one, Article 25(B)(7),[158] applicable without such agreement with the insured person, was defined for cases where the legislation of the competent Member State envisages the reimbursement of treatments received from purely private providers, *i.e.* out of the social security system. In this case the economic result of reimbursement for the patients would be the same as if the Directive had been applied, even if under the latter there may be an increase in administrative burden (*i.e.* prior authorisation or gatekeeping functions by a GP).

Both provisions should be scrutinised and clarified by the Administrative Commission. They could even be repealed by the EU legislature considering the existence of the Directive.

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[153] Article 25(B)(9) of Regulation (EC) No 987/2009.

[154] Article 25(B)(8) of Regulation (EC) No 987/2009.

[155] Article 25(B)(4) and (5) of Regulation (EC) No 987/2009.

[156] The competent Member State will issue an E 126 form / SED S067 in order to obtain from the Member State of treatment the invoice information and to certify that the healthcare provider was authorised.

[157] Article 25(B)(6) of Regulation (EC) No 987/2009: "*By way of derogation from paragraph 5, the competent institution may undertake the reimbursement of the costs incurred within the limits of and under the conditions of the reimbursement rates laid down in its legislation, provided that the insured person has agreed to this provision being applied to him/her.*"

[158] Article 25(B)(7) of Regulation (EC) No 987/2009: "*If the legislation of the Member State of stay does not provide for reimbursement pursuant to paragraphs 4 and 5 in the case concerned, the competent institution may reimburse the costs within the limits of and under the conditions of the reimbursement rates laid down in its legislation, without the agreement of the insured person.*"

3.3.1.4. The extent of the reimbursement

The tariff of reference for unplanned healthcare is, as a general rule, the one established by the Member State of treatment. The Regulations oblige the competent Member State to reimburse or pay a bill that covers the cost of the treatment provided. From this point of view, the Regulations could be considered economically neutral for patients, if we ignore possible co-payments.

Member States have no way to control, monitor or reduce its spending derived from unplanned healthcare, as it does not depend on the efficiency of the national healthcare system.[159] For them, the economic impact depends on the type of health system involved. For national health services, any reimbursement paid is an extra cost in addition to the annual fixed costs they bear.[160] For insurance funds and reimbursement systems that do not have public facilities, the economic neutrality depends on the foreign prices: they could even save money by taking advantage of possible lower prices charged abroad.

Co-payment

The reimbursement of any possible co-payment is not envisaged under unplanned healthcare, as far as the co-payment is not considered a benefit in kind[161] and the so-called '*Vanbraekel* supplement'[162] does not apply. Obviously, Member States are free to cover foreign co-payment on a voluntary basis,[163] but there is no legal obligation.

The Regulations[164] include a constrained version of the *Vanbraekel* supplement that allows the insured person to request the reimbursement of the co-payment paid under planned healthcare, if the difference between tariffs makes this possible. This provision is in line with the CJEU judgment in *Commission v Spain*,[165] where the CJEU confirmed that although freedom to provide services also applies in the case of unplanned healthcare, co-payment does not infringe upon the mentioned freedom, so there is no need to reimburse it. The CJEU basically founded its judgment on the following two reasons:

1) Unplanned healthcare is not related to undue delay. As there is no malfunction of the healthcare system of the competent Member State, there is no obligation to provide a similar level of coverage as the one provided at a national level.

2) The non-application of the supplement (the non-coverage of the co-payment) is not enough to force the patient to rule out travelling to another Member State or to force an early return. Returning to the competent Member State is not always an option. If the treatment is urgent and cannot be postponed, the patient would be medically compelled to stay. But when returning is an option, the CJEU considers that the patient would not have enough information to evaluate in

[159] Spending derived from planned healthcare, in turn, can be checked, as treatments are subjected to prior authorisation, which can be denied if they can be provided by the competent Member State within a medically reasonable time.

[160] Following this logic, any reimbursement of healthcare provided to patients insured abroad could be also considered an extra income beyond the ordinary funding of the healthcare system.

[161] Point I(3)(d) of AC Decision S5, establishing the costs that cannot be considered benefits in kind.

[162] The *Vanbraekel* supplement was created by the CJEU in order to preserve the freedom to provide health services. Thanks to this supplement, the insured person could receive an additional reimbursement covering fully or partially the co-payment if the tariff in the competent Member State were higher than the costs incurred including said co-payment. If the tariff of the competent Member State were lower, there would not be room for any supplement so the patient would have to bear the cost of the co-payment.

[163] For instance, by applying its own tariffs (provided they top the costs incurred including the co-payment) as envisaged in the aforementioned Article 25(B) of Regulation (EC) No 987/2009.

[164] Article 26(B)(7) of Regulation (EC) No 987/2009.

[165] *Commission v Spain* EU:C:2010:340.

advance the differences between co-payment requirements and tariffs, *i.e*. s/he would not know in advance if there was room for reimbursement of the co-payment. Therefore, the CJEU considers that the effect of the supplement would be uncertain or indirect regarding the making of the decision.

The latter assertion does not appear to be so sound nowadays, as patients can access information on co-payments and tariffs through the Commission itself[166] or through the different National Contact Points created after the implementation of Directive 2011/24/EU. Once informed, the patient will be aware of the existence of co-payment and of the tariff differentiation, so the effect of not granting the *Vanbraekel* supplement could have a certain, direct and negative impact on the free movement of persons and the freedom to provide services.[167]

Another important question is whether the fact that cross-border patients under unplanned healthcare can be subjected to foreign co-payments without the possibility of reimbursement, affects the mentioned freedoms and undermines the economic neutrality of the coordination Regulations for the patient.[168]

Extra costs

The so-called 'extra costs' are costs ancillary to the treatments, such as sanitary transport to the hospital, hospital catering or prostheses. The patient would be reimbursed of said costs in the same conditions as a person insured in the Member State of treatment according to its basket of services. For instance, if transport is provided to national patients for free at point of use or subjected to upfront payment and *ex post* reimbursement, *i.e*. if it is a service included in the basket of services of the Member State of treatment, the EHIC patient has to be transported under the same conditions.[169]

Some doubts arise regarding sanitary transport to bring back the patient to the competent Member State. The Regulations do not envisage repatriation for medical reasons,[170] so, in principle, it may not be covered by the EHIC.[171] However, if the Member State of treatment envisages internal sanitary transport as part of its basket of services, should it provide said transport when the destination is another Member State and then invoice the competent Member State? Under the freedom to provide services, doubts may arise about whether sanitary transport can be denied at EU level being covered internally. In the case of patients that are compelled to stay abroad because of their medical condition, such as *Mr I.* mentioned above,[172] would it not be better for the patient and much cheaper for the competent Member State to bear the cost of a special sanitary transport to bring the patient back home instead of bearing the healthcare costs abroad?

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[166] For instance, by means of the EU Commission EHIC card app mentioned above.

[167] CARRASCOSA BERMEJO, D., Cross-border healthcare in the EU: Interaction between Directive 2011/24/EU and the Regulations on social security coordination, ERA Forum (2014) 15. p. 376 and 377.

[168] Co-payment is a means of financing a healthcare system and preventing abuse; it could be determined according to the average income level of its insured population. When it is imposed on specific cross-border healthcare it loses its purposes while preserving equal treatment. Besides, it affects patients that already finance another healthcare system and could have a lower income level. In this regard, co-payment could be a source of inequity or even double contribution.

[169] If a service is not included in the basket of services of the Member State of treatment, the patient would be charged and, in principle, not refunded. The competent Member State could, however, decide to reimburse the cost according to its own tariffs and legislation. Article 25(B) of Regulation (EC) No 987/2009.

[170] Although it is envisaged in the case of accidents at work if internal transport is envisaged in the national law of the competent Member State. Article 37(1) of Regulation (EC) No 883/2004.

[171] The UK National Health Service, for instance, points out on its website that the EHIC does not cover costs such as being flown back home or being rescued in a ski resort

http://www.nhs.uk/chq/pages/1073.aspx?categoryid=68.

[172] See 3.3.1.1, section *Temporary Stay*.

3.3.2. Unplanned healthcare under Directive 2011/24/EU

In contrast with the blurred legal outline of unplanned healthcare under the Regulations, healthcare under the Directive is much more clearly defined and easier to understand for patients, although not necessarily more beneficial from an economic point of view. It depends, among other reasons, on whether the national implementation has been more generous than the Directive itself. For persons insured in Member States which have comparatively high treatment tariffs, the Directive can be an economically more attractive reimbursement option, as their tariffs may top up the costs incurred abroad including any possible co-payment. However, the Directive would be very difficult to use for unforeseen treatments if the patient must ask for prior authorisation or fulfil other administrative requirements (GP referral). So, in Member States where the legislation does not envisage these requirements the Directive would be a feasible alternative.

The Directive entitles patients to freely select healthcare providers in a cross-border situation and obtain full or partial reimbursement of the costs incurred. As already mentioned, the purpose of the journey is irrelevant, so there is no distinction between unplanned or planned healthcare. There is a certain consensus that the Directive is mainly intended for planned healthcare situations, but there is no provision preventing persons from using this route if they need healthcare while temporarily staying in another Member State.

The basic characteristics of cross-border healthcare under the Directive are the following:

- There are two possible situations depending on whether or not the treatments require prior authorisation.
- Healthcare can be given by private or public healthcare providers, disregarding whether they are part of the national health services or purely private.
- Reimbursable treatments are the ones included in the basket of services of the Member State of affiliation.
- Reimbursement is done in accordance with the tariffs of the Member State of affiliation.
- The patient has to pay the costs of the treatment upfront and then claim eligible costs from the Member State of affiliation. From this point of view, the Directive can be useful for patients who can afford upfront payment. However, some national health insurance funds are contracting healthcare providers abroad. For instance, the Dutch health insurance fund has reached agreements with foreign providers in border and tourist regions, concerning tariffs or quality. As a result, the patients do not have to pay upfront as the fund reimburses the healthcare provider directly.[173]

3.3.3. Unplanned healthcare under purely national legislation

The reimbursement of cross-border healthcare costs can be based exclusively on national law, which could be considered a route different from those based on EU law. Regarding unplanned healthcare, two types of national legislation merit mention.

On the one hand, some national legislations (in **AT**, **NL** and **BE**)[174] envisage worldwide reimbursement of treatment costs against national tariffs, irrespective of the type of

[173] See AC 532/14, Minutes of the Working Party of the AC of 9 October 2014, p. 3.

[174] Under Slovenian legislation, according to a controversial Constitutional Court judgment, there was the possibility of obtaining worldwide healthcare coverage, including treatments excluded from the national basket of services. This decision, dated 21 March 2014, is only relevant for pending cases. The healthcare and health

provider (public, private under contract or purely private) and not subjected to prior authorisation. In **Austria**, the administration applies the tariffs that would have been used if the patient had chosen to consult a private doctor. The lack of prior authorisation requirements seems especially appropriate in the case of unplanned healthcare, when the need of healthcare is unforeseen and, in some cases, urgent.[175]

On the other hand, there are other Member States that envisage a system of worldwide coverage in cases of medical urgency abroad. In **Spain**, for instance, the national legislation envisages the reimbursement of costs regarding unplanned treatments in cases of vital urgency, *i.e*. situations where the lack of immediate treatment may result in the patient suffering an unacceptable loss of functionality of important organs or in death. This reimbursement route is applicable in cross-border situations, but only if the treatment received is included in the Spanish basket of services. The extent of the reimbursement is very comprehensive, as it covers all the health costs incurred and invoiced abroad including co-payment.

3.3.4. Legal and practical problems of parallel application

The existence of different routes of reimbursement has created complexity and confusion, not only for patients but also for providers and national administrations. Patients just want to access cross-border healthcare and be reimbursed. They do not understand the complexity of the current routes that require them to make choices.

National administrations have the duty to inform as imposed by the Directive,[176] so they have to guide patients in this process, even if it is sometimes hard to distinguish which instrument should be applied. They might show the patients the whole picture, a complete overview of the proceedings and the reimbursement options, including the possibilities under national legislation, in order to let them decide which is the most beneficial in their interest.

Providers, on their part, want to minimise the delay in recovery of costs incurred. Thus, they prefer upfront payment as envisaged under the Directive.

3.3.4.1. Parallel application of EU instruments: the Regulations and the Directive

As mentioned above,[177] the rules regarding interaction between the Directive and the Regulations seem insufficient, particularly in the case of unplanned healthcare as far as it only envisages a solution in cases where treatments require prior authorisation under both the Regulation and the Directive.

The interaction rule when prior authorisation is not needed, *i.e*. in the case of unplanned healthcare under the Regulations, should be clarified. However, the AC Secretariat considers that in this case the general rule should apply: if the Regulation is more advantageous to the patient it will be applied unless the patient expressly requests otherwise.[178]

Under unplanned healthcare, the availability of information is paramount, as the patient has to take decisions within a very short notice when facing an unforeseen healthcare necessity, particularly in the case of urgency.

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insurance act was modified on 5 November 2013 (transposition of Directive 2011/24/EU and regulation of the right to healthcare abroad in the legislative act of the parliament). An abstract of the judgment can be found at http://odlocitve.us-rs.si/en/odlocitev/AN03698?q=Up-1303%2F11%2C+U-I-25%2F14.

[175] Regarding other authorised options under planned healthcare see 3.4.3.

[176] See 4.2.2.

[177] See 3.1.1.

[178] AC 246/12, p. 3. AC 532/14 REV. p. 13.

When comparing both instruments, the patient should take into account the following aspects.

The first aspect is the *administrative burden*, *i.e*. prior authorisation[179] and/or other administrative requirements, which could make it difficult to use the Directive for unplanned healthcare, especially in the case of urgency during a temporary stay. If this is the case, the EHIC would be a simpler way to access unplanned healthcare. Besides, in the case of urgency, the use of the Directive will be limited to treatments that do not require authorisation. Except if the implementation has envisaged ad hoc measures in the case of urgency. For instance, **Austria** has ruled out the prior authorisation precisely in the event of urgent care. In **Cyprus** the evaluation of the claim for prior authorisation must take into account the urgent nature and the individual circumstances of the case.

The same applies to the so-called gatekeeping function of the general practitioners, *i.e*. the obligation of being referred by a general practitioner to a specialist or hospital. Again, it seems necessary to rule out this requirement in the case of urgency, as it is done in some Member States (**LV** and **NL**).[180]

The second one is the *extent of the reimbursement*. In general, reimbursement under the Regulations is more generous. However, if the treatment abroad involves co-payment, the Regulations neither envisage its reimbursement, nor the application of the *Vanbraekel* supplement. The Directive could be more beneficial if the tariff in the Member State of affiliation tops up the cost incurred including the co-payment. Obviously, under the Directive the patient could always choose a private provider and avoid co-payment.

In this regard, the interaction could be simplified by applying the *Vanbraekel* supplement for unplanned healthcare under the Regulations. As already pointed out, it can be argued that the circumstances for denying it may have changed.[181] Should that be the case, the Regulations will always be more economically advantageous than the Directive,[182] so the obligation to compare reimbursement under both routes could be ruled out.

A third aspect concerns the *extent of the healthcare coverage*. The Regulations only cover necessary healthcare during a temporary stay. The Directive can always be used by the patient as a complementary instrument for the reimbursement of additional treatments beyond the ones considered necessary under the Regulations. Besides, the Directive could be used when the insured person needs to receive a treatment included in her or his basket of services but excluded from the basket of services of the Member State of treatment and therefore offered there only by a purely private provider. Anyhow, the Directive cannot be used to deny access to healthcare for insured persons who possess an EHIC. The Commission services are against this type of practice performed by providers who could be misinformed or who prefer to be paid up front.[183] This risk has not materialised as an issue[184] even if Member States expressed concerns.[185]

[179] The only Member States that do not require prior authorisation are EE, FI, LT, NL and SE.

[180] In LV the referral from a GP is not required in urgent cases. In NL Article 13 *HIA* obliges insurers to include in their contracts that care or treatment offered by medical specialists, with the exception of urgent care, shall only be "*accessible*" after a referral by a general practitioner.

[181] See 3.3.1.4 regarding the CJEU judgment in *Commission v Spain* EU:C:2010:340.

[182] Eventually, the Directive could be as advantageous as the Regulations depending on the applicable tariffs.

[183] Said principle has to be considered in the implementation of the Directive. For more information on this issue see AC 246/12, 21 (2012). p. 16.

[184] As reported by BE, CZ, DE, EE, EL, ES, FR, HR, IT, MT, NL, PL, PT, SI, SK and UK.

[185] AC 532/14 REV. p. 13.

3.3.4.2. Parallel application of European instruments and national legislation

If the national legislation grants protection that is broader than the EU routes its application shall take preference. This statement can be understood from the position of the CJEU case law regarding the coordination Regulations: their protective legal basis prevents the loss of national rights, *i.e*. their objective is to provide more rights, to favour the position of a person in relation to the situation which would arise for him or her from the exclusive application of national law.[186] This mandatory principle, known as the '*Petroni* principle', is a very useful tool for the general interpretation of the Regulations. Having been created by the CJEU with regard to pensions,[187] it has been followed in other cases such as *Bosmann*[188] concerning other benefits. Along the same lines, the judgment in *Acereda Herrera*[189] regarding the reimbursement of healthcare costs stated that the direct application of the Regulations does not preclude national legislation from granting broader benefits than those provided for by said Regulations.

3.4. Access to planned healthcare in a Member State other than the Member State of insurance

European patients who seek healthcare in a Member State other than the Member State where they are insured do have certain rights conferred on them by European and/or their own national law. In this chapter, this legislation is scrutinised with special focus on the parallel application of the different legal routes.

3.4.1. Planned healthcare under Regulation (EC) No 883/2004

The social security coordination legislation offers the opportunity to receive planned care since 1972.[190] Currently, Article 20 of the Regulation determines the rules under which planned medical treatments can be obtained. Most importantly, it provides that anyone desiring to benefit from this opportunity and receive medical treatment abroad at the expense of the competent Member State "*shall seek prior authorisation from the competent institution"*.[191]

The question arises what is to be done if a patient underwent such a medical intervention without even requesting an authorisation or, although s/he had asked for it, it was refused, or s/he proceeded with the treatment before the authorisation was granted. It is apparent from the Regulation's provisions that – as a principle – those who do not comply with the requirements of the Regulation cannot count on the competent institution to bear the healthcare costs incurred. It was nevertheless unclear whether someone who had justifiable reasons not to ask or not to wait for the authorisation to be granted due to the urgency of the treatment in question, but who otherwise met the conditions laid down in the Regulation, can refer to this legislation and request reimbursement.

The CJEU first elaborated the issue of *ex post facto authorisation* in the *Vanbraekel* case,[192] and most recently in the *Elchinov* judgment.[193] The CJEU firmly held that where the request of an insured person for authorisation has been refused by the competent institution and it is subsequently established, either by the competent institution itself or

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[186] CARRASCOSA BERMEJO, D. *Cross-border healthcare in the EU: Interaction between Directive 2011/24/EU and the Regulations on social security coordination*, ERA forum (2014) 15. p. 368.

[187] *Petroni*, C-24/75, EU:C:1975:129, paragraphs 11 to 13.

[188] *Bosmann*, C-415/93, EU:C:1995:463.

[189] *Acereda Herrera*, C-466/04, EU:C:2006:405.

[190] See footnote 88.

[191] Article 20 (1) of Regulation (EC) No 883/2004.

[192] *Vanbraekel* EU:C:2001:400.

[193] *Elchinov* EU:C:2010:581.

by a court decision, that that refusal was unjustified, that person is entitled to be reimbursed directly by the competent institution in an amount equivalent to that which it would ordinarily have borne if authorisation had been properly granted in the first place.[194] It follows that the legislation of a Member State cannot exclude, in all cases, reimbursement in respect of a medical treatment obtained in another Member State without prior authorisation.[195]

There are several Member States which *explicitly implemented* this point of the case law into their national legislation and/or administrative practice, such as **Belgium**, where the authorisation can be granted *post facto* when the patient could not wait for the reply before leaving the country, or in the event of force majeure; **Finland**, where a patient who has been treated abroad without prior authorisation can apply for it and for full reimbursement of the costs also afterwards; **Slovakia**, where the insured person may also request the issuance of retroactive authorisation no later than within one year from the day on which the treatment was provided if the conditions for granting the authorisation are fulfilled; and the **United Kingdom**, where reimbursement or the issuing of an authorisation is not usually retrospectively authorised where the patient should have applied for prior authorisation but did not do so – unless exceptional reasons apply in a particular case, for example circumstances where it was not possible for the patient to have applied for prior authorisation before receiving the treatment abroad. This is determined on a case-by-case basis, taking account of the facts of the case. Retrospective authorisation and reimbursement is given in cases where the initial decision to refuse authorisation or reimbursement is overruled on review or appeal.

Although the Member States hold considerable *discretionary powers* concerning the *assessment of requests and granting of authorisation*, this power is limited both by the Regulation and the case law of the CJEU.

The competent institution is obliged to accord the authorisation if two conditions are cumulatively met, namely (1) the treatment in question is one of the benefits provided for by the legislation in the Member State where the person concerned resides and (2) where s/he cannot be given such treatment within a time limit which is medically justifiable, taking into account his or her current state of health and the probable course of his or her illness.[196]

(1) The *determination of benefit coverage* appears to be rather unproblematic in most cases, only the **Swedish** legislation was reported to be debated in this regard, where – instead of having an explicit list in terms of what is covered by the healthcare system – the concept of "*science and evidence-based medicine*" is used. Although research results and comprehensive clinical experience should guide the delivery of healthcare, the concept was criticised for being vague.[197]

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[194] *Vanbraekel* EU:C:2001:400, paragraph 34; *Ioannidis* EU:C:2003:101, paragraph 61; *Leichtle*, C-8/02, EU:C:2004:161, paragraph 55; *Keller*, C-145/03, EU:C:2005:211, paragraph 69; *Elchinov* EU:C:2010:581, paragraph 48.

See also VAN DER MEI, A. P., Cross-Border Access to Health Care within the European Union: Some Reflections on Geraets-Smits and Peerbooms and Vanbraekel, Maastricht Journal of European and Comparative Law, (2002) 9/2, p. 211.

[195] *Elchinov* EU:C:2010:581, paragraph 49.

[196] Article 20 (2) of Regulation (EC) No 883/2004.

[197] The CJEU also addressed the question of determining benefit packages especially in its judgments in the *Geraets-Smits and Peerbooms* case (EU:C:2001:404) and the *Elchinov* case (EU:C:2010:581). Its main conclusions were that (1) it is for each Member State to decide which medical benefits are reimbursed by its own social security system (*Elchinov* EU:C:2010:581, paragraph 59); (2) it is not in principle incompatible with Union law for a Member State to establish, with a view to achieving its aim of limiting costs, limitative lists excluding certain products from reimbursement under its social security scheme (*Geraets-Smits and Peerbooms* EU:C:2001:404, paragraph 86); (3) Union law cannot in principle have the effect of requiring a Member State to extend the list of medical services paid for by its social insurance system (*Geraets-Smits and Peerbooms*

(2) Since the *medically justifiable time limit* must be determined on a case-by-case basis, this holds potential for diverse application in the Member States. However, the CJEU defined certain factors which shall form an essential part of the clinical assessment.[198] Most of the Member States set up sophisticated assessment procedures with the involvement of different actors such as clinical specialists or expert committees.

Notably, a few Member States defined *legal maximum waiting times* and introduced *waiting time guarantees*, meaning that if the treatment in question cannot be provided for the patient within the waiting time specified in the national legislation, a prior authorisation shall be granted. In **Spain**, a prior authorisation is granted automatically if the expected waiting time exceeds the maximum legal waiting times established at a national level regarding some specific treatments.[199] In **Sweden**, it is guaranteed by the law that a patient shall have instant contact with the healthcare system for consultation, seeing a GP within seven days, consulting a specialist within 90 days, and waiting for not more than 90 days after being diagnosed to receive treatment; if the waiting time guarantee is not upheld, the request for prior authorisation cannot be rejected. Similarly, in **Slovenia**, if at the time of registration the waiting time which exceeds the longest admissible waiting time was set and there is no other healthcare provider in the country where the waiting time is not exceeded, the patient has the right to healthcare in another EU or EFTA State.

From the patients' point of view, setting reasonable maximum waiting times can be seen as a source of safety and certainty, and must therefore be considered a good practice. The possibility of *defining maximum waiting times at a European level* is also worth considering. However, despite its obvious benefits for the patients, it would be difficult to adopt such a measure, since it would not only require significant investments in the healthcare sector in certain Member States in order to achieve the codified waiting times, but it also goes beyond coordination and as such the current competences of the Union.

The CJEU also specified *procedural requirements* which aim to limit the Member States' discretionary power, to guarantee an impartial and objective evaluation of the requests and to ensure transparency of the procedures in order to strengthen the patients' legal position by guaranteeing that they are not exposed to an uncontrollable, untraceable bureaucratic mechanism.[200]

Another good practice reported by some Member States is establishing a so-called *automatic authorisation rule*, which means that if the insured person's request is not decided within the procedural time limit, this can be considered a decision in favour of the person in question. This rule appears also in Regulation (EC) No 987/2009 in relation to the cooperation between the Member State of residence and the competent Member State when the insured person requesting prior authorisation resides outside the

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EU:C:2001:404, paragraph 87; *Elchinov* EU:C:2010:581, paragraph 58); and (4) where a treatment has been sufficiently tried and tested by international medical science, the authorisation cannot be refused on that grounds (*Geraets-Smits and Peerbooms* EU:C:2001:404, paragraph 97). The experimental nature of treatments was also dealt with by the EFTA Court in Joined Cases E-11/07 and E-1/08, *Olga Rindal* (Case E-11/07); Therese Slinning, represented by legal guardian Olav Slinning (Case E-1/08) and the Norwegian State.

[198] See among others *Watts* EU:C:2006:325, paragraphs 62 and 68; and *Elchinov* EU:C:2010:581, paragraph 66.

[199] Regional competent institutions can set even more restrictive time limits.

[200] According to the CJEU the administrative procedure must be based (1) 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 (among others *Elchinov* EU:C:2010:581, paragraph 44); (2) on a procedural system which is easily accessible and capable of ensuring that a request for authorisation will be dealt with objectively and impartially within a reasonable time and refusals to grant authorisation must also be capable of being challenged in judicial or quasi-judicial proceedings (among others *Watts* EU:C:2006:325, paragraph 116); and (3) refusals to grant authorisation, or the advice on which such refusals may be based, must refer to the specific provisions on which they are based and be properly reasoned in accordance with them. Likewise, courts or tribunals hearing actions against such refusals must be able to seek the advice of wholly objective and impartial independent experts (among others *Watts* EU:C:2006:325, paragraph 117).

competent Member State.[201] In **Belgium**, the patient has to submit a claim for authorisation accompanied by a medical report by the specialist doctor to the advising doctor of his or her sickness fund. The advising doctor decides within 45 calendar days; if no reply is received within that period, the authorisation is deemed to be granted and an S2 form is issued. In **Spain**, the same time limit is applied with the same legal consequence, whereas in **Poland** the decision must be made not later than 30 days.

Nevertheless, these deadlines – 30 and 45 days – seem rather long taking into account the specific nature of the issues at stake in these procedures. It is certainly left to the Member States to define their administrative procedures and the processing times thereof, but the interest of the patients should motivate them to reply to requests as soon as possible, thus not applying general administrative processing times but setting much shorter deadlines. For instance, in **Slovenia** an administrative decision concerning a prior authorisation should be issued within 30 days, but in practice it is usually made within several days, if necessary under 24 hours.

What could further increase the level of legal certainty in favour of the patients is the introduction of an EU-wide *maximum processing time,* including the automatic authorisation rule. However, the arguments put forward with regard to the maximum legal waiting time for treatments are valid in this case as well.

Under the social security coordination regime, an insured person who is authorised by the competent institution to go to another Member State with the purpose of receiving the treatment appropriate to his or her condition shall receive the benefits in kind provided, on behalf of the competent institution,[202] meaning that – in principle – these benefits give rise to full reimbursement which has to be borne by this institution.[203]

Generally, the financial provisions included in the Regulation[204] and its implementing Regulation[205] do not seem to cause major problems. However, *the reimbursement of ancillary costs* shows certain diversity throughout the Union. The CJEU laid down[206], and the implementing Regulation did codify,[207] a duty to apply the equal treatment principle and to grant reimbursement with regard to additional expenses if such duty exists when these costs arise from movements within the competent Member State.

In **Finland**, if a patient has a prior authorisation according to the Regulation, travel expenses can be reimbursed, as well as overnight stays or travelling of accompanying persons or home visits. In **Croatia**, the right to reimbursement includes the reimbursement of transportation costs with public transport for the shortest route. In **Hungary**, the costs of travel and the accompanying persons may be reimbursed – taking into account the patient's request and the advice of the physician – based on equity. The **Maltese** authorities do not provide reimbursement for costs of travel, accommodation or transport to the patient who travels for treatment with an S2.

3.4.2. Planned healthcare under Directive 2011/24/EU

The coordination mechanism on planned care had been long in place when "*a handful of dissatisfied patients, some seeking redress at the European Court of Justice by invoking*

[201] Article 26 (A) (2) of Regulation (EC) No 987/2009.

[202] Article 20 (2) of Regulation (EC) No 883/2004.

[203] Article 35 (1) of Regulation (EC) No 883/2004.

[204] Article 35 of Regulation (EC) No 883/2004.

[205] Articles 25 (4)-(5) and 26 (6)-(8) of Regulation (EC) No 987/2009.

[206] *Watts* EU:C:2006:325, paragraphs 139-140 and *Acereda Herrera*, C-466/04, EU:C:2006:405, paragraph 38.

[207] Article 26 (8) of Regulation (EC) No 987/2009.

the principles of free movement of goods and services"[208] offered the CJEU the opportunity to change the landscape of Union legislation on healthcare provision.[209] The main breakthrough of the case law's approach was the following: whereas the basic principle of planned care under the coordination system was that prior authorisation from the competent institution was required, under the case law the main rule was that no prior authorisation could be prescribed. The cases in which the requirement of prior authorisation was accepted were *exceptional cases* where Member States could justify the existence of the authorisation system.[210]

Directive 2011/24/EU follows this logic of the case law by stipulating that the Member State of affiliation shall not make the reimbursement of costs of cross-border healthcare subject to prior authorisation except in cases set out in the Directive itself.[211] Therefore, when transposing the Directive, the Member States could choose whether or not they opt for introducing a scheme of prior authorisation under the Directive. Most of them did choose to restrict the free movement of patients in this way.

Prior authorisation under the Directive

Prior authorisation required in certain cases under the Directive's regime	AT, BE, BG, CY, DE, DK, EL, ES, FR, HR, HU, IE, IS, IT, LU, LV, MT, PL, PT, RO, SI, SK, UK
No prior authorisation required under the Directive's regime	CZ, EE, FI, LT, NL, NO, SE
Not applicable / not yet implemented	CH, LI

The exceptions which grant the competent institutions the right to make the reimbursement of medical costs abroad subject to prior authorisation can be divided into two groups: they partly concern (1) the planning requirement[212] and partly (2) medical quality and safety issues.[213] These exceptions appear in the legislation of the Member States which introduced prior authorisation under the Directive, except for France, which decided to transpose only the cases based on the requirement of planning.

The *grounds for planning* which already appeared in the case law of the CJEU are repeated in the Directive: healthcare may be subject to prior authorisation if (a) it involves *overnight hospital accommodation* of the patient in question for at least one night or (b) it requires the use of *highly specialised and cost-intensive medical infrastructure or medical equipment*. Nevertheless, the scope of these exceptions is somewhat blurred, since the exact *definitions of overnight hospital accommodation and of highly specialised and cost-intensive medical infrastructure or medical equipment* are not included in the Directive. It is clear from the Directive though that these criteria shall be fulfilled in the Member State of affiliation, which shall notify the categories of

[208] MCKEE, M.; BUSSE, R.; BAETEN R.; GLINOS, I., *Cross-border healthcare collaboration in the European Union: Placing the patient at the centre*, Eurohealth, (2013) 19/4, p. 4.

[209] The CJEU's main consideration was that (1) healthcare services are not different from any other services which move freely within the Union (among others *Elchinov* EU:C:2010:581, paragraph 36); (2) therefore, any national measures and legislative arrangements which hinder patients, as the recipients of these services, to obtain medical treatments abroad must be seen as a barrier to free movement and as breaching Union law unless properly justified (among others *Kohll* EU:C:1998:171, paragraph 35).

[210] Although eu law does not in principle preclude a system of prior authorisation, the conditions attached to the grant of such authorisation must nonetheless be justified with regard to the overriding considerations examined and must satisfy the requirement of proportionality. Among others *Elchinov* EU:C:2010:581, paragraph 41.

[211] Article 7 (8) of Directive 2011/24/EU.

[212] Article 8 (2) (a) of Directive 2011/24/EU.

[213] Article 8 (2) (b) and (c) of Directive 2011/24/EU.

healthcare subject to the planning requirement – thus to prior authorisation – to the Commission.[214]

(a) Whereas in most of the Member States the determination of the exact scope of the first situation is lacking, it is worth noting that **Belgian** law defines hospitalisation by reference to whether overnight stay is required in the State of treatment, and not whether that is required in Belgium. In **Romania**, overnight stay implies hospitalisation that exceeds 24 hours.

The Commission's report on the operation of the Directive drew attention to the phenomenon that several Member States require prior authorisation if the healthcare provision involved overnight stay in the Member State of treatment.[215] That is, however, not in line with the current wording of and the intention behind the adoption of the Directive. The prior authorisation scheme based on initial planning serves the purpose of ensuring sufficient and permanent access to a balanced range of high-quality treatment, of controlling costs and of avoiding the wastage of financial, technical and human resources in the Member State of affiliation.[216] It is thus desirable to precisely determine which treatment does fall into this category and which does not. This categorisation shall be made by the Member State of affiliation and shall not be dependent on the Member State of treatment or on the way the treatment is provided in that Member State.

(b) Concerning treatments requiring the use of highly specialised and cost-intensive medical infrastructure or medical equipment, numerous Member States set a list of treatments which necessitate a prior authorisation on these grounds. This technique is used by **Belgium**, **Spain, France, Croatia, Hungary, Luxemburg, Malta, Poland, Portugal, Romania, Slovenia, Slovakia** and the **United Kingdom.**

In terms of *administrative procedure* and requirements attached to the right to reimbursement, numerous patterns can be identified among the Member States. On the one hand, most of the Member States which apply a prior authorisation requirement created a uniform procedure where the authorisation process under the Regulation and under the Directive are merged and go through the same steps. On the other hand, some Member States decided to keep the procedures under the two different legal tools separated.

Authorisation procedure under the Directive's regime

No prior authorisation procedure under the Directive's regime	CZ, EE, FI, LT, NL, NO, SE
Uniform authorisation procedure under the two different legal tools	AT, BE, BG, DE, EL, FR, HR, HU, IS, LU, LV, PL, PT, SI, SK, UK
Separate authorisation procedure under the two different legal tools	CY, DK, ES, IE, IT, MT, RO
Not applicable / not yet implemented	CH, LI

[214] Article 8 (2) of Directive 2011/24/EU.

[215] Report from the Commission to the European Parliament and the Council, Commission report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, COM (2015) 421 final.

[216] Article 8 (2) (a) of Directive 2011/24/EU.

As Member States are free to impose on border-crossing patients criteria of eligibility and regulatory and administrative formalities as on patients receiving healthcare on their own territory,[217] many Member States insist on a *medical doctor's referral* if a patient wishes to invoke his or her right to reimbursement and it is required also when the healthcare service is obtained on the territory of the Member State of affiliation.[218]

The Directive provides that the costs of cross-border healthcare shall be reimbursed or paid directly by the Member State of affiliation up to the level of costs that would have been assumed by the Member State of affiliation, had this healthcare been provided in its territory without exceeding the actual costs of healthcare received,[219] meaning that the Member States apply their own domestic tariffs. However, in situations where different national tariffs can be applicable to the same treatment (*e.g*. depending on the insurance status of the patient or the type of provider), this rule of the Directive does not always offer a satisfactory solution and leaves space for diverse interpretation. This problem could be easily tackled by stipulating that if different tariffs can be applied, the option which is the most favourable for the patient must be chosen.

3.4.3. Planned healthcare under purely national legislation

Remarkably, some national legislations provide for an additional path for patients (1) to ensure that also those who cannot benefit from the above opportunities can gain access to the treatment which their medical condition requires, or (2) to ensure that they can do so under more favourable circumstances.[220]

(1) Numerous Member States offer the possibility to request authorisation in relation to healthcare services which are otherwise not included in the benefit package of the country or are not provided in the territory of the country for any other reasons.

According to both **Swiss** national rules and national law in **Liechtenstein**, the government establishes a list of benefits in kind that are not available in these countries and may therefore be obtained abroad. The **Estonian** Health Insurance Act provides for a possibility for insured persons to get health services which are not provided in Estonia, in a foreign country (not only in the EU, but in the whole world). Treatments not provided in the country can be authorised in a very similar manner in **Croatia**, **Iceland** (for example, when a PET scan or transplantation other than kidney transplantation is requested), **Poland** and **Slovenia**. In the latter country, insured persons have the right to healthcare in another country (EU Member State or any third state), or the right to

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[217] Article 7 (7) of Directive 2011/24/EU.

[218] The requirement of a medical referral is closely related to the gatekeeper function of general practitioners. Gatekeeper function is regulated in public healthcare systems of some Member States: generally in AT, in BG, CY, DK for group 1 patients, EE (although referral is not required for trauma, tuberculosis, eye disease, dermatosis or venereal disease or if gynaecological or psychiatric care is provided or if the provider of specialised medical care leaves the patient under observation or treatment by the provider of specialised medical care due to the state of health of the patient, by students who are insured in EE and studying abroad), ES, FI (medical centres after the SOTE reform), HR, IE, LV, SI and UK.

In some public healthcare systems it is more informally stimulated, *i.e.* a patient may choose a gatekeeper regime for slightly lower social security contributions: in CH, DE, HU (if the patient needs medically necessary treatment, it is advised to see a general practitioner, *i.e.* '*háziorvos*', first). Or, reimbursement might be more favourable if a GP refers a patient to a specialist: in BE, FR (for persons who have not declared a referring GP or who consult a doctor other than their referring GP, the reimbursement rate will be lower and the doctor can charge extra fees), NO (regular primary doctor refers a patient; if the patient consults a specialist directly, s/he must pay higher cost-sharing charges, and the specialist may get a lower refund).

In some Member States, a GP is not established and has no function as a gatekeeper: in CZ, IS, LI (the GP is not a gatekeeper, but after consulting a physician for the first time, the patient can only see a second physician for the same illness if the first one gives his or her authorisation), LU, RO (a patient needs a referral from the family doctor or a specialist doctor in order to receive the medical care in a hospital), SE.

As a rule, there is an exception from referral by the GP in the case of emergency.

[219] Article 7 (4) of Directive 2011/24/EU.

[220] PACOLET, J. and DE WISPELAERE, F., Planned cross-border healthcare – PD S2 Questionnaire, Report prepared in the framework of Network Statistics FMSSFE, 2014, p. 16.

reimbursement of such costs, if any available possibilities of medical treatments are exhausted and with the treatment abroad healing or improvement or prevention of worsening of medical condition can be expected. In **Hungary**, the so-called equity procedure is the most frequently used cross-border healthcare route, which intends to ensure that treatments not recognised by the social insurance can be claimed abroad, if they are medically acceptable and result in a realistic health gain. While assessing the request, the competent institution may also decide the treatment to be executed in Hungary with the assistance of a foreign specialist. If it is established that a healthcare service cannot be provided in **Portugal** and the Portuguese competent institution authorises the patient to travel abroad, it will assume the full payment of all medical expenses, accommodation, travel, meals and medication. **Romania** applies such a procedure to patients who are sent to a country outside the EU. A referral for a treatment abroad is approved only if the treatment is not available in Romania, for patients who are registered with a GP and who exhausted all available medical possibilities within the country. In **Sweden**, the competent institutions (Country Councils) are free to refer a patient to a healthcare provider in another Member State, in which case they have to bear the costs.

(2) **Austrian** national law allows patients to receive healthcare abroad without prior authorisation. A patient who received cross-border healthcare in another Member State (or elsewhere) is entitled to reimbursement of costs in the same amount as if this healthcare measures would have been received from an Austrian service provider who has no contract with Austrian social insurance. The right to reimbursement of costs received in another Member State is according to national Austrian law always limited to 80% (for non-hospital treatments) or a certain lump sum (for hospital treatments). **Belgian** national law exhaustively enumerates situations in which treatments obtained abroad can be reimbursed, on the basis of the Belgian law and Belgian tariffs. These include for example persons suffering from TBC, provided that the advising doctor considers a sanatorium cure abroad to be necessary; persons who have their main domicile in a frontier area and who received treatment from a healthcare provider established abroad, yet within a 25 kilometre radius from their domicile, provided that no similar institution is located more closely in Belgium; and persons who obtain certain treatments in Luxembourg or France, provided that their main domicile is located in certain Belgian cantons.

3.4.4. Legal and practical problems of parallel application

What patients are likely to find very confusing about the Union's legislation on cross-border healthcare (including both unplanned and planned care) is that different legal tools (partly) cover the same issues (such as authorisation and reimbursement) and apply different rules to the same issues under their own, individual regimes.

Article 2(m) of the Directive indicates that the Directive should apply without prejudice to the coordination Regulations, which implies that they are applicable in parallel and that there is no order of priority between them. At the same time, the Directive also provides that with regard to requests for prior authorisation made by an insured person with a view to receiving cross-border healthcare, the Member State of affiliation shall ascertain whether the conditions laid down in the coordination Regulations have been met. Where those conditions are met, the prior authorisation shall be granted pursuant to those Regulations unless the patient requests otherwise.[221] It is questionable though whether there is a case in which it would be more advantageous for the patient to apply the Directive's regime, if the Regulation can be applied too. If the Regulation cannot be applied (*e.g*. in the case of a treatment received from a purely private provider), then of course the Directive might offer a solution for the patient, but if the insured person is entitled under both legal instruments, it would be desirable to pinpoint that the

[221] Article 8 (3) of Directive 2011/24/EU.

Regulation has an *absolute priority* as it is more beneficial for the patient. This does not exclude that the patients could still be provided with the right to expressly refuse to use the Regulation's mechanism for instance in the case of planned outpatient care, which can be obtained without prior authorisation in accordance with the Directive, if they confirm that they are aware of the implications of this decision on their entitlements (*i.e*. the possibly different financing mechanism).

Some *practical problems due to the parallel application* of the two different legal tools were reported.

In **Belgium**, when a person requests prior authorisation, the sickness fund informs him or her as to the differences between the Regulation and the Directive and asks him or her to choose expressly between them. In principle, the Regulation is consulted first. Then, the law implementing the Directive is applied. As a third step, the more favourable national law is applied: where the medical circumstances for a hospitalisation are more favourable abroad than in Belgium and the treatment falls within the Belgian insurance package, the advising doctor can grant authorisation to receive the treatment abroad. Nevertheless, there is a concern that sickness funds do not always follow this method in practice and do not comply with their obligation to inform the patients about all their possibilities. It is reported by **Denmark** that the application of the two tools does not only result in a complex and often prolonged application process; it also places a high administrative burden upon the authorities, which aim to ensure that the citizen benefits from the most advantageous option, and thus often deal with the applications twice. Reportedly, in **Spain** it causes difficulties that patients are not used to pay for medical treatments upfront (this applies to other benefit in kind systems as well); and it can also be highly problematic and discourage patients to use the Directive's route that the treatment tariffs in other Member States usually exceed the domestic tariffs, thus leaving part of the costs to be borne by the patient. In **Finland**, people might find it hard to find information on the real costs of treatments or up-to-date information on the services abroad. It is also challenging that there are remarkable differences in the administrative apparatus in various countries especially when considering the processing times. In **France**, insured persons do not understand or criticise the tariffs which are used as a base for the reimbursement of care abroad. The amounts reimbursed are often much lower than the expenses actually incurred. The cause of the disputes may be that the tariffs applicable in France are not public. The option to be chosen by the insured person between the tariffs of the country of care and of the country of affiliation raises problems since patients lack information. In general, they do not know which institution to contact abroad in order to get reliable information. Most of the time they choose the French tariffs which might be disadvantageous. Some private healthcare institutions in charge of the supplementary coverage refuse to refund the expenses not covered by the statutory scheme if they do not receive an official form from the French social security or if the invoices are not translated into French. Some of them refuse to proceed to any refund for the sole reason that the invoice has been issued abroad. In **Hungary** it was observed that the technical settlement of the issues of finance of healthcare providers and pharmacies is much more complex if a foreign insured EU citizen receives the healthcare benefit or has medicine prescribed for himself herself. For this reason, some healthcare providers (*e.g.* general practitioners in villages or small pharmacies) send the EU citizen, who is insured in another Member State, to another service provider to ensure that the administrative burden and costs are lower. **Latvian** patients do not often use the Directive's route as they should advance the medical costs; as in the majority of cases Latvian tariffs are substantially lower than healthcare tariffs in other Member States; as extra costs occur related to travel and accommodation; and as they are afraid of linguistic difficulties.

It can thus be concluded that the most problems reported are related to (1) the lengthy and burdensome administrative procedures, (2) the disadvantageous financial arrangements and (3) the lack of comprehensive and reliable information.

In addition, there were a few national *court cases* which shed light on the practical problems as well. In **Spain**, there was a case that showed that a court had problems distinguishing and applying the different instruments of reimbursement correctly. The judge ruled that the plaintiff was entitled to reimbursement under the national legislation, controversially considering that there was a vital urgency, but simultaneously it limited the amount of the reimbursement by applying the limits envisaged in the Directive. In **Finland**, the court found a procedural fault in the authorisation procedure, since the competent institution had not given the client the opportunity to have his or her say after the expert opinion from the public healthcare institution. The procedural instructions of the institution were changed after the judgment to avoid similar mistakes in the future.

Furthermore, also a number of *good practices* can be identified seeking to ensure the smooth operation of the complex legal framework.

The **Cypriot** national practice shows that the existence of a single committee handling cases both under the Regulation and the Directive facilitates a coherent and consistent approach to the parallel application of these instruments. In **Denmark**, the insured person might receive more reimbursement according to the Regulation than the Directive and *vice versa* depending on the concrete case; therefore, if reimbursement is rejected or unsatisfactory, the person is encouraged by the competent authority to reapply using the option yet untried. The Ministry of Health will probably pass new guidelines for the regions requiring them to apply based upon both legislations in order to ensure the *best possible reimbursement to the citizen.* In **Slovenia**, administrative problems were settled bilaterally between the respective National Contact Points.

Although administrative, organisational and legal anomalies might occur, more than half of the Member States seem not to have faced major problems due to the parallel application of the Regulation and the Directive.

Still, a significant problem which was repeatedly mentioned was the *lack of patients' solid knowledge of their rights and the implications of their choices.* This points to the unquestionable importance of informing the patients, an issue which is discussed in the last chapter of this report.

3.5. Special rules for frontier workers

3.5.1. Special rules under de coordination Regulations

According to the EU coordination Regulations, the peculiarity that defines frontier workers is that, on the one hand, they do not reside in the State where they work and are insured[222] and, on the other hand, they must as a rule return to the State of residence[223] daily or at least once a week.[224] Member States cannot invoke the non-performance of the residence requirement by the frontier workers as grounds for barring their entrance or registration in their social security system. Consequently, they should be treated as national insured employees or self-employed persons, as far as they cannot be discriminated against on grounds of nationality like any other migrant worker. Besides, as the CJEU has recognised, frontier workers take part in the labour market of the Member State of employment and have established, in principle, a sufficient social "*link*

[222] Applying the general conflict rule *lex loci laboris.*

[223] Where their centre of interest is. See Article 11 of Regulation (EC) No 987/2009.

[224] See Article 1(f) of Regulation (EC) No 883/2004. According to the wording of this Article, frontier workers do not have to be residents in one of the neighbouring countries. A person residing in Madrid who works in London or Paris and returns to Madrid every week can apparently be categorised as a frontier worker. See CARRASCOSA BERMEJO, D., The concept of the frontier worker and unemployment protection under EU coordination regulations, In SANCHEZ RODAS NAVARRO, C. *et al,* Good Practices in Social Law, Thomson Reuters Aranzadi (2015). p. 127

of integration". They would be entitled to benefit from the principle of equal treatment as compared with national workers and resident workers.[225]

Considering those specific characteristics, the coordination Regulations envisage the following ad hoc rules regarding frontier workers' access to healthcare while they are active and when they are retired.

Firstly, frontier workers have, as a privilege, a *double healthcare coverage*. They have unrestricted rights to benefits in kind in the Member State of employment, *i.e*. the competent Member State, and in the Member State of residence,[226] according to its legislation and as if they were insured there.[227] The frontier workers are obliged to register with the institution of the place of residence by presenting the PD S1 issued by the Member State of employment in order to certify that they have the right to benefits in kind and that said Member State of employment is going to bear the cost of the healthcare received in the Member State of residence.[228]

As a general rule, the same applies to the *family members* of a frontier worker, who also enjoy derived unrestricted rights to benefits in kind in both Member States. However, there is an exception when the Member State of employment is listed in Annex III of Regulation (EC) No 883/2004.[229] The family members of a frontier worker employed in said States are only entitled to unplanned healthcare in the Member State of employment, with all its limitations, and have to request an authorisation in order to obtain planned healthcare from the competent Member State.[230]

Annex III should have been reviewed before 31 October 2014 by the Commission on the basis of a report by the AC. The AC unanimously approved in June 2015[231] the final report presented by an ad hoc group composed of representatives of the Member States still listed in Annex III.[232] The report underlined that it was not possible to provide a detailed impact assessment as far as the group could not find hard data on the significance, frequency, scale and costs of the application of the provisions of Annex III. However, the available figures suggested that the financial impact of the abolition of the Annex would be rather marginal,[233] concluding that the reasons to maintain it would rely on political considerations.[234] In the light of that report, the Commission shall decide

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[225] In order to access social advantages, it has been said that "*the link of integration arises, in particular, from the fact that through the taxes which they pay in the host Member State, by virtue of their employment there, migrant and frontier workers also contribute to the financing of the social policies of that State*". See *Caves Krier,* C-379/11, EU:C:2012:798, paragraph 53 and *Commission v Netherlands*, C-542/09, EU:C:2012:346, paragraph 65. However, thanks to bilateral double taxation agreements frontier workers often do not pay taxes in the State of employment.

[226] As defined in Article 1(j) of Regulation (EC) No 883/2004.

[227] See Articles 17 and 18 of Regulation (EC) No 883/2004.

[228] See Article 24 of Regulation (EC) No 987/2009. The PD S1 is issued upon request of the insured person or upon request of the institution of the place of residence. The PD S1 remains valid until the competent institution informs the institution of the place of residence of its cancellation. Healthcare costs incurred by a frontier worker and her or his family members will be reimbursed on the basis of actual expenditure.

[229] Currently HR, DK, FI, SE and UK. However, HR, FI and SE submitted notes to the Administrative Commission requesting their removal from the list (see Note AC 265/14 of Finland, Note 273/14 of Croatia and Note AC 382/4 of Sweden). The Annex also includes two EFTA States, NO and IS.

[230] The competent Member State could take into account the information provided by the Member State of residence regarding whether the treatment required can be provided in its territory without undue medical delay

[231] AC note 324/15.

[232] Created by the AC at its 338th meeting on March 2014. Composed by representatives of DK, IS, IE, NO and UK.

[233] There are only a very limited number of frontier workers working in the countries which are still in Annex III. Persons tend to choose the Member State of treatment based on reasons such as habit, family support and familiarity with medical provisions, so they seldom use the healthcare services of the Member State of employment of the frontier worker.

[234] Some of the Member States listed in Annex III argue that providing double coverage to the family members of the frontier workers is not justified by the equal treatment principle. They consider that double coverage could even put other insured persons at a disadvantage and does not increase freedom of movement as far as

whether to submit a proposal concerning a review or removal of the Annex, the latter being the most probable, as far as the AC report does not provide compelling reasons not to do so.[235] Member States shall ensure that, if that is the case, they inform properly on the changes in rights and obligations as a result of its removal.[236]

Secondly, the Regulations envisage two special rules granting additional healthcare protection for retired frontier workers. The costs derived from the rights to benefits in kind in the Member State of residence, in favour of the pensioner or of her or his survivors, has to be borne by the competent Member State.[237]

The first rule enables a former frontier worker to continue a healthcare treatment (including investigation and diagnosis) begun in the Member State of employment (the competent Member State) before being retired due to old age or invalidity. As this additional right to healthcare is limited to the specific treatment, it usually has a temporary nature.[238] In the case of a chronic illness, however, it cannot be ruled out that it becomes a lifelong right. The same rights apply, *mutatis mutandis*, to members of the family of a frontier worker if the competent Member State is not listed in the already mentioned Annex III of Regulation (EC) No 883/2004.

The second rule grants an additional, and in principle indefinite, right to full healthcare coverage in the Member State of employment to certain retired frontier workers. In particular, this rule protects pensioners who: a) in the five years preceding the effective date of obtaining an old-age or invalidity pension, have been pursuing an activity as an employed or self-employed frontier worker for at least two years; and b) both the Member State of employment and the Member State of residence are listed in Annex V of Regulation (EC) No 883/2004.[239] This is, thus, a reciprocal right voluntarily granted by the seven Member States listed in said Annex. For instance, a pensioner who was a frontier worker in France during the last three years before retiring receives two pensions: one from France and one from Belgium, where s/he also worked before s/he became a frontier worker. Belgium is the competent Member State as the pensioner resides there. This Member State has to bear the costs of the benefits in kind in France (planned and unplanned) issuing an PD S3[240] as far as both these Member States are included in Annex V of Regulation (EC) No 883/2004.

The same applies to members of the family of the frontier worker if the competent Member State is not listed in the already mentioned Annex III of Regulation (EC) No 883/2004, and they have claimed healthcare in the Member State of employment of the frontier worker according to Article 18(2) of Regulation (EC) No 883/2004. This rule applies even if the frontier worker died before her or his pension commenced, provided s/he was a frontier worker for at least two years in the five years preceding her or his death. These additional healthcare rights for the retired frontier worker (own right) and her or his family members (derived right) expire if the beneficiaries become insured as an employee or self-employed person in a Member State.[241]

these persons enjoy full healthcare coverage in the Member State of residence and unplanned healthcare coverage in the competent Member State.

[235] See Article 87(10) (b) of Regulation (EC) No 883/2004.

[236] See Article 87(11) of Regulation (EC) No 883/2004.

[237] See Article 28(5) of Regulation (EC) No 883/2004.

[238] See Article 28(1)(2) of Regulation (EC) No 883/2004.

[239] AT, BE, FR, DE, ES, LU and PT. See also Article 28(2) of Regulation (EC) No 883/2004.

[240] See Article 29 of Regulation (EC) No 987/2009.

[241] See Article 28(3) of Regulation (EC) No 987/2009.

3.5.2. Special rules under the Directive on the application of patients' rights in cross-border healthcare

Frontier workers are not explicitly mentioned in Directive 2011/24/EU, something that can give rise to doubts. Applying the Directive, in principle they should be treated as any other person residing outside the competent Member State. Retired frontier workers would be treated as other pensioners. Anyhow, a separate ad hoc treatment of frontier workers in the Directive would have been advisable.

For *active frontier workers* and their family members it is clear that the Member State of affiliation is the competent Member State, as far as the two exceptions contained in Articles 20(4) and 27(5) of Regulation (EC) No 883/2004 do not apply to active frontier workers and their family members, because their healthcare costs are always reimbursed on the basis of actual expenditure. For *retired frontier workers*, however, those rules could be relevant if the pensioner resides in a Member State that opted for being reimbursed on the basis of fixed amounts,[242] as this latter Member State is the authorising Member State under the Regulations and would therefore be the Member State of affiliation bearing the reimbursements under the Directive.

It is also clear that frontier workers and their family members are not covered by the Directive for healthcare treatments received in the Member State of residence, as far as they are not in a cross-border situation.

Doubts arise regarding their right to cross-border healthcare under the Directive in the competent Member State, *i.e*. the Member State of employment and also the Member State of affiliation under the Directive. In this scenario, it would appear logical to ensure that there is not an actual cross-border situation. Frontier workers would not be entitled to reimbursement under the Directive as far as they are entitled to full healthcare coverage under the social security scheme of the competent Member State as if they were residing there. The same would apply to their family members if the competent Member State is not listed in Annex III. Would be in a similar situation: the retired frontier worker who wants to be treated in the competent Member State mentioned in Annex IV of Regulation (EC) No 883/2004 or in the Member State where s/he was frontier worker and where s/he also has full healthcare coverage according to Article 28(2) and (3) and Annex V of Regulation (EC) No 883/2004.

However, as pointed out above, family members of active frontier workers insured in a Member State listed in Annex III are not in the same situation, as they do not enjoy full healthcare coverage in the competent Member State. In this case, if they receive a healthcare treatment in the competent Member State it seems reasonable to state that they are in a cross-border situation for the purposes of Article 7(1) of the Directive, as they are not treated as a national insured person. Therefore, it also seems reasonable that they have the right to reimbursement under the Directive of the healthcare costs incurred.

It has been stated in a guidance note by the Commission services issued on 21 May 2012[243] that Article 7(2)(b) of the Directive could be relevant for the aforementioned specific group, *i.e*. family members of frontier workers insured in a Member State listed in Annex III of Regulation (EC) No 883/2004.

Article 7(2)(b) of the Directive is far from clear and needs some clarification.[244] Among its possible interpretations, it could be understood that the competent Member State, the one that "*is, in the end, responsible for reimbursement of the costs*" (not the State of

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[242] The Member States mentioned in Annex 3 of Regulation EC/987/2009.

[243] See AC 246/12, p. 22 and 23.

[244] See *e.g*. AC 532/14 REV p. 8 and 16: "*many delegations had asked about the meaning of Article 7.2.b) of the Directive 2011/24/EU, in particular whether private healthcare falls under this article*".

affiliation when they are not the same), should assume the cost of healthcare provided in its own territory if no prior authorisation is required under the Directive and the treatment in question has not been provided in accordance with the Regulations. In such a case, the competent Member State would assume the costs of the healthcare in accordance with the terms, conditions, criteria for eligibility and regulatory and administrative formalities that it has established, provided that these are compatible with the Treaties.

The mentioned guidance note underlines that this Article does not create any new rights to access to healthcare and only establishes which Member State is liable to bear the cost of the treatment once it has been received. In view of these considerations it can be stated that this Article is not relevant for family members of active frontier workers as far as the competent Member State is always the Member State of affiliation and no clarification is needed.

Under this assumption, Article 7(2)(b) would only be relevant in the case of retired frontier workers, *i.e*. pensioners in general, when both Member States (competent and affiliation) are not the same, and this only occurs when pensioners are not residing in the competent Member State but in a Member State that is compensated on the basis of fixed amounts. Besides, the competent Member State, where the pensioner wants to receive non-authorised healthcare under the Directive, does not have to be listed in Annex IV of Regulation (EC) No 883/2004.[245] As DG SANCO stated on October 2014, [246] this Article 7(2)(b) is the result of a compromise reached by the Member States regarding the sharing of healthcare costs. "*The compromise was that the competent Member States would cover the costs of healthcare which is not subject to prior authorisation in the Member State of residence. The Member State of residence would cover the costs that are subject to prior authorisation*". For instance, what happens when a person receiving a **United Kingdom** pension and residing in Spain wants to receive in the United Kingdom a treatment that is not subject to prior authorisation under the Directive? Because of the aforementioned compromise, the United Kingdom would be responsible for the reimbursement of the treatment costs. Conversely, should the healthcare be authorised (by Spain, as Member State of affiliation) then Spain would reimburse the treatment costs.

Article 7(2)(b) also states that the "*Member State may assume the costs of the healthcare in accordance with the terms, conditions, criteria for eligibility and regulatory and administrative formalities that it has established, provided that these are compatible with the TFEU*". This assertion could be applied, for instance, to the basket of services, the co-payment required or other general formalities such as the 'gatekeeping' procedure with a general practitioner.[247] However, it is not clear if it could be used for denying access to purely private healthcare providers[248] when the national legislation does not envisage its reimbursement, *i.e*. when there is no internal freedom to provide healthcare services. For instance, if a British pensioner is treated in the United Kingdom by a purely private healthcare provider and reimbursed under the Directive, s/he would enjoy a right that a British pensioner residing in the United Kingdom does not have.

[245] If it were mentioned in the Annex, Article 7(2)(a) would apply and there would be no reimbursement.

[246] See AC 532/14 REV p. 16 "[…] as *to who is responsible for the cost of healthcare received outside the Member State of residence (where that Member State has opted to receive reimbursement on the basis of fixed amounts) by pensioners and family members*."

[247] See, in this sense, 'Guidance note of the Commission services on the relationship between Regulations (EC) 883/2004 and 987/2009 on the coordination of social security systems and Directive 2011/24/EU on the application of patients' rights in cross border healthcare', p. 23.

[248] "*[...] many delegations had asked about the meaning of Article 7(2)(b) of Directive 2011/24/EU, in particular whether private healthcare falls under this article*"; AC 532/14REV 9-10-2014, 'Draft Minutes of the Working Party of the Administrative Commission on cross-border healthcare', p. 16.

3.6. Healthcare under social security agreements between the Member States

Although numerous bi- and multilateral agreements exist between EU Member States which touch upon the issue of healthcare provision,[249] there is one which was reported to play an essential role in the access to cross-border planned treatment, namely the bilateral agreement between **Malta** and the **United Kingdom**.

The services offered under the Malta-United Kingdom bilateral agreement are considered to be an extension to the healthcare services offered by the Maltese healthcare system, and when considering requests for treatment abroad, priority is given to healthcare services offered under this agreement. Based on this arrangement, Maltese patients are offered medical treatment in United Kingdom NHS hospitals just like any United Kingdom national registered with the NHS system, and patients are not required to pay for the treatment. In addition to the medical treatment, approved patients are means-tested to assess whether they qualify for free air tickets. The Maltese health authorities also have accommodation agreements with various service providers who offer accommodation services to patients receiving treatment. Payment to these institutions is made directly by the Maltese health authorities. Patients receiving treatment in the United Kingdom are also provided with transport from and to airports and for hospital appointments.

[249] PACOLET, J. and DE WISPELAERE, F., Planned cross-border healthcare – PD S2 Questionnaire, Report prepared in the framework of Network Statistics FMSSFE, 2014, p 16.

4. PUBLIC AND/OR PRIVATE PROVISION OF HEALTHCARE

In the present chapter aspects of public and private provision of (cross-border) healthcare are analysed. With full awareness of the complexity of healthcare systems in all layers (from health insurances or national health service schemes to various forms of healthcare provision) in various Member States some notions are being standardised in order to simplify the text. Among them are:

- Patient (any natural person seeking or receiving preventive or curative healthcare):[250]
  - public patient: a patient covered by social health insurance[251] or national health services and acting as such in relation to healthcare providers;
  - private patient: a patient acting as a private seeker and direct payer of healthcare; such patient could be
    - covered neither by social health insurance nor national health services, could be privately insured; or
    - publically covered, acting as a private patient at the time of the healthcare delivery, but may act as a public patient later on when asking to be reimbursed from the public healthcare system);[252]
  - national patient (a public or private patient seeking or receiving healthcare in the country where s/he is covered by the public healthcare system);
  - mobile patient (a public or private patient seeking or receiving cross-border healthcare);
- System:
  - healthcare system (political and legal organisation of a public and private healthcare system in the respective Member State);
  - public healthcare system (organised within the social security system as social health insurance or national health service, although national health services may sometimes be considered as outside of social security *stricto sensu*);[253]
  - private healthcare system (organised in parallel to a public healthcare system, at the private health insurance market and with purely private healthcare providers).
- Provider:
  - public healthcare provider (public or private healthcare provider included in the public healthcare system);

[250] Also palliative healthcare could be added, although non-medical services are in the forefront.

[251] Social health insurance is also known as mandatory health insurance or statutory health insurance.

[252] Also Directive 2011/24/EU on the application of patients' rights in cross-border healthcare makes a distinction between an "*insured person*" and a "*patient*" (who might be a public or private patient). *Cf.* Article 3(b) and 3(h).

[253] *E.g.* IE, UK and PT. Therefore, also Directive 2011/24/EU refers to providers who are not part of the "*social security system or public health system*" of that Member State (Article 1(4) of the Directive).

- private healthcare provider (a natural or legal/juridical person providing healthcare within or outside of the public healthcare system; if within the public healthcare system, referred to as contracted or conventioned provider);

- purely private healthcare provider (a private healthcare provider outside of the public healthcare system).

4.1. Mixtures of public and private providers of healthcare

It could be argued that in every Member State a specific mix of public and private responsibilities for healthcare exits. It depends not only on the State's level of economic and social development, but also on the responsibility it assumes for promoting health of individuals and ensuring healthcare benefits. Hence, healthcare and its provision is not only a legal and economic, but also a political and ideological issue.

One of the core legal questions of social security law is how the burden of securing good health and the ability to be productive in a society should be distributed between public and private legal subjects. To what extent is it the duty of legal subjects governed by civil law (the individual him or herself, his or her family or employer), and where should solidarity, *i.e*. the responsibility of the community represented by legal persons governed by public law (the state, municipalities or other local/regional communities[254] and public institutes), commence?

Until a couple of decades ago, we could witness not only the trend of increasing legal regulation, *i.e*. juridification,[255] but also of de-privatisation or socialisation of income security, also in case of increased costs due to sickness. Arrangements governed by public law were given priority over private law solutions. The rule of law demands that social security, including healthcare systems,[256] has to evolve constantly in order to reflect changes in social relations.[257] Recently, a reverse trend could be observed, *i.e.* shifting the responsibility for healthcare (back) to private persons.

Public and private responsibilities, when implementing the internationally and constitutionally protected right to social security and health (care) rights are interrelated at various levels.

One of them is the administration of the healthcare system, since the normative design of the public healthcare system is shaping possible markets of private health insurances. Private health insurance may range from basic (for those not covered by a public scheme), supplementary (for co-payments, *e.g*. in **HR** or **SI**), additional (for services not covered by the public scheme), substitutive (*e.g*. for high-income earners in **DE**) and parallel (for faster access to the same services offered also by a public healthcare system) health insurance.[258] In some Member States private sickness insurers may also

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[254] For instance, in SE the county councils are responsible for the largest part of the health and medical care, but the municipalities have the primary responsibility for certain groups (like basic care and treatment for elderly persons, the chronically ill, the disabled and other persons living in special types of accommodation such as care/nursing homes and service flats). A limitation in the responsibility of the municipalities is that it does not include examination or treatment by a doctor. All such care is the responsibility of the county council. Thus, there is a need for continuous cooperation between the different authorities in the care of the elderly and the disabled, a team work that is sometimes criticised for not working satisfactorily.

[255] More on various dimensions of juridification, *e.g.* BLICHNER, L. CHR., MOLANDER, A., What is juridification?, Arena, Centre for European Studies, University of Oslo, Working Paper No 14, March 2005.

[256] Although sometimes considered to be outside of social security, but clearly within social security (coordination) in EU law.

[257] According to the Slovenian Constitutional Court, the legislature does not only have the right, but is under the obligation to adapt the legislation, if this is dictated by the changed relations in the society (Decision No U-I-69/03, 20.10.2005, OdlUS XIV, 75).

[258] *E.g*. in SE there has been an emergence of supplementary private health insurance which increases the share of private funding to almost 20% of all healthcare. A supplementary insurance primarily provides faster

administer the public healthcare system (*e.g*. in **CH** next to public sickness funds, or exclusively in **NL**).

Other levels are the way of financing and the scope of benefits. Public healthcare systems are financed by taxes and social security contributions and private healthcare systems by insurance premiums. The costs for benefits in kind (healthcare) can be covered in full, or certain co-payments of insured persons are required (with possible private insurance against such direct payment, as mentioned above).[259]

At the same time co-payments are a way of (privately) financing healthcare providers. They themselves may be public, contracted private or purely private.

Public healthcare systems are under the obligation to guarantee healthcare benefits to an entitled person in time of sickness or injury. There is a variety of options to provide healthcare (*i.e*. medical services and medicinal goods) to entitled persons. Public healthcare systems may do so

- themselves directly, by owning and administering healthcare providers (*e.g*. hospitals, like in **AT**; **DK**, where regional councils own regional hospitals; **UK**; **IE** or **MT**;

- by contracting healthcare providers (*e.g*. GPs, health centres, policlinics, hospitals, pharmacies, spas *etc*), which may be public or (profit or non-profit)[260] private providers (provision of benefits in kind), *e.g*. in **Germany** or the **Netherlands**;

- by limiting their responsibility to reimburse healthcare costs, but regulating (quality, safety and prices of) healthcare providers through other mechanisms; the reimbursement of healthcare costs might be a rule in some Member States (*e.g*. in **BE**, **FR**, **LU**), but is gaining importance also in all other Member States at least with regard to cross-border situations; or

- by means of a combination, for instance by providing some benefits themselves and concluding contracts for others, or stipulating that some services in the public interest cannot be provided by private providers (*e.g*. blood products and organ transplants, coroner's services, public health services in **SI**).

We shall focus on the interplay between public and private providers (*e.g*. physicians, nurses, midwifes, health centres and hospitals), providing healthcare to public and private patients,[261] especially in cross-border situations. For instance, when healthcare is delivered by public providers to public patients and when it is delivered by private healthcare providers to private patients, the distinction between public and private healthcare provision is rather clear.

However, also public providers may (under certain conditions) deliver healthcare to private patients, and *vice versa* private providers may be contracted to deliver healthcare

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access to healthcare and may also cover healthcare that is usually not offered by the public healthcare, such as naprapathy, chiropractic, home service, fast health advice etc.

[259] STRBAN, G., Cost sharing for Health and Long-term Care Benefits in Kind, MISSOC Analysis 2014/1, 39 p.

[260] The latter may be motivated by altruism or religion. BENNET, S., The Mystique of Markets: Public and Private Healthcare in Developing Countries, London School of Hygiene and Tropical Medicine, London, 1991, p. 35, argues that the objectives of these organisations are more closely aligned with those of the government and there is a greater scope for collaboration.

[261] Also just some non-medical services and goods (*e.g*. provision of food in hospitals) may be contracted out to private organisations. WHO, The role of the Private Sector and Privatisation in European Health Systems, Regional Committee for Europe, Copenhagen, 2002, p. 6.

to public patients. Choosing the desired way of receiving healthcare might be even more challenging for cross-border patients, who might lack all the relevant information.

4.1.1. Private providers delivering public healthcare

Maybe an even more important distinction than between public or private ownership of a healthcare provider, *e.g*. a primary health centre or a hospital (static view), is the distinction between activities of public or private provision of healthcare (more dynamic view), *i.e*. the regime under which a healthcare provider is operating. More specifically, public patients might be interested in receiving healthcare paid by the public healthcare system, regardless whether it is provided by a publicly or a privately owned organisation.

Member States themselves shape a *network of public healthcare provision* (in some Member States referred to as public health service). In such network, public (owned by the state, municipality or region) and private healthcare providers (owned by congregations or private persons) are included.[262]

They are often referred to as *contracted providers* (*e.g*. in **AT**,[263] **BG**, **CZ**, **DE**, **PL**, **PT**, where the ministry of health concludes conventions, **RO**, **SI**, **SK** and **UK**). For instance, in **Latvia** an agreement with the National Health Service is required and in **Lithuania** a contract with territorial branches of the National Health Insurance Fund. Ad hoc agreements exist *e.g*. in **Malta**.

In **Estonia** contracted providers are listed in government regulation, and in **Spain** a specific agreement, *i.e*. a *concierto* is concluded with a private provider, who is then listed by the Regional Healthcare Service.

In **France** providers are registered or contracted, *i.e*. *conventionné* with the French healthcare scheme or with a public health institution. However, there is a distinction between 'contracted sector I' and 'contracted sector II' providers. The former (sector I) apply the entire state registration agreement, including state-regulated fees, and reimbursement to the patient may be higher. The latter (sector II) apply the state registration agreement with the exception of the clauses pertaining to rates. Hence, they are free to set their own rates, meaning that there is less solidarity and reimbursement might be lower. Such system could lead to a lack of transparency, especially for mobile patients.[264]

In **Belgium** the notion of conventioned providers is used. They are providers who fully adhere to collectively negotiated tariffs. A similar situation exists in **Luxembourg**, where providers have to be authorised and conventioned. Under **Dutch** law, providers are private; they operate in a market setting, but within public law.

Interestingly enough, in **Finland** a voucher can be obtained for private providers from which a municipality has purchased treatment. In **Sweden**, accreditation and a contract with a county council are required.

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[262] A network of public healthcare provision is (usually) planned by the state or local community, since it reflects the healthcare needs of inhabitants. From a national point of view, it may be a closed network of contracted healthcare providers or open network of all healthcare providers in the state. An interesting question of competition law (in the internal market) could be the competition between public and private healthcare providers for public funds, *i.e*. from a public healthcare system, especially if there is a closed network of public healthcare.

[263] For instance, in AT providers which are run directly by Austrian Health Insurance (AHI) or by private persons/companies who have a contract with AHI are considered to be part of the AT social security system.

[264] It is possible to check the category of a doctor on an official website (http://annuairesante.ameli.fr/). This link can be found on the CLEISS website. The site gives the name and address of the doctor and the category s/he belongs to, but it does not indicate the price of a consultation or the reimbursement rate. For contracted hospitals the law of 2010 tried to improve the information provided.

In **Croatia** there is a system of concession for private providers. Similarly, in **Slovenia** private providers require an administrative concession as well as a contract with a mandatory health insurance carrier (Health Insurance Institute of Slovenia).

In **Ireland**, there are Health Service Executive (HSE)[265] hospitals and hospitals authorised to provide services to the HSE for public patients with full and for those with limited eligibility. In **Italy** private facilities are accredited with the National Health Service (*Il Servizio sanitario nazionale – SSN*) and healthcare is purchased by specific agreements with a region.

Contracts with private healthcare providers are not necessarily territorially limited. They may be concluded with providers in *another Member State* (*e.g*. the **BE** Sickness and Invalidity Institute, the *RIZIV/INAMI*, concluded contracts with foreign hospitals for hadron therapy not available in BE).

In some Member States *almost all* healthcare providers work within the public healthcare system (*e.g.* in **BE** they are within the social security system through the aforementioned 'conventioning method'; in **FR** almost all private hospitals are contracted) or at least a majority of them (*e.g*. in **EE** providers are mostly covered by private law and many are incorporated in the social security system; purely private providers operate in limited areas only; in **LI** the number of providers outside of mandatory health insurance is very small; in **LT** providers are mainly governed by public law; in **MT** healthcare is mainly provided by the state, while the private sector exists for those who wish to access private healthcare; in **SI** almost all primary care private providers are covered, which does not apply to all dentists; in **SE** public and private providers are generally publicly funded, but the legislation has opened up more and more for private providers). It may also be the case that the majority of the healthcare providers are public providers (publicly funded and managed) and that there are only some private providers (like in the **ES** National Health Service).

Conversely, at certain levels (most notably at primary healthcare level), providers might be exclusively or predominately private, although many of them are contracted or conventioned (*e.g*. in **DE**, **LU**, in **LV** 70 to 80% of health centres are private, mostly in Riga; in **PL** up to 85% of general healthcare is provided by private providers, 65% of outpatient specialist services and only %6 of hospital treatments; in **PT** with the reform of 2005 approximately 90% of National Health Service hospitals were transformed into public enterprises, *i.e*. *EPE – entidades públicas empresariais*). In many Member States, predominately private and only to a certain extent included in public healthcare system are also dental practices and pharmacies.

Joint public-private ventures, from which the public sector purchases services, may be established in some Member States (*e.g.* **CY**). For instance, in some regions of **Spain** there are public hospitals and medical centres that have been provided by means of Public-Private Partnership (PPP) contracts that include the provision of medical services. These facilities have been privately funded and are privately managed but are publicly owned (the private partner provides the service on behalf of the public administration) and are therefore considered part of the Regional Healthcare Services. It seems that also in **Portugal** some public hospitals are managed by private entities in the form of a PPP. In the **Slovak Republic** public providers are owned by the state or a municipality, but some state-owned providers have been organised as companies under commercial law (*e.g*. cardio centres are joint-stock companies operating under private law).

However, also in Member States where *no contracts* are concluded with public healthcare providers (and the system is based on the reimbursement of costs), there is a distinction

[265] More on HSE, which is running all of the public health services in Ireland, at www.hse.ie.

between public and private providers. For instance, in **Belgium** the law[266] does not, strictly speaking, regulate the medical profession, but by defining the framework for reimbursement, they regulate the sector.

Usually, special provisions apply to *hospitals*, since they require planning essential for public health and even survival of the population, maintaining the financial balance of the social security system and reaching the objective of maintaining a balanced medical and hospital service open to all, and any wastage of financial, technical and human resources should be avoided.[267] Hospitals are planned in many Member States using various planning instruments (*e.g*. in **CH** they have to be listed by the competent canton; in **DK** private hospitals are listed in the national health act; in **RO** emergency hospitals are set up and operate as public hospitals only; in **DE** *Plankrankenhäusern* have a special status, as well as in **AT**).[268] In some Member States also purely private hospitals may be paid by the public healthcare system (although not being included in it). This might be in the case of urgent treatment or if the public and contracted/listed providers cannot meet the requirement of treatment within a certain period (*e.g*. so-called extended free choice or *udvidet frit sygehusvalg* after two months in **DK**).

Some Member States are *planning reforms* that would emphasise the role of private providers of public healthcare. For instance, the government of **Finland** is preparing a big reform, which is planned to change the ideas of social care and healthcare quite fundamentally. The problem in Finnish healthcare is that municipal healthcare centres have long queues and are overcrowded. Finland belongs to those countries that have the largest socio-economic health differences in the OECD. Healthcare and social services (including long-term care) should be transferred to entities larger than a municipality (*i.e*. to social and healthcare areas). The areas will provide services themselves, or alternatively use private or third-sector service providers to offer services. The government has proposed that all service providers should be organised as private companies. Therefore, public providers should also be reorganised as (public) limited companies. The government encourages initiatives from private and third-sector providers. At the same time critical voices have risen against the heavy reliance on private providers.[269]

4.1.2. Purely private healthcare providers

Purely private healthcare providers were either not selected or have not applied to be included in a network of public healthcare provision. They are often referred to as *non-contracted* or non-conventioned providers (in **AT**; some non-conventioned private hospitals in **BE**; in **EE**; **SI;** and many **other** Member States).

Nevertheless, they are authorised to provide healthcare on the territory of a Member State to private patients (who may be socially insured as well, but have for one reason or other, also for avoiding waiting lists, chosen to act as private patients). They have to obtain a licence (*e.g*. in **CY**) or permit (*e.g*. in **FI** and **SI**) or accreditation (*e.g*. in **HU**) by the ministry of health or authorisation by the municipality and a Region (*e.g*. in **IT**).

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[266] The Law concerning the mandatory insurance for medical care and allowances coordinated on 14 July 1994 and its implementing measures.

[267] *Cf. Geraets-Smits and Peerbooms* EU:C:2001:404, *Müller-Fauré and van Riet* EU:C:2003:270, and *Watts* EU:C:2006:325. Not considered in the case law and subsequently in Directive 2011/24/EU is that in some Member States primary health centres might require planning as well.

[268] In AT, special rules apply to hospitals due to constitutional reasons. All hospitals which are financed by AHI and the Federal Lands via taxes by the Federal Health Fund (*Landesgesundheitsfonds*) are considered to be public hospitals. Beside these public hospitals also private hospitals exist which have a contract with an AHI carrier. These private hospitals are again co-financed by a fund (*PRIKRAF/Privatkrankenanstalten-Finanzierungsfonds*) fed by contributions of the AHI carrier. These private hospitals are treated equal to public hospitals. All healthcare provider bodies which have no contractual relationship to AHI or who are not (partially) financed by it are considered to be private.

[269] OLLI KANGAS O. and KALLIOMAA-PUHA L., ESPN Country Report [Finland], European Social Policy Network, Brussels: European Commission, 2016.

Moreover, physicians themselves also require a licence to practice medicine, which has to be periodically reviewed.

As a rule, purely private healthcare providers have *shorter (or no) waiting lists*, also due to less patients (*e.g*. in **AT**, **BE**, **CY**, **EE**, **ES**, **FR**, **HR**, **IE**, **IT**, **LI**, **LV**, **MT**, **PT** and **SI**). Therefore, they may devote more time to them during their visit and provide additional conveniences, like coffee or a newspaper (reported *e.g*. for **EE**). They might also provide more privacy (*e.g*. single rooms in hospitals) than contracted providers who serve a larger number of public patients.

At the same time, they might have fewer patients also because their *tariffs are higher*. This applies *e.g*. for non-conventioned providers in **Belgium**, or non-contracted providers in **France** (whereby there are only a few in France, which are free to set their fees and there is virtually no reimbursement for the patient), and **Switzerland** (although there are not many private patients in CH). A similar situation is found in other Member States (*e.g*. **CY**, **CZ**, **EE**, **ES**, **HR**, **IE**, **IS**, **IT**, **LI**, **NL**, **PL**). For instance, in **Slovenia** prices for non-contracted providers are set by the Ministry of Health following the proposal by the Medical Chambers of Slovenia and are as a rule higher than for contracted healthcare. In **Hungary** purely private healthcare can be three to five times more expensive than public healthcare.

In the **Slovak Republic** the prices are liberalised and set on the market, *e.g*. clinics providing one-day surgery or stomatology in regions with a higher willingness to pay may prefer direct payments instead of a contract with health insurance in order to charge a higher price. Hospitals which carry out private activities are also free to set their fees (*e.g*. in **FR**). The bills have to be settled either directly by the patients or by their private health insurance.

In some Member States also purely private providers may be *reimbursed by the public healthcare* system, but usually at a lower tariff than public healthcare providers (*i.e*. public and private providers under the public healthcare system). The question might be raised whether they are still purely private providers. In any case they remain non-contracted and non-conventioned providers. For instance, non-contracted practitioners of choice, *i.e*. *Wahlärzte* in **Austria** may charge higher fees than public providers and are reimbursed 80% of the fee under the public healthcare system (which may make a difference of more than 20% due to distinctive levels of fees). Similar rules apply to non-conventioned providers in **Belgium** and there is also partial/small reimbursement of such providers in **Denmark**. However, in many Member States purely private providers are *not* reimbursed from the public healthcare system (unless in a case of urgent treatment).

4.2. Steering a patient or the freedom to choose between public and (purely) private providers

4.2.1. A clear distinction between public and private healthcare provision?

In some Member States, there is a *clear division* between public and purely private provision of healthcare. For instance, in **Liechtenstein** providers are allowed to practice either inside the social security system or outside of it, but not within both legal regimes at the same time. In **Austria** and **Poland** public providers may treat private patients only as long as they do not have a contract for public provision of the same services.[270] A

[270] In AT, contracted doctors are obliged to provide benefits in kind and not treat patients as private patients. However, there is an exception if a medical practitioner provides services in two different professional areas and a contract exists only for one of them. In PL, private entities can provide services publicly and commercially. Public entities can sell their services as long as they do not have a contract for the same services with the NFZ. An interesting question in this regard may be whether a specific physician is allowed to practise (and provide healthcare) for various healthcare entities.

clear distinction between public and private provision seems to exist also in **Switzerland**, where a provider who does not want to practice under the social security law must clearly announce this to the competent authorities and possible patients. However, the number of such providers is very small. The distinction is clear also in **Finland**, where public healthcare is provided by municipalities.[271]

However, in many Member States, public healthcare providers (*i.e*. public or private providers within a public healthcare system) are *allowed* to medically treat private patients as well. This goes for public providers and even more so for private providers delivering public healthcare. They are, as a rule, allowed to (partially) remain on the private healthcare market and deliver medical services to private patients. For instance, in **Belgium** there are part-time conventioned and part-time non-conventioned providers. In **Spain** private providers of the National Health Service governed by public law can also keep offering private services at the same time, although this is not standard practice. The same goes for Estonia, under an important condition, *i.e*. that private provision does not affect the performance under the contract for public healthcare provision. In **France**, hospitals conduct a public activity, but some of them may also have private patients.[272] Interestingly, in **Hungary** the provider must have an operating permit for separate treatments, which should be during office hours or in a hospital room separate from those for public patients. Similarly, in **Slovenia** the same person can act as a public or private patient and can be treated by the same provider, but s/he can act and be received as a private patient, *i.e*. a self-paying patient (*samoplačnik*)*,* only outside of public working hours. In **Italy** accredited private providers can offer services to public and private patients, which applies also in many other Member States (*e.g*. **CY**, **DE**, **HR**, **IE**, **IS**, **LV**, **LT**, **MT**, **PT**, **RO**, **SK**, **UK**).

When the same provider offers the same medical services for public and private patients, a *tendency* might arise at the healthcare provider to treat them as private patients. The advantage for a patient might be that there are no waiting lists and they could be treated immediately in a nicer setting and the personnel might invest a bit more effort due to direct payment. The reasons for acting as a private patient may vary. Private healthcare provision might have a better reputation, investments in public facilities might be slowed down and salaries of medical and supporting professions lowered or stagnating, which was especially the case in some Member States during the time of the recent economic recession. This might lead to shortages even in basic medical supplies and infrastructure.[273] Moreover, patients may desire to exercise consumer control over providers. If no third party (social health insurance or national health service) is involved in the transaction, this makes the provider accountable directly to the patient, and the provider responds accordingly.

However, such direct payment of a private patient is generally less convenient for the majority of patients and may be afforded only by a limited number of well-off private patients. The prices for private patients are set distinctively as for public patients and are as a rule higher than the agreed prices for public healthcare provision. A specific problem may exist where direct payments are informal. Although much of the evidence of such covert or hidden payments is anecdotal, since it is illegal in many countries, experts acknowledge that such payments exist in some countries.[274]

The question of steering a patient becomes even more relevant for a *mobile patient*. A mobile public patient was (and still is) allowed to visit public healthcare providers in the Member State of treatment, as a rule after obtaining a prior authorisation under Regulation (EC) No 883/2004. The possibility of visiting purely private providers and be

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[271] In LU there seem to be no purely private providers acting outside of the public system. On the contrary, all providers in NL seem to be private.

[272] Even if a law of 26 January 2016 aims at reducing this system, it is likely to keep applying in many cases.

[273] See *e.g*. *Petru*, C-268/13, EU:C:2014:2271.

[274] G. Strban, Cost sharing for Health and Long-term Care Benefits in Kind, MISSOC Analysis, 2014/1, p. 12.

publically reimbursed (as a rule without prior authorisation) was partially created by the decisions of the CJEU and even more so with the adoption of Directive 2011/24/EU.

The CJEU argued that prior authorisation might hinder (passive) free movement of medical services also if it were to present a (non-proportional) ban on reimbursement of private hospital treatment in another Member State.[275] The Directive provides for prior authorisation only as an exception, which might be tolerated when hospital stationary (*i.e.* overnight) treatment or highly specialised and cost-intensive medical infrastructure or equipment is required.[276] There is no distinction between public and (purely) private providers in another Member State. The Directive applies to healthcare provision regardless of how it is organised (as social health insurance or national health service), delivered (in kind or reimbursement of costs, as well as public or private) and financed (by contributions, taxes or other means). No distinction between public and (purely) private providers under the Directive (as opposed to the social security coordination Regulations) is emphasised also in the guidance note.[277] Moreover, possible practice of informal direct payments may be damaging especially for a mobile patient, who cannot ask for reimbursement of healthcare costs in the Member State of affiliation, if no official (and in some countries officially translated) invoice can be produced.

4.2.2. The patient's free and informed choice

As a rule, a patient is *free to choose* to visit either a public or a (purely) private healthcare provider. A mobile patient should not lose his or her right to use the EHIC[278] due to the public and private mix of providing healthcare in a certain Member State. Nevertheless, it is argued that acceptance of the EHIC might still be limited in practice (like in **DE** or **UK**).[279] It is possible that private providers will require direct payment and a public patient can lose the right to use his or her EHIC (*e.g.* in **LV**), or will have to wait until the next month if public services for the existing month are exhausted (*e.g*. in **RO**).[280]

However, in some Member States *in reality* the healthcare system does not provide a wide range of choices for a patient (*e.g*. in **CY** there is only one public hospital in each district and the patients prefer staying in their own district instead of going to a private hospital in Nicosia). Conversely, in some Member States the right to extended free choice may exist. For instance, in **Denmark** an insured person can also access healthcare

[275] *Stamatelaki* EU:C:2007:231.

[276] Article 8 of Directive 2011/24/EU. See also *Commission v France* EU:C:2010:579 (on major medical equipment).

[277] It is argued that the Directive covers all providers, including non-contracted or private providers, while Regulation (EC) No 883/2004 does not impose any obligation on the Member States with regard to treatment given by providers who are not subject to the national legislation of the Member State of treatment, such as certain non-contracted or private providers (p. 4). All healthcare providers, including non-contracted or private providers without contracts with the national health system, are covered by the Directive. Under the Directive Member States cannot refuse reimbursement in cases of treatment by certain non-contracted or private providers which are not covered by the Regulations. See Guidance note of the Commission services on the relationship between Regulations (EC) Nos 883/2004 and 987/2009 on the coordination of social security systems and Directive 2011/24/EU on the application of patients' rights in cross border healthcare, note from the Commission of 21 May 2012 (AC 246/12), p. 4, 8, 13, 17. An Appendix to this guidance note was issued on 28 May 2013 reinforcing the Commission's view.

[278] *E.g*. in CZ it is convenient and quite common that EU mobile patients are treated within the public system on the basis of their EHIC. In fact, many foreign patients, especially from DE (and also other countries) are treated within the CZ system. It is convenient also for *e.g*. DE health insurance companies, as the healthcare is provided on a high level, with lower costs. This, on the other hand, does not reduce the possibility of patients from abroad to use the CZ private system – *e.g*. services of private dentists or plastic surgery *etc*. Similar services are quite popular among foreign patients, as they are less costly compared to other countries.

[279] In the UK there is some anecdotal evidence of healthcare providers now refusing the EHIC card on grounds that Directive 2011/24/EU takes precedence. There is an incentive for healthcare providers to do this as it minimises delay in receipt of payment, *i.e*. they are paid upfront instead of needing to arrange reimbursement.

[280] More on refusal of the EHIC by healthcare providers in Pacolet, J. and De Wispelaere, F., The European Health Insurance Card, Reference year 2015, European Commission, June 2016, p. 26.

provided by other, *i.e*. non-listed or purely private, providers if public and listed private providers cannot meet the requirements for treatment within two months). Similarly, but only among public providers, if the waiting time guarantee is not upheld in **Sweden**, the patient is entitled to receive healthcare in other county council.

Steering the patients towards public or more likely purely private provision of healthcare by healthcare providers is as a rule not allowed. For many Member States it is clearly emphasised that providers have no discretion to force the patients to use purely private and higher priced services. The patients have to waive the right to be treated by the public healthcare system (in which case they lose their right to use the EHIC, *e.g*. in **IE**). Moreover, a written consent to be treated by purely private providers might be required (*e.g.* in **ES**, if a mobile patient does not have an EHIC and agrees in writing to use private healthcare services, s/he could be treated outside of the social security system and reimbursement could only be requested under the Directive).[281]

However, especially the mobile patient usually *lacks all specific information* on the public and private healthcare provision in the Member State of treatment, in order to make an informed and truly free choice. Some healthcare systems might be quite complex (*e.g*. mobile patients might not be aware of the **FR** hospital system, making it far from obvious that there is a real choice made by the patient). In some Member States public providers may also offer private healthcare. In this case it is actually essential which door the patient opens, the one for public or the one for private healthcare. The situation is even more blurred in Member States where private practices are established within public health centres, especially for foreign tourists, hence, also those from other Member States.[282]

Therefore, in some Member States there is an assumption that if a patient enters the public healthcare provider (public or private contracted one) s/he wants to be treated as a public patient. The desire to be treated as a private patient has to be expressly communicated from the outset of the treatment.[283]

In some Member States the distinction between public and (purely) private *providers has to be clearly marked*. Contracted providers have to display the fact that they have a contract for providing public healthcare (*e.g*. in **AT** or **ES**). For instance, in **Croatia** they have to use a sticker, showing they are contracted providers, which is the case also for medicinal aid suppliers in **Slovenia**. In **Switzerland** a provider practising outside the public healthcare system has to inform possible patients about such practice. Also in the **Czech Republic** purely private providers have to inform patients before the treatment that they will have to pay it directly. Since many foreigners use private services, information is provided in multiple languages. Patients have to be informed also in other Member States (*e.g*. in **HU**, **SK**, **RO**). Moreover, doctors may have to show their status in the waiting room, specifying whether they are conventioned, conventioned only part-time or not conventioned at all (*e.g*. in **BE**).

Information can be provided also by *sickness funds*. For instance, in **Liechtenstein** the federation of sickness insurers has to publish a list of all care providers who signed the tariff contracts. Sickness funds might develop internet tools showing the status of the healthcare provider (*e.g*. in **BE**), or waiting lists with public healthcare providers (*e.g*. in

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[281] Compare with the reimbursement rules in Article 25(B) of implementing Regulation (EC) 987/2009.

[282] Reportedly, this may apply to Member States (*e.g*. HR), where tourism is among the leading branches of economy.

[283] *E.g*. the UK Department of Health guidance states: "*If providers (including providers from the independent sector contracted to deliver NHS services) accept a visiting patient for treatment, they must not assume that such patients wish to be considered as private patients even though the patient is not coming through a usual NHS route and is not referred formally by their state health system. This is because they are exercising their rights under the Directive and may themselves receive reimbursement from their state system for eligible costs under the provisions of the Directive. At the same time, patients who specify from the outset that they do wish to be treated privately may be charged in the same way as at the equivalent cost to private patients resident in England*."

DK, **SI**). Internet information (which is provided in all Member States and has been encouraged also by establishing the National Contact Point for cross-border healthcare) and information directly from providers is making the situation clear (*e.g*. in **MT**). In some Member States GPs may present the alternatives between public and private providers (*e.g*. in **IT**, which is mainly to the benefit of Italian patients). This might apply also in Member States where a referral of a GP is required (hence, *e.g*. in **LV** the distinction for LV patients is rather clear).

Sometimes, the distinction between public and (purely) private providers is *not very clear*. For instance, in **Austria** the distinction might not always be clear with regard to hospitals, although private hospitals normally show that they are private by displaying "*Privatkrankenanstalt*". Similarly, in **Estonia** confusion might occur with contracted hospitals partially providing private healthcare as well, but they do inform patients if they have to pay directly or large hospitals ask for partial pre-payment for private services to make sure the patient is using the electronically registered appointment time. In **Cyprus**, the distinction is either obvious or empirical. Especially the empirical distinction may cause difficulties for less informed mobile patients.

In **Finland** outsourced services may blur the situation, especially in institutional care and if vouchers are used. Moreover, in **France** there might be a lack of transparency of prices to be paid, but equal treatment of mobile patients covered by EU law should be guaranteed. Nevertheless, it might be difficult to know whether equal treatment is always applied in practice. Reportedly, in Iceland, it is difficult for the patient to know the difference, apart from the distinctions in waiting lists and prices. It could be argued that also in the **UK** the information is not always easily accessible to patients and would have to be made available in easily understood formats.[284]

4.3. Equal or different pricing

In cross-border healthcare one of the core questions for the mobile patient is how much s/he will have to pay for the healthcare in the Member State of treatment. This question as a rule does not arise when cross-border healthcare is sought and provided according to the social security coordination Regulations. In the latter case prior authorisation is a rule, the patient may only visit public healthcare providers, and the payment is settled among the involved Member States and their institutions.

The situation got more complex with the CJEU decisions, more or less codified in Directive 2011/24/EU, according to which public and purely private providers may be contacted, as a rule without prior authorisation, and the service has to be paid by the patient, who may be reimbursed later on in the Member State of affiliation according to the prices in that State.

Therefore, it is essential that the Member State of treatment ensures that healthcare providers apply the *same scale of fees* for domestic and cross-border patients in a comparable medical situation.[285] Some Member States oblige conventioned healthcare providers to use negotiated tariffs for mobile patients, regardless of whether their right stems from Regulation (EC) No 883/2004 or Directive 2011/24/EU. For instance,

[284] To help achieve this, the NHS (Cross-Border Healthcare) Regulations 2013 place a legal requirement on both NHS England and local CCGs to provide patients with the information they need. Department of Health, Cross Border Healthcare and Patient Mobility in Europe: Information to accompany the implementation of Directive 2011/24/EU – on patients' rights in cross-border healthcare.

[285] Article 4 of Directive 2011/24/EU. Moreover, Article 4 (2) (b) of the Directive obliges healthcare providers to inform patients *inter alia* on treatment options and prices. However, providers will be acquainted with the prices they usually apply and not all the prices, which may be differ between public providers, between private providers, and most obviously between public and private healthcare providers.

Belgium has adopted the Act on Various Provisions on Health,[286] with which the health insurance law was adapted with regard to tariffs which the healthcare providers may claim from foreign insured persons. It should prevent indirect discrimination on the grounds of nationality.

This law was clearly motivated by the CJEU decision in the case *Ferlini*.[287] In this rather specific case, the CJEU compared the legal position of a person covered by the Joint Sickness Insurance Scheme according to the EU Staff Regulations and the legal position of an insured person in Luxemburg. It argued that higher incomes of EU officials when services are not income-dependent cannot be a valid grounds for differentiation in prices. Therefore, Mr Ferlini and the members of his family, who were affiliated to the Joint Scheme, were considered to be in a situation comparable to that of nationals affiliated to the national social security scheme. It should be noticed that Ms Ferlini, the wife of an official of the European Commission, was also residing in Luxemburg, where she gave birth.

However, it is not always possible to *compare the legal positions* of all mobile patients with that of national public patients. As national patients, also mobile patients may act as private patients, *i.e*. seeking healthcare with purely private providers, in order to avoid waiting lists and at the same time be willing to pay higher healthcare prices. Moreover, if all (public and private) mobile patients would be priced at the same scale as national public patients, only a small group of national private patients (and an even smaller group of non-EU patients, if not covered by any international agreement) would be subject to higher private prices of healthcare.

Therefore, mobile patients, *behaving* as public patients (*e.g.* adhering to waiting lists at public, including contracted private providers, in some Member States showing his or her EHIC) should be compared to national public patients and treated as such. Conversely, mobile patients behaving like private patients (also avoiding waiting lists by visiting purely private providers and paying them directly) should be compared to national private patients and treated as such.

Directive 2011/24/EU itself makes the distinction between insured persons (*i.e.* public patients) and (all) patients (who may behave as public or private patients).[288] A more practical issue may be that purely private healthcare providers will not be acquainted with public prices, since they do not apply them for national patients, and would be hesitant to calculate public prices for (private) mobile patients.

It could be argued that not the mere status of a mobile or of a national public patient, but the substance (provided healthcare) should be compared. Therefore, many Member States apply the same scale of fees for national and mobile patients, depending on their behaviour as public or private patients (*e.g*. in **CY**, **CZ**, **ES**, **FI**, **FR**, **HR**, **IE**, **IS**, **IT**, **LI**, **LV**, **LT**, **PL**, **SI**, **SE** and **UK**[289]). For instance, in **Estonia** for planned healthcare under the Directive at contracted hospitals the tariffs are the same as for domestic public patients and non-contracted hospitals are free to set the price, whereby they are not allowed to differentiate national and mobile patients. In this way (public or private) national and mobile patients are treated equally and the same (public or private) scale of fees apply to comparable groups of patients.

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[286] In Flemish *Wet houdende diverse bepalingen inzake gezondheid* and in French *Loi portant des dispositions diverses en matière de santé*), *Belgisch Staatsblad/Moniteur Belge* 29 March 2013.

[287] *Ferlini,* C-411/98, EU:C:2000:530, where the CJEU argued that the unilateral application of scales of fees for medical and hospital maternity care (to EU officials) which are higher than those applicable to residents affiliated to the national social security scheme constitutes discrimination on grounds of nationality.

[288] Article 3(b) and (h) of Directive 2011/24/EU.

[289] In the UK, patients who specify from the outset that they do wish to be treated privately may be charged in the same way as at the equivalent cost to private patients resident in England. Department of Health, Cross Border Healthcare and Patient Mobility in Europe: Information to accompany the implementation of Directive 2011/24/EU – on patients' rights in cross-border healthcare.

4.4. Supervision

Supervisory and control mechanisms are important in every Member State. They should guarantee that a free and informed choice can be made by a patient who wishes to access either public or purely private healthcare. Moreover, they should prevent excessive or unjustified charges imposed especially on mobile patients.

Therefore, not only transparency and full information is required, but also supervision, guaranteeing the proper implementation of national and EU law, is essential. Supervision of healthcare providers may be performed by *state* or *local communities'* bodies, *special agencies* and *public healthcare system* institutions (*e.g*. verifying the fulfilment of contractual obligations). For instance, in some Member States the public healthcare institution (social health insurance fund or NHS) may monitor direct payments made by the patients to contracted providers. They may even terminate a contract with private healthcare providers if they find that such provider deliberately defers treatment in order to be able to charge direct payments (*e.g*. in **LV**) or administers waiting lists and ordering of patients against the law (*e.g*. in **SI**, where also a claim for possible damages is admissible).

Supervision may be exercised by *professional bodies*. They may execute internal (within the healthcare provider itself) or external supervision (by a special medical association, like the medical chambers). Another external supervision of healthcare provision is administrative control over the legality of the businesses conducted by public and private healthcare providers. It may be exercised by the ministry of health, as a form of regular or irregular supervision. The latter can also be initiated by a patient (*e.g*. in **SI**).

Next to administrative, legal and financial supervision, *complaint procedures* and *judicial review* is available in many Member States. Mobile patients have the same complaint end review possibilities as national patients. Of course, these possibilities are only useful if they are aware of all the options. The relation between a healthcare provider and a patient may be a bit of a grey area in some Member States, regulated more by rules of professional bodies than legislative acts.

It goes without saying that *extra charges* on top of existing public tariffs or private prices for mobile patients, just because they are coming from another Member State, would clearly be against EU law. This would constitute an unlawful distinction on the grounds of nationality, if not justified on objective grounds.

Also in this case many bodies and institutions may be included in the supervisory processes, from public healthcare institutions (social health insurance funds or national health service), to ministries of health and *health inspectorates*. For instance, in **Latvia** the Health Inspectorate supervises that price lists are available at public and private providers. Moreover, in the **Slovak Republic** the failure of a provider to comply with healthcare regulations is linked to a possible fine and the provider's permission to provide healthcare may be revoked in the event of repeated infringements.

In all Member States the *same rules* have to apply to national and mobile patients. This may be formally stipulated in legislative acts (*e.g*. in **HR**). For instance, in **Poland** the law from 2014 prohibits differentiating the healthcare prices, and in **Cyprus** any form of discrimination on grounds of nationality is prohibited according to Law 149(I)2013, which covers also equal tariffs for domestic patients.[290] In **France** Articles L6112-1 and L6112-

[290] Moreover, in CY the Safeguarding and Protection of the Patients' Rights Law 2005 (*Ο Περί της Κατοχύρωσης και της Προστασίας των Δικαιωμάτων των Ασθενών Νόμος του* 2004, N. 1(I)/2005), addresses, amongst others, the prohibition of unfavourable discriminations.

5 of the Public Health Code prohibit the invoicing of extra rates for urgent hospital care, which applies to public and contracted private hospitals.[291]

Special rules may be found also in public contracts with healthcare providers (*e.g.* in **RO** and **LT**) or in special orders of the minister of health describing the rules on provision and payment of healthcare services to mobile patients (*e.g*. in **LT**). More informal guidelines and brochures were published in many Member States.

The control mechanism may also rely primarily on the patient, who may complain, and the public healthcare fund or national health service may also intervene on his or her behalf. For instance, in **Belgium** a successful complaint would lead to the reimbursement of the surplus. A similar claim is possible also in **Spain**. Moreover, systematic breaches of this rule may be followed up by the Service for Medical Control, leading to sanctions (*e.g*. in **BE**).

Moreover, supervision may be exercised via *EU mechanisms*, like SOLVIT centres or the European Commission itself, when ensuring proper implementation of the EU legislation on cross-border healthcare.

4.5. Public healthcare system costs and financing

4.5.1. Reimbursement rules for public and private healthcare provision

When cross-border healthcare is used according to Regulation (EC) 883/2004, the national public healthcare system has control over the *public healthcare budget*, since prior authorisation is normally required for such care. When the path of Directive 2011/24/EU is used, such control tends to get weaker. The national public healthcare carrier in many Member States has to negotiate a healthcare programme with national public (*i.e*. public and contracted private) healthcare providers to a smaller extent, since reservations have to be made for non-authorised healthcare (or care for which authorisation was not but would have to be issued) provided in another Member State, which has to be reimbursed by the Member State of affiliation. This may negatively influence the functioning of the national healthcare system, or higher social security contributions and taxes may have to be collected in order to maintain the same scope of healthcare in the Member State of affiliation.[292]

The condition for *reimbursement* is that the treatment is among the benefits in the Member State of affiliation.[293] The costs should be reimbursed *up to the level* that would have been assumed by the Member State of affiliation, had this healthcare been provided in its territory. A more extensive coverage of medical costs in the Member State of

[291] In FR, for planned care in hospitals who do not follow public service aims, the prohibition of extra fees for patients from another EU country is laid down in Article L174-20 of the Social Security code.

[292] See *Petru* EU:C:2014:2271, where the CJEU faced the question of why equal or equally effective healthcare cannot be provided in due time in the Member State of affiliation. The Advocate General made an interesting distinction between occasional shortages on the one hand and structural, generalised and prolonged, systemic deficiency, which was not adopted by the CJEU. One may wonder what the consequences might be. Could the quality of healthcare be reduced (would it still be equal or equally effective), or would the so-called basket of (public healthcare) benefits have to be reduced (*argumentum ad absurdum* only to provide urgent healthcare)? This has an influence on the public and private relationship, since in such case healthcare would have to be provided to a larger extent by purely private providers. The decision concerned prior authorisation according to the Regulation. According to the Directive, the question might be whether the general interest of the State would force it to limit the application of the rules in reimbursement of cross-border healthcare costs (and notify the EC, according to Article 7(9) and (11) of the Directive).

[293] Also Recital 13 of the Directive reiterates that only costs of healthcare to which a person is entitled according to the legislation of the Member State of affiliation should be reimbursed.

affiliation compared to the ones in the Member State of treatment could be required, *e.g*. if the latter had a larger co-payment regime than the State of affiliation.[294]

However, reimbursement should *not exceed the actual costs* of healthcare received,[295] which is emphasised also in all Member States. Hence, enrichment (or 'making money')[296] with the so-called *Vanbraekel supplement*,[297] which had to be paid, even when the actual costs in the Member State of treatment were lower than the reimbursement tariffs in the State of affiliation, is avoided. This has already been indicated also by the CJEU.[298]

Member States may apply *different methods of reimbursing* cross-border healthcare. Some Member States treat foreign providers as national, purely private ones. In **Austria** for instance, the right to reimbursement is linked to a system of prior authorisation. If cross-border healthcare was received with authorisation, the reimbursement is the same as for national contracted providers and if it is received without it, the reimbursement is the same as with national non-contracted providers, *i.e*. 80% of the price (due to additional administrative costs). Similarly, in **Germany** the reimbursement is according to German tariffs, but a deduction is made by social health insurance carriers for administrative costs, a lack of control of healthcare provision (*Wirtschaftlichkeitsprüfungen*) and co-payments according to German law.[299] Also in **Belgium**, foreign providers are considered to be non-conventioned, which leads to slightly lower reimbursements than for conventioned ones (this does not apply for doctors and dentists). The same applies for **Finland**, where reimbursement according to the Directive equals the one for Finnish private sector providers (and is lower than for public sector providers).

In **Switzerland**, reimbursement is made only according to Regulation (EC) No 883/2004, and if the Member State of treatment makes a distinction between public and private providers, so does the Swiss insurer for the reimbursement (*e.g*. if a person was treated in AT, DE, BE or FI). This similarly applies to **Liechtenstein**.

Some Member States reimburse the healthcare costs according to the cost that would incur in the national public healthcare system (*e.g*. in **CY**, **CZ**, **EE**, **ES**, **HR**, **IE**, **HU**, **IS**, **IT**, **LU**, **LV**, **LT**, **MT**, **PL**, **PT**, **RO**, in **SK**: average public price, in **SE**: price of a treatment in the county council where a patient is resident, and **UK**). For instance, in **France** public costs are taken into account for non-authorised treatments. For authorised treatments they may be calculated according to the tariffs of the State of treatment or French tariffs, depending on the legal path the patients choose.

Interestingly enough, in the **Netherlands** for non-contracted non-hospital care the insurance carriers are entitled to limit the amount up to a level that is considered to be reasonable according to Dutch market conditions, leaving it almost entirely up to them to decide how much they will actually reimburse. Reportedly, there was an interesting debate in the Netherlands concerning reimbursement. The Dutch legislature argued that Article 7(4) of the Directive allows limitation of the reimbursement up to the level of care offered in the Netherlands. Hence, if reimbursement of non-contracted care obtained in

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[294] An explanation of reimbursement in case of comfort requests by the patient could be found in the Appendix to the guidance note of the Commission, point II. 2.

[295] Recital 32 and Article 7(4) of Directive 2011/24/EU.

[296] HATZOPOULOS, V., HARVEY, T., Coming into line: The EU's Court softens on cross-border healthcare, Health policy, economics and law, 8, 2013, p. 1.

[297] *Vanbraekel* EU:C:2001:400. Compare with Article 26(7) of Regulation (EC) No 987/2009.

[298] *Elchinov* EU:C:2010:581, paragraph 81, as well as the operative part of the judgement (maybe not so explicit in English, but very clear in German, French and Bulgarian, which was the language of the case, *i.e.* "*jedoch nur bis zur Höhe der tatsächlichen Kosten*", "*dans la limite des frais réellement exposés*", "*но в границите на действително направените разходи*", respectively).

[299] See http://www.eu-patienten.de/, September 2016.

the Netherlands can be reduced to zero, so could reimbursement of non-contracted care received abroad. After an intense debate, and considering that the number of contracted foreign providers is still very low, the government was forced to withdraw the proposal, mainly for internal political reasons. Moreover, could it be argued that purely private healthcare is not among the benefits in the Member State of affiliation and hence treatments at purely private healthcare providers could not be reimbursed? The situation might get complicated if the treatment is within the so-called basked of benefits in the Member State of affiliation, but not in the Member State of treatment. Then it would have to be provided by purely public providers and still be reimbursed by the Member State of affiliation (*e.g*. argued for **SK**).

In some Member States not only public costs, but average costs at public and purely private providers in their country are taken into account for reimbursement purposes (*e.g*. in **SI**).[300] Interestingly, some Member States do not provide reimbursement of costs at all up to a certain minimum amount (*e.g*. **HU** up to 2,000 HUF, approximately € 6.25).

As a rule, Member States may also deduct co-payments according to their legislation. If private insurance for co-payments exist, private insurance companies may be required to reimburse the part covered by privately insured co-payments (*e.g*. in **SI**).

As a rule, *no distinction* is made in the scale of reimbursement (according to the Directive) if the healthcare provider in the Member State of treatment is public or (purely) private (*e.g*. in **AT**, **EE**, **FI**, **FR**,[301] **HR**, **IE**, **IT**, **LV**, **LT**, **MT**, **PL**, **PT**, **RO** and **SI**).

4.5.2. Private gatekeeper in another Member State?

The so called *gatekeeping function* of the general practitioner (GP) could be preserved in Member States where it is regulated, and so-called doctor hopping or doctor shopping prevented (mainly to control the costs of hospitals and clinics),[302] also according to Directive 2011/24/EU. The Directive enables the Member State of affiliation to impose the same conditions, criteria of eligibility, regulatory and administrative formalities to a cross-border patient as they apply to healthcare provision on its territory. This includes the assessment by the GP with whom the patient is registered.[303] Question is whether an insured person could choose a GP and register with him or her in another Member State, since the GP provides outpatient treatment and no formalities may be discriminatory or constitute an obstacle to the free movement of patients, services and goods.

This question is interesting also from the public or private healthcare provision aspect, since in some Member States the primary healthcare level is publicly and in many Member States predominately *privately organised*. This is even more the case if we compare the primary healthcare level to the secondary and tertiary levels, *i.e*. hospitals and clinics.

A 'family doctor' (or 'primary care practitioner' or 'GP') can be *consulted* in another Member State, but as a rule *cannot assume the public healthcare task and responsibility* of performing a gatekeeper function to secondary and tertiary healthcare. For instance, some Member States require the same conditions for cross-border healthcare as for

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[300] If reimbursement is sought under Directive 2011/24/EU, costs are reimbursed according to the average price of such healthcare in Slovenia, but not more than the actual costs. The law (*ZZVZZ*) does not limit the average price to the healthcare provided in the public network. Hence, it might be argued that in the average price both public and purely private prices are taken into account. It should be noted that such average prices are higher (more beneficial for the EU mobile patient than the average taken only from mandatory health insurance).

[301] This is the result of case law: a person insured in France has the right to be reimbursed for a treatment provided in a private UK hospital even though the treatments are not covered by UK law (Cass. soc., 28 March 2002, case 00-15.903).

[302] STRBAN, G., *Temelji obveznega zdravstvenega zavarovanja*, CZ, Ljubljana, 2005, p. 260.

[303] Article 7(7) of Directive 2011/24/EU.

healthcare delivered on their territory,[304] which is in line with the administrative formality of a gatekeeper's function. At the same time they may allow public patients to consult a GP in another Member State. For instance, in **Spain** this should be acceptable, as far as the Royal Decree 81/2014 establishes that the request for evaluation by a GP cannot be an obstacle to the freedom to provide services. Patients insured in **France** and receiving healthcare abroad do not have to comply with the French 'referring GP' procedure (possibly avoiding the gatekeeping function altogether).

Some Member States may explicitly exclude the possibility of a GP's gatekeeper function in another Member State. For instance, in **Croatia** there is a free choice of a doctor and a dentist, but as a rule only at the insured person's place of residence. In **Portugal** a GP of another Member State cannot replace the function of a professional of the Portuguese National Health Service. Moreover, in **Slovenia** the primary care level is excluded from cross-border healthcare, because a patient has to consult his or her GP first, *i.e.* always visit a gatekeeper before consulting any other physician in Slovenia or any other Member State.

Conversely, as a rule *public patients from another Member State* are not required to comply with the GP gatekeeper function in the Member State of treatment (*e.g*. explicitly mentioned as information provided by the FR national contact point).[305]

4.6. Reverse discrimination or a better legal approach?

The social security coordination Regulations apply as a rule to the public provision of healthcare, and Directive 2011/24/EU shall not affect the laws and regulations in Member States relating to the organisation and financing of healthcare in situations not related to cross-border healthcare, *i.e*. in *purely national situations*. This means that a national public patient may not be able to visit purely private healthcare providers in his or her home Member State (*i.e*. the state of affiliation or insurance),[306] but this would be possible if s/he crossed a border and received purely private healthcare in another Member State, since the Directive covers public and purely private healthcare providers.

In such a situation so-called *reverse discrimination* might occur, *i.e*. when an EU citizen finds him or herself in a purely internal legal situation of a certain Member State. Since s/he is not in a cross-border situation, s/he cannot rely on EU law (on the free movement of services) to obtain a certain benefit. Only national law of the Member State concerned could be invoked, which might turn out to be less favourable than EU law.[307]

A mobile patient relying on the Directive will have the option to choose a public or purely private healthcare provider in the Member State of treatment. Limitations in healthcare

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[304] *E.g.* the ES Royal Decree 81/2014 envisages "*the same conditions and steps are required that would have been imposed had the healthcare been delivered on Spanish territory for the corresponding healthcare services assigned*". Said steps and conditions refer basically to the GP's gatekeeper function.

[305] "*If you are insured in another EU member state or Switzerland, the provisions of French law pertaining to the healthcare pathway (appointing a primary care physician, who must be consulted before consulting a specialist) do not apply to you. You must show the (general practitioner or specialist) doctor you see your S2 certificate as proof that the healthcare pathway does not apply to you, and to make sure that you are not charged an extra fee*", http://www.cleiss.fr/particuliers/venir/soins/ue/soins-programmes_en.html (August 2016).

[306] In many Member States cooperation between public and contracted private providers exists only within the public healthcare system (and in medically urgent matters). There is hardly any cooperation between public and purely private providers as well as (public or private) providers in other Member States. Only rarely are contracts concluded with providers in another Member State (for treatments not available in the home country).

[307] VERSCHUEREN, H., Reverse Discrimination: An Unsolvable Problem, in: MINDERHOUD, P., TRIMIKLINIOTIS, N. (eds), Rethinking the free movement of workers: the European challenges ahead, Wolf Legal Publishers, Nijmegen 2009, p. 99. STRBAN, G., Social security of EU migrants – an interplay between the Union and national laws, Faculty of Law, University of Budapest, 2011, p. 91. JORENS, Y. (ed.); SPIEGEL, B. (ed.); FILLON J-C, STRBAN G., Key challenges for the social security coordination Regulations in the perspective of 2020, trESS Think Tank report 2013, p. 11, 17, 27, 50, 51.

provision, like waiting lists, may apply to public providers, but not to purely private ones. Such patient could be treated by purely private physicians, who would be directly paid by the mobile patient. However, the latter will be reimbursed by the public healthcare system in the Member State of affiliation. The patient, whose situation is limited to one Member State, might have no access to purely private healthcare providers. Such concern was voiced by several Member States.[308] Special situations might arise for pensioners.[309] Moreover, the discrimination argument may also be advanced by purely private healthcare providers, who cannot be paid or reimbursed by the public healthcare system. It cannot be ruled out that purely private providers located very close to a border would be tempted to establish themselves in the neighbouring Member State in order to provide healthcare with the possibility of reimbursement under the Directive. This could be a side effect of applying the freedom to provide services in the healthcare sector.[310]

It is true that the Directive expressly stipulates that it does not oblige a Member State to reimburse costs of healthcare provided by healthcare providers established on its own territory, if those providers are not part of the public healthcare system (*i.e*. social security system or public health system) of that Member State.[311]

However, such reverse discrimination has negative implications on the legal position of persons whose case is limited to purely internal situations, and may lead to *unjust outcomes*. The question is what the solution could be. Could it really be argued that reverse discrimination is in complete accordance with the law, *i.e*. EU law and national law of the Member States?

On the one hand, it could be argued that there is actually *no discrimination*. Similarly as in international private law, when more than one legal regime applies to a person, the most suitable one can be chosen. In the case at hand, this would be EU law. On the other hand, also the CJEU has already recognised the rights based on *EU citizenship* without any (direct) movement within the Union.[312] It could be argued that the argument of Union citizenship could be applied also to combat undesired results of reverse discrimination.

Reverse discrimination could also be against the *national* constitutional law prohibiting discrimination. The question emerges whether the legislation of the Member State tolerates a less favourable legal status for individuals compared with the one they would enjoy under EU law.[313] Since a non-discrimination provision cannot be applied alone, it has to be linked with at least one personal circumstance and one human right. For instance, it might be linked to discrimination on the grounds of property (money is required to visit purely private providers) or the health situation (with purely private providers there are no waiting lists) in relation to the right to social security or the right to (public) healthcare.

Although the Directive is *de iure* not concerned with purely internal legal situations, it may *de facto* influence them. Some national public healthcare systems would have to

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[308] *E.g*. the Italian delegation underlined an issue regarding private care providers. The Directive covers privately provided healthcare. However, if patients receive care from a domestic private provider without a cross-border element, they cannot be reimbursed, which is controversial. Minutes of the Working Party of the Administrative Commission, A.C. 532/14REV, Brussels 9 October 2014, EMPL/-2261/14 – EN, p. 9.

[309] *E.g*., could a pensioner resident in Member State B, covered by Member State A, be treated in the latter by purely private providers due to cross-border movement, although there is no such possibility for persons insured and resident in Member State A?

[310] CARRASCOSA BERMEJO, D., ERA Forum (2014) 15/3, p. 366.

[311] Article 1, paragraph 4 of Directive 2011/24/EU.

[312] *Zambrano,* C-34/09, EU:C:2011:124; also *Government of the French Community and the Walloon Government v The Flemish Government*, C-212/06, EU:C:2008:178.

[313] EICHENHOFER, E., Application of the Coordination Regulation in the context of Decentralisation and Regionalisation in matters of Social Security, in: Y. JORENS (ed.), 50 years of Social Security Coordination, Past-Present-Future, EU 2010, p. 84.

provide benefits in kind and at the same time they might have to *extend the reimbursement of costs rules*, enabling also medical treatment by a non-contracted (purely private) healthcare provider also in purely national situations. The question is, could the reimbursement of purely private providers (in the home Member State and in the Member State of treatment) be set at zero (as proposed in the **NL**). Could it be limited to 10, 20, 30 or 80% (as in **AT** and **DE** and some other Member States providing lower reimbursement for healthcare provided by purely private providers)?

National health policy should not only be concerned with technical rules of reimbursement of costs. Their main concern should be equal (and equitable)[314] access to high quality and sustainable healthcare for all.[315] For some Member States it is argued that quality control of purely private providers is more difficult to ensure than of contracted private providers.

Could the solution be to *modify EU law* instead, the Directive and possibly the TFEU? The question might be whether it really has the power to change the substance of national public healthcare systems and in a way harmonise, not just coordinate them.

[314] Article 3 of the Convention on Human Rights and Biomedicine. STRBAN, G., Cost sharing for Health and Long-term Care Benefits in Kind, MISSOC Analysis 2014/1, p. 9.

[315] Communication from the Commission, Working together, working better: A new framework for the open coordination of social protection and inclusion policies in the European Union, COM(2005) 706 final, Brussels, 22.12.2005, reinforced in 2008 by the Communication from the Commission, A renewed commitment to social Europe: Reinforcing the Open Method of Coordination for Social Protection and Social Inclusion, COM(2008) 418 final, Brussels, 2.7.2008.

5. INFORMATION ON CROSS-BORDER HEALTHCARE

When empowering patients, information is the key. In the internet era, people get tons of information each day. Thus, it is of utmost importance to provide them with clear, easily accessible, understandable, up-to-date and accurate information. In the Member States various actors are involved in information spreading practices and a big variety of means of information-sharing is used, both of an online and offline nature.

5.1. Information flows

Reportedly, patients in the different Member States can rely on various information sources when investigating cross-border healthcare issues. Although each Member State had to establish a National Contact Point and healthcare providers are obliged to provide certain information, patients have preferences when it comes to collecting cross-border healthcare information.

Preferred sources of information on cross-border healthcare

Competent healthcare institutions	AT, BE, CH, CY, DK, EE, EL, FI, FR, HR, HU, IS, IT, LI, LT, LU, LV, MT, NL, PL, PT, SK, UK
National Contact Point(s)	AT, BE, BG, CY, CZ, DE, DK, EE, EL, ES, FI, FR, HR, HU, IE, IS, IT, LT, LU, LV, MT, NL, NO, PL, PT, RO, SE, SI, SK, UK
Healthcare providers	EE, IE, LV
NGOs	RO

Since obtaining cross-border healthcare is a multi-player situation, different information flows can be identified between the parties involved, namely (1) information from the healthcare authorities[316] – for the patients and the healthcare providers; (2) information from the healthcare providers for the patients and the healthcare authorities; and (3) information from the patients – for the healthcare providers and the healthcare authorities.

(1) *National healthcare authorities* – irrespective of how the healthcare system is organised in the Member State concerned – are the most traditional sources of information when it comes to healthcare rights, entitlements and conditions attached to them. They have the required knowledge both concerning legislative background and concerning daily practice. They are often even involved in one way or another in the legislative procedures. Thus, they are very well-positioned to offer expert advice to patients in cross-border healthcare situations and to inform healthcare providers on their duties in such cases.

In the framework of the principle of good administration, the coordination Regulations provide rules on the Member States' information obligations. According to these rules, the healthcare authorities are required to respond to all queries within a reasonable period of time and provide the persons concerned with any information required for exercising the rights conferred on them by the coordination Regulations.[317] The Regulations do not specify what 'reasonable time span' means in this respect. The question can be raised whether a deadline could be inserted into the Regulations stipulating that all queries must be answered within – for example – five working days

[316] Including ministries, healthcare institutions and National Contact Points.

[317] Article 76(4) of Regulation (EC) No 883/2004. See also Article 3(1) of Regulation (EC) No 987/2009.

unless a longer time span is justified by the special nature of the question (*e.g*. if advice from an expert has to be sought in order to answer).

It must be noted, though, that these authorities, healthcare funds, health insurers – besides taking into account the patients' interests – have financial concerns too: while patients want to benefit from the most favourable situation possible, the national healthcare authorities have to balance between the interest of the patient and of the national healthcare system itself. Consequently, they might tend to encourage patients to opt for the alternative which is more economical for the state. Moreover, the Regulations oblige the Member States to inform patients only about their rights under the Regulations, so – in theory – they can comply with this obligation without even mentioning that alternatives do exist also outside the scope of the Regulations.

The Directive did create special bodies responsible for providing information for patients in relation to cross-border healthcare: the National Contact points (NCPs). Their very existence is a great achievement and an added value of the Directive. They are neutral sources of reliable, transparent and easily accessible information on cross-border healthcare issues. Since they are created to carry out this specific task, it can be rightfully expected that the persons working at the NCPs can answer most of the patients' relevant questions related to cross-border treatments, and in case they cannot, that they have the competence to find the answer quickly through their professional network of NCPs in other Member States, healthcare providers, healthcare authorities and other organisations. Whether this is the case remains uncertain. Therefore, it is highly important that the NCPs work closely together both with the European and national institutions involved and with each other.

The Directive precisely determines the scope of information which has to be communicated to the patients and clearly splits the responsibility between the Member State of affiliation and the Member State of treatment. Whereas the Member State of affiliation is obliged to provide information on the patients' rights and entitlements under its national legislation,[318] the Member State of treatment is obliged to provide information on the standards and guidelines on quality and safety laid down by this Member State.[319]

Reportedly, national authorities often receive inquiries not only from patients but also from healthcare providers in relation to cross-border healthcare. Since – as mentioned above – national authorities have the required expertise on these – mostly legal – issues, they shall cooperate with the healthcare providers and inform them on all relevant aspects. Thematised seminars, webpages designed for healthcare professionals or a hotline for providers are possible good practices.

(2) Although patients might trust *healthcare providers* the most – as they usually have direct, face-to-face contact with them – and expect the information primarily from them,[320] they are often neither trained nor willing to function as a source of non-medical information. The Directive, however, confers a specific obligation on them as well: they have to provide individual patients with all relevant information to help them make an informed choice, including information on treatment options, on the availability, quality and safety of the healthcare they provide in that state, on prices, as well as on their authorisation or registration status, their insurance cover or other means of personal or

[318] Article 5(b) of Directive 2011/24/EU.

[319] Article 4(2)(a) of Directive 2011/24/EU.

[320] European Commission – Eurobarometer (2003): European Union citizens and sources of information about health. http://ec.europa.eu/public_opinion/archives/ebs/ebs_179_en.pdf (16 September 2013), p. 5.

collective protection with regard to professional liability.[321] One may wonder though whether healthcare providers are prepared to fulfil these obligations.[322]

Training opportunities should be offered for healthcare professionals and for other staff members of healthcare providers to enable them to provide patients with the information required. At the same time, national healthcare authorities – in cooperation with the European Commission – should develop a monitoring system to ensure that all the obliged parties fulfil their information obligations.

Healthcare providers do not only need to provide information for patients, they have to communicate financial information (and other relevant information related to the specific healthcare provision in question) to the national healthcare authorities in order to receive reimbursement for the costs of the treatment provided for a foreign patient under the coordination regime.

(3) Certain information has to be provided by the *patients* as well: they have to provide information on their entitlements for healthcare providers by presenting proof (usually an EHIC, PRC, PD S2, authorisation under the Directive or a medical referral in lack of an authorisation where applicable) and to communicate financial information (and other relevant information related to the specific healthcare provision in question) to the national healthcare authorities in order to receive reimbursement for the costs of the treatment received from a foreign provider under the Directive's regime (and also under the coordination regime in the case of reimbursement systems where the patients are invited to pay the costs of the treatment on the spot).

Normally, this latter information provision takes the form of an invoice. Patients are required to hand in the original invoices and other relevant medical documentation. Reportedly, some Member States insist on official translations of these documents which might cause considerable costs for the patients and the exact content of the invoices are also not always clear. The Directive obliges the healthcare providers to issue clear invoices[323] and the Member States to cooperate in order to clarify the content of invoices.[324]

Nevertheless, the difficulties related to unclear invoices and different invoicing methods could be significantly reduced by introducing a standardised European invoice, the form of which would be the same in each Member State just like the Portable Documents used under the Regulation regime.

[321] Article 4(2)(b) of Directive 2011/24/EU.

[322] See also JELFS, E. and BAETEN, R., Simulation on the EU Cross-border Care Directive, 2011. http://www.ose.be/files/publication/2012/CrossBorderHealthcareSimulation_FinalRep_09052012.pdf, p. 21.

[323] Article 4(2)(b) of Directive 2011/24/EU.

[324] Article 10(1) of Directive 2011/24/EU.

Sources of information on cross-border healthcare

FROM / TO	Healthcare authorities	Healthcare providers	Patients
Healthcare authorities	Cooperation with other healthcare authorities within the country and in other Member States	Financial information related to reimbursement under the Regulation	Financial information related to reimbursement under the Directive
Healthcare providers	Information on different aspects of cross-border healthcare provision, especially on their obligations	Not mentioned by the Regulation or the Directive, but existing: professional organisations at national level and at EU level (*e.g.* Standing Committee of European Doctors - CPME, European Hospital and Healthcare Federation – HOPE)	Presenting proof of entitlement, such as an EHIC, PRC, PD S2, authorisation under the Directive or a medical referral in lack of an authorisation where applicable
Patients	Information on different aspects of cross-border healthcare provision, especially on their rights and entitlements	Relevant information to help patients to make an informed choice	Not mentioned by the Regulation or the Directive, but existing: patient organisations, NGOs at national and EU level (*e.g.* European Patients' Forum)

5.2. The form and means of the information

Information is shared in various forms: some ways of sharing information are more traditional (*e.g.* leaflets, personal or phone consultation) or more widely used (*e.g.* websites), whereas others (*e.g.* smart phone applications) are rather new and progressive setting an example for other countries to follow.

Means of spreading information on cross-border healthcare reportedly used in different Member States

Website of ministry of health	AT, CY, IT, MT, PT, SK
Website of competent healthcare institutions	AT, BE, CH, DK, EE, EL, FI, FR, HR, HU, IS, IT, LI, LT, LV, MT, NL, PL, PT, SK, UK
Website of National Contact Point(s)	AT, BE, BG, CY, CZ, DE, DK, EE, EL, ES, FI, FR, HR, HU, IE, IT, LT, LU, MT, NL, PL, RO, SE, SI, SK, UK
E-mail	CY, DE, ES, HR, HU, SI
Phone	CY, DE, ES, FI, HR, HU, LV, MT, PL, SI, SK
Smartphone application	CZ
Mass media	LT
Personal consultation	CY, DE, ES, FI, HU, LV, MT, SI, SK
Leaflets / information letter / posters	HU, IT, LT, LU, MT, PL, RO, SI
Videos	PL
Thematised seminars	MT
E-learning course	PL

5.3. Content of the information

It is essential that both the content and the form of the information are appropriate.

It is reported that in several Member States (*e.g.* **ES** – in some regions – or **LI**) information is not only hard to find but also too general to get all the details a patient intending to receive healthcare abroad might need. NCPs have a unique role and a great potential which should be used more effectively in some Member States. It should be investigated how the development of the network of the NCPs can be facilitated by the Union, for instance via standardising the content of their websites, training their staff on EU level or connecting the national entities by a European one. It can be seen as a good practice that certain meetings and workshops involving communication and social security experts from national ministries and institutions and from the European Commission have been taking place with the aim of focusing on how to better coordinate EU communication actions with those of the Member States, by creating synergies, avoiding overlaps and filling gaps.[325]

Besides, some Member States do not provide information in English or the information provided in English is not of the same value (*e.g.* **Portugal**). Although Member States are not obliged to share information in any other languages than their own, in practice, it would be very useful to have these contents in the most widely used language in Europe. This would also allow the patient to compare the possibilities and circumstances offered in the different Member States.

It is very important that patients receive comprehensive information all at once. Thus, it is worth considering to standardise the content of the websites of the NCPs and to

[325] http://ec.europa.eu/social/main.jsp?catId=849&langId=en&eventsId=552&furtherEvents=yes.

require that – besides their national language – they provide the same value of information also (at least) in English. Moreover, since the European Commission's EHIC application became rather popular and proved to be useful in unplanned cross-border healthcare situations, a similar smartphone application could be developed also for other cross-border healthcare rights related to planned care.

6. CONCLUSIONS

Access to cross-border healthcare has become *more complex* due to the constant development of national healthcare systems, including the mixture of public and private providers of healthcare, and developments in EU law, especially as a result of CJEU case law and its codification in Directive 2011/24/EU on the application of patients' rights in cross-border healthcare. A mobile patient is confronted with the complexity of healthcare systems, in which many legal relations are established (*e.g*. between a public patient and a public healthcare institution, the State and/or local or regional communities, and public or private healthcare providers) and various legal paths to access healthcare in another Member State are available. Among these paths are the coordination Regulations, the Cross-border healthcare Directive 2011/24/EU, the Residence Directive 2004/38/EU (with the requirement of comprehensive sickness coverage), the Free Movement of Workers Regulation (EU) No 492/2011 (as some benefits might be social advantages), and the Treaties, all subject to interpretation by the CJEU. Next to this there are possibilities under national law and bilateral agreements between certain Member States, which are important mainly in regional cross-border cooperation. All this taken into account, it should not be forgotten that distinctive rules apply for unplanned and planned cross-border healthcare. Mobile patients might perceive such complexity as a 'healthcare jungle', in a field that is already (also in a purely national setting) characterised by information asymmetry (usually to the detriment of the patient).

It is argued that clear information should be available for various possibilities of *affiliation* of EU mobile citizens (including students, pensioners and frontier workers) to the healthcare schemes of the Member States, where the complexity of the system or the lack of information regarding the process of affiliation can pose a problem (although not many problems were reported, but such generalisation is of no use to a mobile patient facing a specific problem). The solution could be that healthcare systems are fine-tuned and that there are no gaps in health coverage. But even if there are gaps, they should be solved to the benefit of mobile persons, as the Belgian example of administrative practice shows. The complexity of national procedures to affiliate to the healthcare schemes of the Member States should be screened and best practices to facilitate access to healthcare should be shared among the Member States with the support of the European Commission.

It should, however, be emphasised that the affiliation of economically active mobile EU citizens is reportedly a rather unproblematic area, both in contribution-based and in residence-based systems. The way national healthcare systems are financed does not seem to play an obstructing role either. In that regard it is not surprising that, regardless of coordination provisions facilitating cross-border access to healthcare, Member States have generally not introduced specific national measures to facilitate mobile EU citizens' access.

In contrast, access for non-active EU citizens appears to be less unproblematic, as the grey area in EU legislation is larger. In that regard, more unified information and an EU-wide clarification of the "*comprehensive sickness coverage*" condition under Directive 2004/38/EC would be required. The relationship between the comprehensive sickness requirement and sickness benefits coordination would be necessary in order to avoid different (narrower or broader) interpretations by the CJEU (as is the case with the sufficient resources requirement for non-active persons). Moreover, the different concepts of residence in the Regulations and in the Directive cause problems. For instance, if a person stays in another Member State for more than three months, s/he has to register as a resident. To that end, s/he needs comprehensive sickness insurance cover. It needs to be clarified which role healthcare entitlements based on EU social security coordination can play in that regard, certainly after recent CJEU case law which seems to confirm the deep impact of legal residence on the EU coordination framework.

More information would also be required on possibilities to receive *unplanned* or *planned* treatment in another Member State, be it at public or private healthcare providers.

However, merely providing complete, clear and easily accessible information is not enough. Certain *legal questions* remain unanswered and they have to be solved by legal action. The distinction between unplanned and planned care remains controversial. Both its existence under the Regulation's regime and its lack under the Directive's regime lead to certain concerns. The fraudulent use of administrative procedures under the Regulations must be closely monitored and preferably prevented, and if the parallel application of the two tools continues, it would be desirable to expressly codify into the Directive that the reimbursement of costs of medical services which become necessary during a temporary stay abroad (*e.g*. unplanned hospital treatment) cannot be made dependent on a prior authorisation of any kind. Otherwise, problems with the application of the Directive to unplanned treatment would continue. The question is whether the application of the Directive to unplanned care was actually the intention of the legislation and whether the application only to planned treatment and a proper interpretation of the existing rules would not solve many problems.

A solution would be to introduce clear rules on unplanned and planned treatment in a single legislative instrument. If this is not feasible, clarifying and additional rules in the Directive, also better regulating the interaction with the Regulation would be necessary. Moreover, the Regulation might be amended as well. The notion of unplanned healthcare under the Regulation is based on undefined legal concepts such as "*temporary stay*" or "*necessary treatment*" with 'chronic' interpretation problems. The implementing Regulation, the AC Decisions and Recommendations and the CJEU have tried to clarify this blurred legal outline that sometimes makes it difficult to determine which situation the mobile person is in, and more importantly, which Member State has to bear the healthcare costs and to what extent. Healthcare providers might even be tempted to reduce the scope of medically necessary treatments rejecting the usage of the EHIC and demanding upfront direct payments by mobile patients.

Not only amendments, but also the consolidation of certain legal rules would be appropriate. For instance, some provisions of the implementing Regulation, especially Articles 25(B)(6) and 25(B)(7), should be scrutinised and clarified by the Administrative Commission. They could even be repealed by the EU legislature considering the existence of the Directive. The same goes for Annex III of Regulation (EC) No 883/2004. Also Article 7(2)(b) of the Directive is far from clear and would require legal clarification, also with respect to access to purely private healthcare providers in the Member State that is "*in the end, responsible for reimbursement of the costs*". The existence of the so-called *Vanbraekel* supplement in the implementing Regulation might be questioned.

Concerning planned cross-border healthcare it is worth considering the possibility to introduce EU-wide maximum waiting times concerning certain treatments and waiting time guarantee which allows the patient to obtain the treatment abroad in the event that it cannot be provided in the competent Member State within this waiting time, although for now the EU lacks competence to adopt harmonising measures in the field of social security. Similarly, the introduction of a European maximum processing time together with the automatic authorisation rule would strengthen the patients' legal position and grant them the certainty to receive a reply to their request within a reasonable time. The question can be raised whether a deadline could be inserted into the Regulations stipulating that all queries must be answered within – for example – five working days unless a longer time span is justified by the special nature of the question (*e.g*. if advice from an expert has to be sought in order to answer).

It is desirable to precisely determine which treatment does fall into the category of healthcare subject to prior authorisation under the Directive's regime. This categorisation shall be made by the Member State of affiliation and shall not be dependent on the Member State of treatment or on the way the treatment is provided in that Member State.

The difficulties related to unclear invoices and different invoicing methods could be significantly reduced by introducing a standardised European invoice, the form of which would be the same in each Member State just like the Portable Documents used under the Regulations' regime.

Moreover, purely national rules have to be taken into account. There should be a clear rule that if the national legislation grants wider protection than the EU legal routes, it shall be of preferential application also in cross-border situations between Member States. This would be an emanation of the co-called *Petroni* principle, which would be stretched from the fields of pensions and family benefits to the field of cross-border healthcare.

The mixture of *public* and contracted private providers on one side, and *purely private* providers on the other poses a particular problem, especially for mobile patients who at a certain point act as private consumers of healthcare services and goods, although they are in the period before and after that acting as public patients (with possible period authorisation and certainly when requesting reimbursement of healthcare costs in the home Member State).

There is a tendency to treat mobile patients as private patients, with no waiting lists, but with higher fees, which have to be paid directly. The burden of requesting *ex post* reimbursement of costs is shifted to private patients. Such steering of mobile patients might deprive them of their rights and is against national and EU law on the prohibition of (*de facto*) discrimination if not justified on objective grounds. Therefore, not only proper information, but also strict supervisory/complaint/review mechanisms have to be installed, with possibilities of terminating the contractual relation with the public healthcare provider, if the situation of a mobile patient was abused. The will, expressly stated or emanating from mobile patients' behaviour should be decisive in whether s/he should be treated as a public or as a private patient.

Also reimbursement rules should be unified and reverse discrimination of national patients prevented. It could be argued that the instruments enabling cross-border healthcare aim primarily at equal treatment of mobile patients with national patients. However, national patients might have no access to purely private healthcare providers on the account of the public healthcare system. The EU cannot disregard this, since the situation of (mainly) Union citizens is concerned. It might be difficult to argue that the Directive does not apply to purely private providers and that a basket of benefits is only public. However, Member States have the possibility to determine the reimbursement rate of costs incurred at purely private providers, equally in national as well as in cross-border situations. The related question might be how low a Member State can go? At the same time a good practice may be to offer a patient extended free choice (like in Denmark) in a home country, if the required medical treatment is not available in due time.

In order to make a truly *free and informed choice*, unified and transparent *information* has to be provided. It is not enough that each Member State provides more or less complete (or more or less piecemeal) information applying all or some modern communication tools. The legal duty of institutions and healthcare providers to provide relevant information is regulated in implementing Regulation (EC) No 987/2009 (Article 22(1)) and Directive 2011/24/EU (Article 4(2)(b)).

It is highly important that the National Contact Points work closely together both with the European and national institutions involved and with each other. It could be suggested that information is provided EU-wide, in a uniform manner, and that it is easily accessible (also language-wise) to the patients. Establishing an EU contact point for cross-border healthcare may be worth considering.

Thematised seminars, webpages designed for healthcare professionals or a hotline for providers are possible good practices to educate healthcare providers to make sure they can fulfil their information obligations under the European cross-border healthcare

legislation. Training opportunities should be offered for healthcare professionals and for other staff members of healthcare providers to enable them to provide patients with the information required. At the same time, national healthcare authorities – in cooperation with the European Commission – should develop a monitoring system to ensure that all the obliged parties fulfil their information obligations.

As long as a single EU website is not established, the content of the websites of the National Contact Points should be standardised and – in addition to their national language – should provide the same value of information also in other languages (and at least in English). Moreover, since the European Commission's EHIC application became rather popular and proved to be useful in unplanned cross-border healthcare situations, a similar smartphone application could be developed also for other cross-border healthcare rights related to planned care.

We may conclude with the statement that all legal rules pertaining to cross-border healthcare and their interpretation should be to the *benefit of mobile and national patients*. Access to (cross-border) healthcare has to encompass not only geographical access, but also timely access (which is sometimes lacking in the home country), financial access (which may pose problems if costs of healthcare have to be advanced by the patient, who might not be fully reimbursed), informational access (which is seriously lacking in cross-border healthcare) and procedural access (regarding the steps needed to be taken in order to receive healthcare in another Member State). Next to these forms, access has to be equitable, meaning that all mobile patients should have equal access to cross-border healthcare of the highest quality. At the same time, based on EU citizenship, the same should apply to patients who are (for one reason or other) not moving within the EU.

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